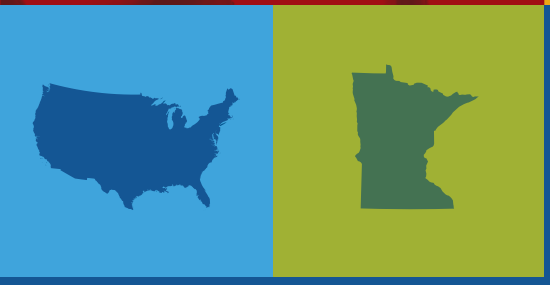
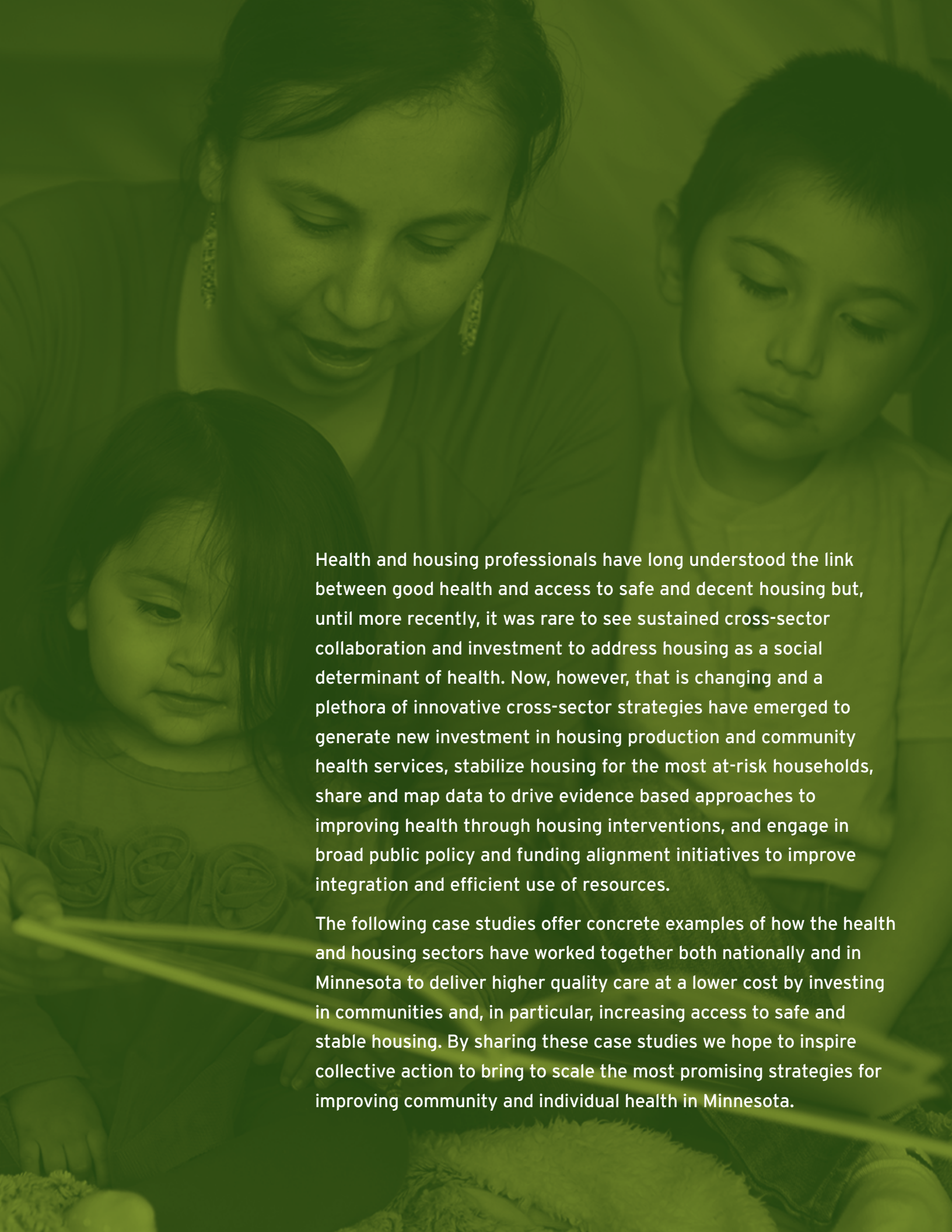
GREATER MINNESOTA HOUSING FUND



HEALTH & HOUSING CASE STUDIES



Health and housing professionals have long understood the link between good health and access to safe and decent housing but, until more recently, it was rare to see sustained cross-sector collaboration and investment to address housing as a social determinant of health. Now, however, that is changing and a plethora of innovative cross-sector strategies have emerged to generate new investment in housing production and community health services, stabilize housing for the most at-risk households, share and map data to drive evidence based approaches to improving health through housing interventions, and engage in broad public policy and funding alignment initiatives to improve integration and efficient use of resources.

The following case studies offer concrete examples of how the health and housing sectors have worked together both nationally and in Minnesota to deliver higher quality care at a lower cost by investing in communities and, in particular, increasing access to safe and stable housing. By sharing these case studies we hope to inspire collective action to bring to scale the most promising strategies for improving community and individual health in Minnesota.

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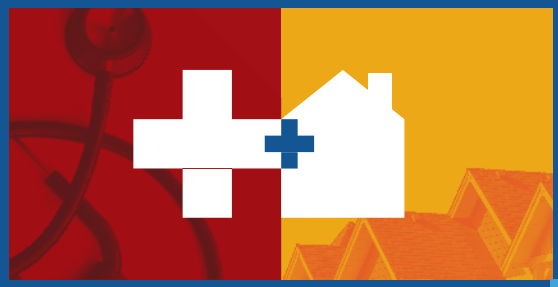
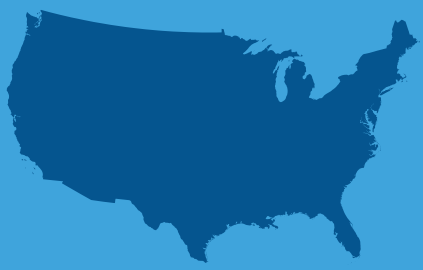


NATIONAL HEALTH & HOUSING CASE STUDIES



National Case Study

Chicanos Por La Causa - UnitedHealthcare My Connections™

Anchor Institution Housing Investments Reduce Medicaid Costs

PROJECT PARTNERS:
UNITEDHEALTHCARE, CHICANOS POR LA CAUSA, SAINT JOSEPH THE WORKER, DRESS FOR SUCCESS, SAINT MARY'S FOOD BANK

TIMETABLE:
2011 TO PRESENT

OVERVIEW

UnitedHealthcare (UHC) which acts as a for-profit Medicaid managed care organization—and is also America's largest health insurer—provided a $21 million dollar low-interest loan to Chicanos Por La Causa (CPLC), an established Phoenix-based community development corporation (CDC), which owns and operates affordable housing and community clinics, to purchase and renovate two apartment complexes as part of its housing and services model targeting high-cost Medicaid patients. This innovative health and housing model addressed CPLC's lack of funding for affordable housing preservation and the need to reduce high insurance costs for frequent hospital users lacking adequate access to primary health care services. By early 2020, CPLC and UHC expect to house 350 homeless patients whose combined annual healthcare expenses—when living unsheltered on the streets—exceeds $17 million. The UHC investments are expected to result in a 3-5 percent health care cost savings.

KEY PROGRAM COMPONENTS

- ### Health Sector Investment in Housing Rehabilitation
  UnitedHealthcare provided a $21 million low-interest loan to Chicanos Por La Causa (CPLC), a community development corporation, to purchase and renovate two apartment complexes that included 499 housing units. As a result of the loan, CPLC was able to complete renovations within budget and keep tenants housed in the buildings during the renovation. The housing rehabilitation included extensive interior and exterior upgrades.

- ### Rent Subsidies Enhanced Affordability and Housing Stability
  UnitedHealthcare's investment also provided the project with rental subsidy. Up to 100 units (20 percent of the project's total) are set aside for UHC clients who are high-frequency users of emergency room services. UHC selects the tenants for these set-aside units from the pool of members who belong to its Medicaid plan and other health plans. Although it costs $1,200 to $1,800 a month to house each patient, referred UHC clients pay rents that are approximately 50 percent less than market-rate rents. The remaining rental units are affordable to lower-income households at or below 60 percent annual median income [AMI]).

- ### Targeted On-Site Supportive Services to Promote Improved Health
  UnitedHealthcare members who live in the CPLC housing have access to UHC MyConnections™ health services and on-site health navigators who help them to meet their healthcare needs by providing a myriad of supports, including counseling and transportation. In addition, they have access to other supportive services through MyCommunity Connect™ Clinic and Center located within the nearby Maryvale Community Center. The MyCommunity Connect™ Center services include clinical care, social service supports, nutrition programs, a wellness rewards program and workforce development training — all made possible by investments from UHC.

National Case Study

CHICANOS POR LA CAUSA - MY CONNECTIONS™

Anchor Institution Housing Investments Reduce Medicaid Costs

Goal & Purpose	Make targeted investments that create stable, affordable housing to stabilize health conditions and reduce hospital use.
Strategy	Leverage investments by anchor institutions to provide needed rehabilitation to existing housing to ensure safe and healthy living conditions for residents while maintaining rent affordability to promote housing stability.
Health & Human Service Partners	UnitedHealthcare (clinical care, wellness rewards program), Saint Mary's Food Bank (food pantry and nutrition program) Saint Joseph the Worker, and Dress for Success (workforce development).
Housing Partners	Chicanos Por La Causa (housing development)
Target Population	Medicaid patients who are high-frequency users of emergency room services and who are homeless or at-risk.
Geography Served	Maryvale neighborhood in Phoenix, Arizona
Funding Sources	**Private loans and investments, federal grants, nonprofit program funds and LIHTC:** Housing and Urban Development Neighborhood Stabilization Program Grant, Low-Income Housing Tax Credit Program, UnitedHealthcare, and USDA Supplemental Nutrition Program.
Timeframe	Development for MyConnections™ began with the MyConnect™ Center in 2011; housing renovation followed in 2016.
Key Outcomes	Early findings from the MyConnections™ pilot indicate a reduction in inappropriate hospitalizations and that some patients have reduced their monthly Medicaid costs by as much as 80 percent.
Lessons for Replication	• Significant private investment by health insurer helps accelerate the pace of production. • Targeted tenant selection helps drive ROI. UnitedHealthcare (UHC) selects tenants from the pool of members who belong to its Medicaid plan and other health plans. UHC targets patients whose annual healthcare costs exceed $50,000 and who want to participate in all components of the program. • Funding access to on-site health navigators improves outcomes. • A range of incomes can be served by mixing units with project-based rent subsidies with other units priced affordably for households without rent assistance whose incomes are at or below 60 percent AMI.

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National Case Study

Boston Road

Public Policy & Funding Alignment Directs Medicaid Savings to Housing

PROJECT PARTNERS:
NEW YORK STATE DEPARTMENT OF HEALTH, BREAKING GROUND, NEW YORK CITY DEPARTMENT OF HOMELESS SERVICES, SERVICES FOR THE UNDERSERVED

TIMETABLE:
2012 TO PRESENT

OVERVIEW

The New York Medicaid Redesign Team (MRT) formed in 2011 to improve patient health outcomes, streamline processes, and reduce program costs. One of the initiatives that resulted from the MRT team's efforts was their Supportive Housing initiative, which uses Medicaid savings to fund new construction of supportive housing, pilot test new models of care, and provide rental subsidy to high-cost Medicaid recipients.

One example of MRT's supportive housing developments is the Boston Road permanent supportive housing facility, which provides affordable housing and supportive services to formerly homeless adults in the Bronx, including individuals with special needs and those living with HIV/AIDS. The 12-story building includes 154 residential units, community space, and office space. This model addresses the lack of funding for new affordable housing supply and the need to reduce high insurance costs that result from frequent hospital users.

KEY PROGRAM COMPONENTS

- ### Medicaid Redesign Provided Capital *for Housing Development*

  Boston Road was developed by nonprofit developer Breaking Ground, which owns and manages over 3,500 housing units in New York and Connecticut. Financing for the development included a *$6.3-million-dollar capital grant from the Medicaid Redesign Team,* $18.5 million in Low-Income Housing Tax Credit equity, $5.9 million in bonds issued by the New York State's housing finance agency, $10.2 million in loans from New York City's Department of Housing and Preservation Development, $3.7 million from the State's Homeless Housing and Assistance Program fund, and $3.35 million in developer fees deferred by Breaking Ground.

- ### Layering Federal *Rent Subsidies Enhanced Affordability*

  Boston Road includes 154 units of subsidized, affordable housing (including 94 apartments for formerly homeless individuals and 60 apartments for low-income individuals who have earned income from employment). Several public investments made by federal and local government provide rental subsidy for Boston Road tenants, who pay no more than 30 percent of their income for rent. Funding sources include: Low-Income Housing Tax Credits (LIHTC), tax-exempt bonds, Housing Choice Vouchers, and Medicaid dollars.

- ### Supportive Services Included *Clinical Case Management and On-Site Nursing*

  Services for the Underserved (SUS) provide clinical case management for residents and an on-site nurse who helps residents manage their comprehensive care needs. Breaking Ground, SUS, and other local services organizations work together to provide other service offerings including sliding-scale veterinary treatment; meal preparation, budgeting and resume workshops; and organized recreational activities such as field trips, holiday parties, and movie nights.

National Case Study

Boston Road

PUBLIC POLICY & FUNDING ALIGNMENT DIRECTS MEDICAID SAVINGS TO HOUSING

Goal & Purpose	Provide stable housing with the goals of reduced Medicaid expenditures, improved patient health outcomes, increased Olmstead compliance, and reduced homelessness.
Strategy	Public Policy & Funding Realignment to allow leverage of Medicaid dollars to increase production of new Permanent Supportive Housing, test new models of care, and provide rent subsidies for high-cost Medicaid recipients.
Health & Human Service Partners	**New York State Department Health**—Bureau of Social Determinants of Health (development financing), **Services for the Underserved** (supportive services), and local service organizations.
Housing Partners	**Breaking Ground** (housing development and housing property management) and **New York City Department of Homeless Services** (housing referrals).
Target Population	Low-income adults with multiple serious health conditions who are Medicaid beneficiaries and are formerly homeless or at-risk. Many have special needs or are living with HIV/AIDS.
Geography Served	Bronx, New York
Funding Sources	**Long-term government bonds, LIHTC, loans, capital grants, program grants and deferred developer fees:** Breaking Ground, Homes and Community Renewal (New York State housing finance agency), Low Income Housing Tax Credit Program, and New York City Department of Housing Preservation and Development, New York State Medicaid Program, New York State Office of Temporary and Disability Assistance Homeless Housing and Assistance Program (HHAP).
Timeframe	The New York Medicaid Redesign Team formed in 2011. Operations for their supportive housing initiative began in 2012. Construction of Boston Road began in 2013; the project opened in 2016.
Key Outcomes	Averaged outcomes across all MRT supportive housing initiatives include reducing overall Medicaid expenditures by 15 percent with a reported average savings of $37,500 per individual annually, a 40 percent reduction in inpatient stays, a 26 percent reduction in emergency room visits, a 44 percent reduction in inpatient rehabilitation admissions, a 27 percent reduction in inpatient psychiatric admissions, and a 29 percent increase in care coordination after housing enrollment.
Lessons for Replication	CMS approved an amendment to New York's existing Section 1115 waiver allowing the state to reinvest $8B of federal savings generated by MRT reforms. New York used a portion of these funds to finance supportive housing development in the form of a capital grant.

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National Case Study

Dignity Health Community Investment Program

Investment Fund Strategy to Address Social Determinants of Health

PROJECT PARTNERS:
DIGNITY HEALTH, COMMUITY DEVELOPMENT FINANCIAL INSITUTIONS, CREDIT UNIONS, HEALTHCARE CLINICS, HOUSING PROVIDERS, NONPROFIT COMMUNITY ORGANIZATIONS AND BUSINESSES

TIMETABLE:
1991 TO PRESENT

OVERVIEW

Dignity Health is the fifth largest healthcare system in the United States, including 39 hospitals in California, Arizona, and Nevada. Dignity Health's care network includes over 60,000 providers in 21 states.

Rooted in a Catholic, social justice background, Dignity Health administers a Community Investment Program that includes loans, grants, lines of credit, and financial investments aimed at increasing access to capital and improving social determinants of health in underserved communities.

The program is funded by hospital reserves. Each year, the Dignity Health board approves up to five percent of its total investable assets for community investments—approximately $100 million dollars, annually.

Investments have included the development of permanent supportive, transitional, and respite care housing; support for clinics to become Federally Qualified Healthcare Centers (FQHCs); rehabilitation of foreclosed single-family homes, commercial loans; and more.

KEY PROGRAM COMPONENTS

- ### Community Investment Loans to Local Nonprofit Organizations and Businesses

  Dignity Health's community investment fund provides secured and unsecured direct loans and lines of credit to community nonprofit organizations and businesses, including pre-development loans. Loan amounts range from $50,000 to $5 million; loan terms range from one to seven years; and interest rates range from zero to five percent interest, depending upon the project. Dignity Health has also provided one loan guarantee for affordable housing construction to Mercy Housing.

- ### Community Catalyst Grants for Neighborhood Transformation

  Dignity Health hospitals contribute a percentage of prior year audited expenses for community grants that align with priorities identified in the local facilities' community health needs assessments (CHNAs). Grants range from $5,000 to $100,000. One example of a project made possible through Dignity Health's Community Investment Program is the state-of-the-art Children's Museum of Phoenix. The project transformed the entire neighborhood by serving as a catalyst for other development.

- ### Health Investment Partnerships with Community Development Financial Institutions (CDFIs) and Credit Unions

  About one-quarter of Dignity Health's community investment portfolio is invested in partnership with CDFIs. This shared risk benefits both investors since neither party provides all the financing for any one project. Borrowers also benefit since they can often access capital at a lower rate with fewer fees from a CDFI. Dignity Health also has more than $500,000 invested in community credit unions in the form of CDs (certificates of deposit), which helps to support financial institutions located in underserved communities by increasing the amount of capital available for small business and home mortgage loans.

National Case Study

Dignity Health Community Investment Program

INVESTMENT FUND STRATEGY TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Goal & Purpose	To improve social determinants of health and quality of life for underserved residents in low-income communities.
Strategy	Impact investments in the form of loans, grants, and lines of credit to community nonprofit organizations and businesses; partnerships with CDFIs and credit unions.
Health & Human Service Partners	Healthcare clinics and nonprofit organizations that provide social services and workforce development support in communities where Dignity Health hospitals are located.
Housing Partners	Supportive housing and affordable housing developers in communities where Dignity Health hospitals are located.
Target Population	Economically disadvantaged and underserved populations in low-income communities, including women, children, people of color, and people living with disabilities.
Geography Served	21 communities across the U.S. with primary investments in California, Arizona, and Nevada.
Funding Sources	Private investments made available through healthcare system reserves.
Timeframe	Dignity Health's Community Investment Program has been in existence since 1991. In 2017, the board made a program policy change to allow for investments in *for-profit* entities engaged in community health improvement activities.
Key Outcomes	• More than $180 million dollars in loans in equity and $75 million dollars in grants over the program's lifetime. • Very low borrower default rate—less than 1 percent. • Good rate of return on investment—about 3.2 percent indexed for inflation.
Lessons for Replication	Adequate staffing is key; sourcing and reviewing projects that fit institution priorities and guidelines can be time-intensive. Provide financial education and counseling to borrowers to reduce defaults.

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National Case Study

Housing Is Health Initiative

Anchor Institution Investments for Housing Production

PROJECT PARTNERS:
ADVENTIST HEALTH PORTLAND, CAREOREGON, KAISER PERMANENTE NORTHWEST, LEGACY HEALTH, OREGON HEALTH & SCIENCE UNIVERSITY (OHSU), PROVIDENCE HEALTH & SERVICES – OREGON, CENTRAL CITY CONCERN

TIMETABLE:
2016 TO PRESENT

OVERVIEW

Five nonprofit hospital systems joined with a health care plan to fulfill their respective Hospital Community Benefits Obligation (HCBO) by providing funding for affordable housing development. Their combined investment of $21.5 million dollars provided the gap financing for three projects totaling $90 million dollars. Together, the three buildings provide nearly 400 units of affordable housing for individuals in recovery who are also in need of permanent supportive housing or who are in existing transitional housing.

The housing was developed by Central City Concern, which operates as a both a housing developer, property manager, and a Federally Qualified Health Care Center (FQHC). This model addresses the lack of funding for new, affordable housing supply and the lack of systems integration between recovery treatment providers and supportive housing providers. This case study highlights three investments funded through this initiative.

KEY PROGRAM COMPONENTS

- ### Housing Paired with Health Care to Support Addiction Recovery - Blackburn Center

  Blackburn Center targets a range of housing needs for adults receiving treatment for substance abuse disorders, mental health disorders, or HIV/AIDS. The building includes 51 units of respite care transitional housing, 10 units of palliative care housing, 34 units of permanent supportive housing, and 80 units of transitional low-income housing. The building also includes a health care facility, pharmacy, commercial space on the first floor. The clinic is estimated to serve about 3,000 patients annually. Services include primary care, mental health care, recovery treatment, acupuncture, and housing and employment services.

- ### Investment Strategies to Address Displacement in Gentrifying Areas - Charlotte B. Rutherford Place

  Charlotte B. Rutherford Place is targeted toward employed clients who seek to exit transitional housing programs. The building is part of the City of Portland's housing strategy to address displacement and gentrification in the historic neighborhoods in North and Northeast Portland so long-time community residents receive housing preference. The building has 51 apartments (34 one-bedroom and 17 two-bedroom units) for households at 30-60 percent of the area median family income (AMI).

- ### Transitional Housing and Stability Services for At-Risk Clients-Hazel Heights

  Hazel Heights is targeted toward clients exiting transitional housing programs who have gained employment, but still have barriers to obtaining permanent housing. The four-story building contains 153 units, including 92 one-bedroom and 61 two-bedroom apartments. Eight units are reserved for households at 30 percent AMI; 30 units are reserved for households at 50 percent AMI; and 115 units are reserved for households at 60 percent AMI. The total project cost was $29.9 million.

National Case Study

Housing is Health Initiative

ANCHOR INSTITUTION INVESTMENTS FOR HOUSING PRODUCTION

Goal & Purpose	Reduce health costs and improve patient outcomes through access to permanent housing for low-income adults who are receiving treatment for mental health, substance abuse disorders, or HIV/AIDS.
Strategy	Leverage investments from anchor institutions to increase the production of permanent supportive housing for low-income individuals in recovery and adults residing in transitional housing.
Health & Human Service Partners	Adventist Health Portland, CareOregon, Kaiser Permanente Northwest, Legacy Health, Oregon Health & Science University (OHSU), and Providence Health & Services – Oregon (development financing), Central City Concern (clinical care and employment services)
Housing Partners	Central City Concern (housing developer)
Target Population	Low-income individuals receiving treatment for substance abuse, mental health disorders, or HIV/AIDS who are at-risk for homelessness; low-income individuals exiting transitional housing who are employed, but still have housing barriers.
Geography Served	Portland, Oregon
Funding Sources	**Loans, grants, nonprofit program funding, Low-Income Housing Tax Credits and New Markets Tax Credits:** Adventist Health Portland, CareOregon, Central City Concern, City of Portland Housing Bureau, Kaiser Permanente Northwest, Legacy Health, Oregon Health & Science University (OHSU), and Providence Health & Services-Oregon.
Timeframe	Financing was assembled in 2016; Hazel Heights and Charlotte B. Rutherford Place were completed in Q4 2018; Blackburn Center was completed in July 2019.
Key Outcomes	Projects have been in operation for just six months to a year, so it is still too early for measurable outcomes. Anticipated outcomes include reduced homelessness, reduced inappropriate hospitalizations and emergency room use, and healthcare cost-savings.
Lessons for Replication	• Nonprofit hospital systems can fulfill their HCBO by supporting the development of affordable housing through grantmaking. • Early contributions by health care organizations ($50,000 each) toward pre-development costs were critical to move projects from concept to reality. • Strong relationships between health care executives and housing providers were key in reaching agreement on how to pool investments. • Rental income from commercial tenants and rental subsidy combined will cover loan servicing and operating costs.

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National Case Study

Miracles Central Apartments

Permanent Supportive Housing & Primary Care for Addiction Recovery

PROJECT PARTNERS:
CENTRAL CITY CONCERN, MIRACLES CLUB, GUARDIAN REAL ESTATE SERVICES, MUTICULTURAL DEVELOPMENT GROUP

TIMETABLE:
2016 TO PRESENT

OVERVIEW

Central City Concern is a nonprofit located in Portland, Oregon that serves individuals and families who are impacted by addiction and homelessness. As a housing developer, property manager, and a designated Federally Qualified Health Center (FQHC), they offer a unique approach to systems integration. Central City Concern operates several FQHC medical clinics and 25 apartment buildings, which provide more than 1,700 transitional and permanent supportive housing units.

One example of their permanent supportive housing developments is Miracles Central Apartments. The project provides 47 Alcohol- and Drug-Free Community (ADFC) housing units for individuals exiting residential treatment. This model demonstrates the need to assemble multiple sources of public and private funding for affordable housing production and illustrates how a lack of systems integration between recovery treatment providers and supportive housing providers can be addressed.

KEY PROGRAM COMPONENTS

- ### Funding for Housing Development

  Financing for the development and construction of Miracles Central Apartments included private investor capital, tax-exempt bonds, loans, grants, and Low-Income Housing Tax Credit (LIHTC) equity. About 50 percent of the development costs for this $13 million dollar project were funded by the City of Portland's Housing Bureau. The top four floors of Miracles Central contain apartment-style housing, while the first floor is reserved for social services and meeting space. The building includes a communal kitchen and dining room to encourage socialization among residents.

- ### Project-Based Rent Subsidy Enhanced Affordability

  Miracles Central Apartments includes 47 units of affordable housing made possible through project-based subsidy. Forty percent of the units are reserved for households earning 60 percent Area Median Income (AMI) or less, and 60 percent of the units are reserved for households earning 50 percent AMI or less. The average length of stay in Alcohol- and Drug-Free Community (ADFC) housing is about 3.7 years, but some individuals stay for much longer.

- ### On-Site Services Promote Housing Stability

  On-site resident service managers are available to help residents develop life skills, create employment action plans, and resolve conflicts to prevent eviction. Residents also receive services to assist with addiction recovery, mental health, and behavioral health, and on-site case managers provide intensive case management as needed to provide comprehensive health and housing stability.

National Case Study

Miracles Central Apartments

PERMANENT SUPPORTIVE HOUSING & PRIMARY CARE FOR ADDICTION RECOVERY

Goal & Purpose	Reduce health care costs and improve health outcomes for adults in addiction recovery programs through access to stable housing and a supportive alcohol-free and drug-free community needed to support recovery.
Strategy	Leverage significant public investment to produce affordable housing with supportive services tailored to adults recovering from substance abuse disorders including integration of clinical care and supportive housing management and access to alcohol-free and drug-free community housing to support recovery.
Health & Human Service Partners	Central City Concern (clinical care) and Miracles Club (supportive services).
Housing Partners	Guardian Real Estate Services, MultiCultural Development Group (housing development), and Central City Concern (property management).
Target Population	Individuals existing residential treatment who are at-risk for homelessness or incarceration.
Geography Served	Portland, Oregon
Funding Sources	**Investor capital, tax-exempt bonds, local government loans and grants and LIHTC:** Central City Concern, City of Portland development fee waivers, City of Portland Housing Bureau, Federal Home Loan Bank (FHLB), JP Morgan Chase, Low-Income Housing Tax Credit Program, National Equity Fund, Oregon Housing and Community Services Low-Income Weatherization Program
Timeframe	Approximately 12 months from start to completion. Project completed in July 2016.
Key Outcomes	According to Central City Concern leadership, most residents who leave permanent Alcohol- and Drug-Free (ADFC) housing exit to some other stable housing arrangement, and nearly 90 percent remain sober a year after exit.
Lessons for Replication	• Significant public investment by local government can accelerate production. • Project based-rental assistance enhances affordability and project stability. • On-site resident service managers help stabilize housing for residents. • Strong relationships between clinical care providers and housing property managers improves outcomes.

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National Case Study

Louisiana Permanent Supportive Housing Financing Program

Public Policy & Funding Alignment Initiative

PROJECT PARTNERS:
LOUISIANA DEPARTMENT OF HEALTH, LOUISANA HOUSING CORPORATION, LOCAL NONPROFIT SERVICE PROVIDERS

TIMETABLE:
2008 TO PRESENT

OVERVIEW

This innovative, state-run permanent supportive housing funding program involved collaboration between state health and housing agencies to deliver seamless housing supports and medical services to low-income individuals with severe long-term physical or mental disabilities.

Integrated management of housing and supportive services at the state-level allowed for more coordinated funding, data collection, and decision-making. This model addresses the lack of systems integration between housing and health departments at the state-level, the lack of funding for pre-tenancy and housing stabilization services, and the lack of funding for service gaps during lapses in Medicaid coverage.

KEY PROGRAM COMPONENTS

- ### Prioritized Existing Funding for Housing Development
  The State of Louisiana leveraged its Low-Income Housing Tax Credits (LIHTC) by requiring that 5 percent of all housing units developed with LIHTC be set aside for its Permanent Supportive Housing (PSH) program. To incentivize developers, the state offers additional points on LIHTC applications that set aside 10 percent of units for permanent supportive housing.

- ### Braided Multiple Sources of Rental Assistance to Enhance Affordability
  Louisiana's Permanent Supportive Housing Program utilized project-based and tenant-based rental assistance (including Housing Choice Vouchers, Section 811 Project Assistance and Continuum of Care Rental Assistance) so that participants pay no more than 30 percent of their income for rent. The state's Housing Authority and Department of Health work together cooperatively to manage the Permanent Supportive Housing Program waitlist and identify qualified tenants to fill new and vacant units.

- ### Closed Gaps in Supportive Service Funding
  While supportive services are funded primarily through Medicaid, the state of Louisiana was able to use Community Development Block Grant (CDBG) Disaster Relief Funds to cover service gaps during lapses in Medicaid, or when individuals do not qualify for Medicaid. This bridge funding is made possible because the program's service providers have both Medicaid and CDBG contracts and can manage access to both sources. To utilize Medicaid funding for housing stability, Louisiana's designates "tenancy support" as a distinct service separate from "case management" as eligible for reimbursement. The state contracts with service providers who hire Community Support Specialists to provide pre-tenancy, move-in and housing stabilization services. The state also uses CDBG funds to employ Tenancy Services Managers who assist care managers and provide mediation with landlords in working with difficult-to-house clients.

National Case Study

Louisiana Permanent Supportive Housing Financing Program

PUBLIC POLICY & FUNDING ALIGNMENT INITIATIVE

Goal & Purpose	Reduce homelessness and drive down health costs by increasing the supply and sustainability of permanent supportive housing.
Strategy	Align public policy and funding by integrating housing and supportive services funding, data collection, and decision making at the state level, braiding federal funding together to close gaps in service funding, and expanding Medicaid funding to include housing stability services.
Health & Human Service Partners	**Louisiana Department of Health—**Includes District Human Services, state Bureau of Health Financing Services (which administers Medicaid), state Office for Citizens with Developmental Disabilities, state Office of Aging and Adult Health, state Office of Behavioral Services, state Office of Public Health (identification of tenants, administration of Medicaid funding), and local nonprofit service providers (case management and tenancy support services).
Housing Partners	**Louisiana Housing Corporation—**Acts as the state's housing finance agency and includes state Housing Authority and state Office of Community Development (administration of housing vouchers and waitlist, administration of CDBG and LIHTC).
Target Population	Persons with significant long-term physical or mental disabilities with incomes at or below 50 percent of Area Median Income who qualify for services under Medicaid or Ryan White.
Geography Served	State of Louisiana
Funding Sources	**Federal grant programs, local government funds, and LIHTC**: Community Development Block Grant (CDBG) disaster relief funds, Continuum of Care Rental Assistance (Shelter Plus Care), Housing Choice Voucher Program, Low-Income Housing Tax Credit Program, Medicaid 1915(c) Home and Community Based Services (HCBS) Waivers and Mental Health Rehabilitation (MHR) benefit, Substance Abuse and Mental Health Services Administration (SAMHSA) Cooperative Agreement to Benefit Homeless Individuals (CABHI), Section 811 Project Rental Assistance, Ryan White HIV/AIDS Program, and VA services.
Timeframe	An estimated three years to launch program. The 2005 Hurricanes Katrina and Rita served as the impetus for the development of this program. In 2008, the program served its first client.
Key Outcomes	Production of 3,500 permanent supportive housing units, 25 percent reduction in emergency room admissions for participants served, 24 percent reduction in average monthly Medicaid costs for participants served, 68 percent reduction in statewide homelessness.
Lessons for Replication	• To utilize Medicaid funding for housing supports, Louisiana's designates "tenancy support" as a distinct service separate from "case management" for reimbursement. • By providing service providers with Medicaid and Community Development Block Grant (CDBG) contracts, funds can bridge lapses in Medicaid and ensure service continuity.

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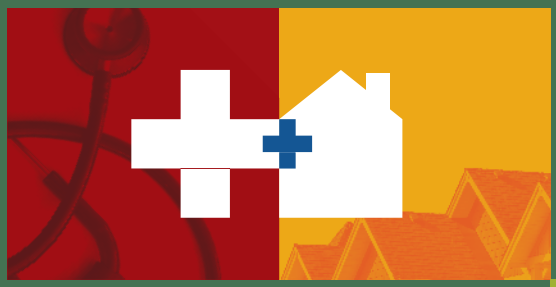

MINNESOTA HEALTH & HOUSING CASE STUDIES

Minnesota Case Study

Dorothy Day Place - Respite Care and Primary Health Clinic

Frequent User Service Enhancement (FUSE) Strategy

PROJECT PARTNERS:
CATHOLIC CHARITIES OF ST. PAUL AND MINNEAPOLIS, REGIONS HOSPITAL, UNITED HOSPITAL, ST. JOSEPH'S HOSPITAL, MINNESOTA COMMUNITY CARE

TIMETABLE:
2017 TO PRESENT

OVERVIEW

Dorothy Day Place, including Higher Ground Saint Paul, Saint Paul Opportunity Center and Higher Ground Saint Paul Residence was completed in the fall of 2019 and is an integrated campus in downtown St. Paul consisting of an emergency shelter for men and women, pay-to-stay transitional housing, permanent supportive housing, medical respite care facilities, and primary health care services.

Catholic Charities of St. Paul and Minneapolis partners with hospitals to reduce hospital visits and lengths of stay for frequent and high-cost users. By integrating respite care and primary health care services with emergency shelter and 370 units of permanent supportive housing, Dorothy Day Place addresses housing instability and lack of primary care that drives excessive reliance on hospital systems by homeless persons with chronic, urgent, or complex health needs.

Hospital partners refer patients to Dorothy Day Place when they have no other home to be discharged to, thereby reducing the length of stay and ensuring that patients have access to primary care to improve health outcomes and reduce health care costs.

KEY PROGRAM COMPONENTS

- ### Integration of Respite Care for Homeless

  Dorothy Day Place encompass two facilities that contain a full continuum of services for homeless, formerly homeless, and those at risk of homelessness. The first building, Higher Ground Saint Paul, was placed in service in 2017 and includes 356 shelter beds, pay-for-stay shelter at minimal cost for men who are working, plus permanent supportive housing units for formerly homeless men and women, and 10 respite care beds for homeless persons being discharged from area hospitals. Funded by Regions Hospital, United Hospital and M Health Fairview St. Joseph's Hospital, the 10 respite care beds are attended by a skilled nurse along with a family therapist. The average length of stay for persons in respite care is 7 to 10 days, after which patients leaving respite care receive assistance to find housing. Each participating hospital agreed to pay proportionately for the number of patients they release to respite care units. This cooperative funding model, combined with family therapy services covered by Medicaid, has saved the hospitals money as projected by "Potential Avoidable Days" calculations.

- ### On-Site Primary Health Care Clinic

  Primary medical care is offered in the second building on campus (Richard M. Schulze Family Foundation Saint Paul Opportunity Center and Dorothy Day Residence) by Minnesota Community Care, a Federally Qualified Health Center (FQHC). Services include physical, mental, and chemical health care services, including dental care and podiatry. The clinic serves its own clientele in addition to those living in the 370 supportive housing units on site. The homeless typically do not have a primary care provider, leading to their reliance on emergency departments and hospitals. By accessing needed primary care at an on-site clinic, patients rely significantly less on much costlier care from hospital systems.

Minnesota Case Study

Dorothy Day Place - Respite Care and Primary Health Clinic

FREQUENT USER SERVICE ENHANCEMENT (FUSE) STRATEGY

Goal & Purpose	Reduce the costs of care and improve health and housing outcomes for homeless, health-challenged individuals who frequently access care at hospitals and emergency rooms for conditions that are better managed through primary care providers.
Strategy	Integrate primary health care and respite care into housing development for high-cost users to reduce unnecessary hospital use and improve health and housing outcomes.
Health & Human Service Partners	• **Regions Hospital (Health Partners), United Hospital (Allina), M Health Fairview St. Joseph's Hospital (M Health Fairview)** -- Funders of respite care units; refer patients for respite care units. • **Minnesota Community Care** – On-site provider of primary health care. • **Other Service Providers (Veterans Health Systems, People Inc, RADIAS, Avivo and others)**—Provide needed services including job training/placement, addiction recovery, housing navigation and stability.
Housing Partners	• **Catholic Charities of St. Paul and Minneapolis** – Developer, property manager, service coordinator for Dorothy Day Place.
Target Population	Persons with significant long-term physical or mental disabilities experiencing homelessness, with specific targeted facilities for persons being released from a hospital, veterans, homeless youth, and persons working toward chemical health; incomes restricted at 30 percent of Area Median Income.
Geography Served	Saint Paul/Ramsey County primarily, but over the past two years, the facility has served residents from 69 of Minnesota's 87 counties.
Funding Sources	$100 million public/private capital campaign for the entire two-building Dorothy Day Place, where the respite care and primary health clinic are located. **Public sources:** MN State Bonding, Minnesota Housing Finance Agency, Department of Human Services, MN Department of Employment and Economic Development, Metropolitan Council, Ramsey County and City of Saint Paul. **Private Sources:** Richard M. Schulze Family Foundation, Target Corporation, 3M and numerous other foundations, businesses, and individuals.
Timeframe	2017 and ongoing.
Key Outcomes	• Respite clients saw a 67 percent reduction in re-hospitalizations compared to those without respite care. • Respite clients saw a 50 percent reduction in emergency room visits compared to those without respite care. • Computed savings to hospitals, based on Potential Avoidable Day charges, were $3.5 million since starting operation in 2017.
Lessons for Replication	• A coalition of public and private funders are needed to meet capital needs, ongoing service and operating funding to bring this approach to a workable scale. • Hospitals can save money and improve health by reducing length of hospital stays, and make use of respite care units through a cooperative funding and referral model. • Providing on-site primary health and dental services for homeless persons who typically do not have primary care can help reduce hospital visits to address chronic conditions.

Minnesota Case Study

Mayo Clinic Capitalizes Affordable Housing Investment Funds

Anchor Institution Investments

PROJECT PARTNERS:
MAYO CLINIC, CITY OF ROCHESTER, OLMSTED COUNTY, ROCHESTER AREA FOUNDATION, APPROXIMATELY 100 LOCAL BUSINESSES

TIMETABLE:
1999 TO PRESENT

OVERVIEW

Mayo Clinic is a world leader and innovator in patient care, medical research and education, and an economic engine for Rochester, Olmsted County and the State of Minnesota. It is the preeminent anchor institution of the City of Rochester and Olmsted County, Minnesota. In 1999, the Rochester area was ending a decade of nearly 20 percent household growth, and due to Mayo Clinic's expansion, hospitality industry and other business expansion, job growth was nearly 30 percent. Many employees were driving over 50 miles to jobs due the severe lack of housing. Employers, civic leaders and philanthropy recognized the situation as a crises, and identified a lack of affordable starter homes and apartments at all levels for the growing workforce. The 1999 housing crisis was effectively addressed over ten years, but returned again in the post-recession era. In both eras of housing shortages, Mayo Clinic committed substantial housing investments, totaling $11 million, which leveraged matching investments from over 100 other employers to jointly address the region's housing demands through a coordinated effort called First Homes.

KEY PROGRAM COMPONENTS

- ### Community Engagement and Planning

  In 1999, Mayo Clinic Rochester, Rochester Area Foundation, and local elected officials worked with Greater Minnesota Housing Fund (GMHF) which prepared a comprehensive housing plan that identified public and private capital resources and set a goal of raising $12 million to help produce 875 affordable homes and apartments for the growing workforce. This goal was exceeded as over 1,500 homes have been developed. Rochester Area Foundation also established First Homes, a bold public-private partnership between the foundation, employers, non-profits, and local government.

- ### Coordinated Campaign for $20 Million to Produce Over 1,500 New Homes

  First Homes was capitalized with initial capital of $7 million from Mayo Clinic in the form of a "challenge grant". Philanthropy and businesses banded together to raise another $4 million from 100 employers to achieve total capitalization of $12 million for investment in affordable housing. First Homes has now operated in Rochester and 12 other cities and towns and fostered the revitalization of Rochester's core neighborhood Kutsky Park. The First Homes Community Land Trusts was also established, creating over 223 permanently affordable homes and is one of the largest land trusts in Minnesota.

  In 2017, a second housing shortage was identified, with Mayo Clinic, Rochester Area Foundation, the City of Rochester and Olmsted County forming the new "Coalition for Rochester Area Housing" with the goal of raising another $6 million for affordable housing from area employers and local governments. Mayo Clinic led again with a new $4 million grant, with the City and County contributing funds. Loans are being made as zero-percent gap loans and low-interest construction & acquisition loans. The Coalition also provides an ongoing forum to coordinate resources, including Tax Increment Financing, Housing and Redevelopment Authority (HRA) levy dollars, and project-based rental housing vouchers. In addition, Olmsted County approved the first use of its statutory HRA Levy authority which now generates $2.5 million annually for affordable housing in Olmsted County.

Minnesota Case Study

Mayo Clinic Capitalizes Two Affordable Housing Funds

ANCHOR INSTITUTION INVESTMENTS

Goal & Purpose	Produce affordable homes and rental apartments to address critical workforce housing shortages.
Strategy	Establish a partnership with the Rochester Area Foundation, City of Rochester, and Olmsted County to create a locally controlled housing investment fund to address a range of housing needs.
Health & Human Service Partners	Mayo Clinic Rochester
Housing Partners	First Homes Properties, Olmsted County HRA, Greater Minnesota Housing Fund (GMHF), Three Rivers Community Action, and Center City Housing, City of Rochester.
Target Population	Olmsted County residents with incomes at or below 80 percent of the Area Median Income.
Geography Served	**First Homes**: Serves a seven county area with homes in 13 different communities. A description of the area is found here: http://www.firsthomes.org/learn-more/communities-served.php. **The Coalition for Rochester Area Housing**: Serves Olmsted County.
Funding Sources	Mayo Clinic, City of Rochester, Olmsted County, Rochester Area Foundation, and approximately 100 local businesses (First Homes).
Timeframe	**First Homes**: 1999 to Present. **The Coalition for Rochester Area Housing**: 2018 to Present.
Key Outcomes	• As of 2020, more than 1,500 homes have been produced through coordinated efforts by Mayo Clinic, Rochester Area Foundation, 100 other employers and local government. • First Homes Community Land Trust (CLT) was established and has created 223 permanently affordable land trust homes in its role as funding intermediary and manager of the CLT. • Coalition for Rochester Area Housing has fostered development of 300 units of affordable housing in 2018-2019. • Olmsted County approved its HRA Levy to provide $2.5 million annually for housing. • 0-percent, 40-year loans will provide permanent supportive housing to single mothers with young children in a project sponsored by the Jeremiah Program now under construction.
Lessons for Replication	• Anchor institutions can stimulate other private and public partners to invest in affordable housing to leverage greater resources and impact. • Anchor institutions can overcome a lack of familiarity with affordable housing finance and development by partnering with an experienced Community Development Finance Institution (CDFI) or other non-profit housing partner • Engaging local leaders from the business and philanthropic community, in addition to the health and housing sectors, further broadens the base of community support, creates more political will, and attracts new public and private capital to local affordable housing efforts.

Minnesota Case Study

Highrise Health Alliance-Minneapolis Public Housing Authority

Frequent User Service Enhancement (FUSE) Strategy

PROJECT PARTNERS:
MINNEAPOLIS PUBLIC HOUSING AUTHORITY, MINNEAPOLIS HIGH RISE REPRESENTATIVE COUNCIL, UCARE, HENNEPIN HEALTH AND HENNEPIN HEALTHCARE, MINNEAPOLIS HEALTH DEPARTMENT

TIMETABLE:
2020 TO 2022

OVERVIEW

In 2019 the Minneapolis Public Housing Authority (MPHA) formed its Human Services department, focusing on health, education and employment, with initial efforts focusing on health strategies. MPHA owns 42 highrise buildings providing homes for over 5,300 individuals.

The location of MPHA highrises in areas of concentrated poverty generated an initial focus on health disparities for highrise residents. Preliminary health data indicate that these residents experience significant health inequities with emergency room visits 2.5 times higher and inpatient hospitalization rates 40% higher than the general rates for low-income 65+ disabled persons in the community.

Addressing these inequities requires new partnerships to access and interpret data and collaborative leadership from key agencies to align fragmented systems and services. MPHA is now launching a new initiative, the Highrise Health Alliance, to improve health for highrise residents by engaging multi-sector leadership in interpreting data, identifying health priorities and aligning services and funding.

KEY PROGRAM COMPONENTS

- ### Collaborative Cross-Sector Leadership

  MPHA has formed the Highrise Health Alliance to bring together housing, health, and mental health experts to share and interpret data, identify priorities, and implement strategies to reduce improve health among highrise residents.

  The Alliance includes a Leadership Team with representatives from a broad range of partners, including residents, which guides the strategic work of the initiative. The Alliance is leveraging its structured engagement format to leverage resources across sectors, identify new or expanded funding sources, and develop a sustainable funding model.

  Current efforts to organize and launch this initiative are funded by a Cross-Sector Innovation Grant from Robert Wood Johnson Foundation, through the Minneapolis Public Health Accreditation Board. Sustained leadership commitment and buy-in from each partner organization is critical to successfully overcoming barriers and making needed systems change.

- ### Data Mapping to Drive Evidence-Based Strategies

  A key component of the initiative is to Identify and access reliable sources of data to better understand resident health needs and inequities and to use that data to guide decision making. As part of this effort, MPHA has gained access to public data from the State Epidemiologist to track and benchmark highrise residents compared with broader community health trends. The goal is to use data to develop and implement services that are tailored, culturally competent, accessible and trauma-informed.

Minnesota Case Study

Highrise Health Alliance – Minneapolis Public Housing Authority

FREQUENT USER SERVICE ENHANCEMENT (FUSE) STRATEGY

Goal & Purpose	To improve health and well-being of MPHA's public housing high-rise residents.
Strategy	Provide a structure to engage cross-sector leadership in mapping data to identify resident health priorities and implement strategies to align services and funding with resident needs.
Health & Human Service Partners	**UCare**, **Hennepin Health** and **Hennepin Healthcare**, **Minneapolis Health Department**. Additional partners to be added over time.
Housing Partners	**Minneapolis Public Housing Authority (MPHA**): Housing provider for high rise residents.
Target Population	• Residents of MPHA public housing high rise units. • Expansion to other MPHA residents or applicability of what is learned to all low-income renters is one long-term possible outcome.
Geography Served	City of Minneapolis, Various high rise locations.
Funding Sources	**HUD** funding for services, **Minneapolis Public Health Department**, **Robert Wood Johnson Cross-Sector Innovation Grant**
Timeframe	2020 to 2022
Key Outcomes	This Highrise Health Alliance is just forming; however, the following outcomes are anticipated: • Residents experience improved ability to manage chronic conditions and achieve improved health and wellbeing as demonstrated by reduction in medically unnecessary emergency room visits; reduction in 911 calls; others TBD. • Share and align results with other public housing agencies and other providers of low-income housing.
Lessons for Replication	• Accessing large data systems is costly and time-consuming but necessary for planning. • Multiple data sources expand the amount of data but require more analysis to interpret accurately. • Data privacy laws regarding personal health data restrict and complicate data sharing. • Multi-sector leadership engagement cuts across silos and builds sustainability. • Sustained effort is necessary to achieve measurable results. • Other PHAs nationally are engaged in mining data to identify the most effective ways to address health disparities for very low-income persons who are PHA residents. Effective ways of sharing information across the various efforts are still being developed.

Minnesota Case Study

Hospital to Home Program & Coming Home Program

Frequent User Service Enhancement (FUSE) Initiatives

HOSPITAL TO HOME PROGRAM PARTNERS:
REGIONS HOSPITAL, HENNEPIN HEALTH, GUILD INCORPORATED, AVIVO, HEARTH CONNECTION
COMING HOME PROGRAM PARTNERS:
M HEALTH FAIRVIEW ST. JOSEPH'S, GUILD INCORPORATED, HEARTH CONNECTION, CATHOLIC CHARITIES

TIMETABLE:
2009 TO PRESENT
TIMETABLE:
2017 TO PRESENT

OVERVIEW

Homeless persons relying on shelters, hospital emergency rooms, and hospital stays for temporary housing and intermittent health care have spawned the need for programs focused on housing stability as a way to lower costs and improve outcomes. In many cases, health needs are better addressed when paired with enhanced case management and access to safe and stable housing.

A wide variety of health conditions, including physical and mental health, chemical dependency, diabetes, asthma, and behavioral health concerns are common with a homeless and unstably housed population. Both of the programs described below collaborate with hospitals as the access points for identifying the target populations and both have achieved striking results with enhanced case management and a housing first approach to health care.

KEY PROGRAM COMPONENTS

- ### Hospital to Home Program

  The Hospital to Home program is focused on reducing Regions Hospital and Hennepin County Medical Center's emergency department use by homeless persons by providing housing services and intensive case management by Guild Incorporated, and Avivo. Case managers work with patients to locate and secure housing and access rental assistance through HUD or Minnesota Housing, and administered by Hearth Connection. Avivo and Guild staff help negotiate leases with private landlords; coordinate patient care (when needed); design tailored, person-centered care based on in-depth assessments; connect clients to Medicaid support; and help build participants' life management skills. Services are mobile and brought to the participant where they live. The need for intense services has proven to decline and become more manageable with stable housing.

- ### Coming Home Program

  The Coming Home program, launched in 2017, addresses research findings by M Health Fairview St. Joseph's Hospital that frequent hospital visitors often had housing stability issues better addressed with intensive case management and housing services provided by Guild Incorporated. Case management begins when frequent medical patients are identified by the hospital staff. Patients are referred to the Coming Home program which connects them to housing at Catholic Charities' Higher Ground facility and other housing. The program provides rental assistance administered by Hearth Connection. In 2018, CentraCare's St. Cloud Hospital, noting the same frequent visitor issues, partnered with Central Minnesota Mental Health Center and Stearns County Probation and Outreach Services to offer similar intensive case management along with rental assistance, working with Hearth Connection.

Minnesota Case Study

Hospital to Home Program & Coming Home Program

FREQUENT USER SERVICE ENHANCEMENT (FUSE) INITIATIVES

Goal & Purpose	To reduce costs and better serve patients with complex health needs by targeting high-need/high-cost patients for intervention that decrease emergency room use, reduce hospital admissions, and improve patient outcomes.
Strategy	Target high- need/high-cost patients with intensive case management, housing stability services, expanded primary care, and training in life skills to reduce use of hospitals and emergency rooms.
Health & Human Services Partners	**Hospital to Home:** Regions Hospital, Hennepin County Medical Center—Refer patients. Guild Incorporated, Avivo—Provide intensive case management and other needed services. **Coming Home:** M Health Fairview St. Joseph's, CentraCare St. Cloud Hospital, Central MN Mental Health Center-- Refer patients. **Guild Incorporated -** Provides intensive case management.
Housing Partners	**Hospital to Home:** Various private landlords--Provide housing. Hearth Connection—Administers state and federal rent subsidies. **Coming Home:** Higher Ground/Catholic Charities; private landlords–Provide housing. Hearth Connection--Administers state and federal rent subsidies.
Target Population	**Hospital to Home:** High users of emergency rooms and persons with chronic medical conditions (such as diabetes, high blood pressure and traumatic brain injury), serious and persistent mental illness, substance abuse disorders, or long histories of homelessness. **Coming Home:** Long-term homeless families and individuals and frequent users of emergency rooms and hospital stays.
Geography Served	**Hospital to Home:** Minneapolis and St. Paul. **Coming Home:** St. Paul and St. Cloud.
Funding Sources	**Hospital to Home & Coming Home Programs** both use HUD Supportive Housing rental assistance plus subsidies administered by Hearth Connection; Housing Supports payments and private fundraising.
Timeframe	**Hospital to Home:** Initial pilot group of seven in 2009 and by 2017 expanded to 40. **Coming Home**: 2017 in St. Paul, 2018 in St. Cloud and ongoing.
Key Outcomes	**Hospital to Home:** • At the time of the study (2016), for the 31 participants served, all moved into stable housing within four months of enrolling, resulting in emergency room visits decreased from 333 before enrollment to 85 after enrollment. • 32 percent of participants had an inpatient hospital stay in the six months before enrollment; and just 13 percent had a hospital stay between six and seven months after enrollment. • Primary care clinic use increased from 625 visits in the six months before enrollment to 647 visits between seven and 12 months after enrollment. **Coming Home:** 71 percent reduction in emergency room visits; 52 percent reduction in hospitalizations.
Lessons for Replication	• This model is particularly effective for those in need of mental health and substance abuse services for whom access to enhanced services can significantly reduce reliance on hospitals and emergency rooms. • Simplified funding would make model more replicable.

Minnesota Case Study

Park Place (Bemidji), Solace Apartments (Mankato), Rising Cedars (Minneapolis)

Permanent Supportive Housing

PROJECT PARTNERS:
PARK PLACE: COMMUNITY RESOURCE CONNECTIONS, SANFORD HEALTH, CENTER CITY HOUSING CORP.
SOLACE APARTMENTS: ASC PSYCHOLOGICAL SERVICES, RIVER'S EDGE HOSPITAL, SOUTHWEST MN HOUSING PARTNERSHIP. **RISING CEDARS:** TOUCHSTONE MENTAL HEALTH; BLUESTONE PHYSICIANS GROUP; UNIVERSITY OF MN DEPARTMENTS OF NURSING, PHARMACY AND SOCIAL WORK; PROJECT FOR PRIDE IN LIVING

TIMETABLE:
2013 TO 2018

OVERVIEW

Placing homeless individuals in safe and stable affordable housing, consistent with the Housing First principle, is the essential foundation for establishing improved health and quality of life outcomes. Maintaining stable housing for those challenged by chemical health issues, criminal records or serious and persistent mental illness all require ongoing support to permanently stabilize individuals and families. The three case studies below include a range of successful health and housing partnerships that focus on three unique life problems that increase the risk homelessness and adverse health, and demonstrate how permanent supportive housing is the critical link to better health and quality of life.

KEY PROGRAM COMPONENTS

- **End Cycles of Homelessness for Persons with Chemical Dependency - Park Place, Bemidji**
  Center City Housing Corp. of Duluth developed Park Place, a 60-unit supportive housing complex to respond to homelessness among largely Native American residents of Bemidji and Beltrami County. Opening on a cold, snowy day in 2017, Park Place supports residents in their efforts to maintain mental and chemical health through congregate meals, social services and an on-site nurse provided by Sanford Health. The project was supported by the Red Lake Reservation Housing Authority and the Leech Lake Bank of Ojibwe Housing Authority.
- **Stable Housing for Women Exiting Incarceration - Solace Apartments, Mankato**
  Solace Apartments provides permanent supportive housing to 30 women who are homeless or at risk of homelessness who have been incarcerated with a drug offense and subject to court-ordered treatment with case management. Southwest Minnesota Housing Partnership (SWMHP) developed the apartments to break cycles of recidivism. Three organizations provide case management services, coordinated by a Resident Services Navigator employed by SWMHP. Anticipating a 4- to 6-month lease-up, the property was fully leased in 2.5 months. Successful family reunifications have already exceeded the goals.
- **Housing for Persons with Serious and Persistent Mental Illness - Rising Cedars, Minneapolis**
  After searching for years for a residential building, Touchstone Mental Health, partnered with Project for Pride in Living (PPL) to build a new facility with 40 residential units and clinic space for their serious and persistent mentally ill, homeless clientele. Bluestone Physicians' group, University of MN Schools of Nursing, Pharmacy and Social Work provide health care services to residents. Design elements that contribute to mental health were used, including allowing more natural light, thoughtful color choices, an exercise room, and clinic space. The award winning project opened in 2013.

Minnesota Case Study

Park Place (Bemidji), Solace Apartments (Mankato), Rising Cedars (Minneapolis)

PERMANENT SUPPORTIVE HOUSING

Goal & Purpose	Provide affordable housing with supportive services to sustain health and housing for formerly homeless and those at-risk of homelessness.
Strategy	Provide targeted services and case management to the specific requirements of a special needs population along with subsidized housing improves both housing and health outcomes.
Health & Human Service Partners	**Park Place:** Community Resource Connections, Sanford Health **Solace Apartments:** ASC Psychological Services, River's Edge Hospital **Rising Cedars:** Touchstone Mental Health, Bluestone Physicians Group, University of MN departments of Nursing, Pharmacy and Social Work
Housing Partners	**Park Place:** Center City Housing Corporation **Solace Apartments:** Southwest MN Housing Partnership **Rising Cedars:** Project for Pride in Living
Target Population	**Park Place:** Chronically homeless, chemically dependent. **Solace Apartments:** Homeless or at risk of homelessness, who have been incarcerated with a drug offense and subject to court-ordered treatment. **Rising Cedars:** Homeless and receiving or eligible to receive waivered services supporting mental health.
Geography Served	**Park Place:** Bemidji Area **Solace Apartments:** Mankato Area **Rising Cedars:** Minneapolis
Funding Sources	**Park Place:** Red Lake Reservation Housing Authority, Leech Lake Bank of Ojibwe Housing Authority, City of Bemidji, Greater MN Housing Fund, MN Equity Fund, and Minnesota Housing. **Solace Apartments:** City of St. Peter, Greater MN Housing Fund, MN Housing, and MN Equity Fund. **Rising Cedars:** City of Minneapolis, Hennepin County HRA, Federal Home Loan Bank Affordable Housing Program, MN Housing Supports, and National Equity Fund.
Timeframe	**Park Place:** Placed in service 2017. **Solace Apartments:** Placed in service 2018. **Rising Cedars:** Placed in service 2013.
Key Outcomes	• 178 units of affordable housing with appropriate services. • In national studies cited by CSH, the proportion of PSH residents formerly homeless remaining stably housed for at least one year is as high as 93 percent. • Decline in Emergency Department visits (before and after stable housing) as high as 78 percent. • Decline in inpatient nights (before and after stable housing) as high as 79 percent.
Lessons for Replication	• Complexity of funding can take four to five years to assemble. • Service and operating funds are of shorter duration than development capital and can jeopardize project stability over time. Better funding alignment could address these issues.

Minnesota Case Study

Minnesota Equity Fund

Impact Investment Fund Strategy

PROJECT PARTNERS:
UNITED HEALTHGROUP, CINNAIRE

TIMETABLE:
2013 TO PRESENT

OVERVIEW

Minnesota Equity Fund (MEF), a nonprofit subsidiary of Greater Minnesota Housing Fund (GMHF), is a social enterprise designed to raise equity capital from Minnesota corporations and banks to invest in high quality, well designed and sustainable affordable housing throughout Minnesota.

United HealthGroup (UHG) has partnered with Greater Minnesota Housing Fund and the Minnesota Equity Fund since 2013 and has collaborated around a common agenda to link housing and health services to invest over $98 million through MEF in a variety of supportive and workforce housing developments.[i] UHG investments have supported the development of a range of Permanent Supportive Housing (PSH) types, targeting military veterans and their families, single mothers, seniors and other formerly homeless persons in cities throughout Minnesota, Wisconsin, Michigan and several other states.

Minnesota Equity Fund raises capital through the syndication of Low Income Housing Tax Credits (LIHTC) awarded to developers by state government to create high priority low income housing developments.

KEY PROGRAM COMPONENTS

- ### Health Sector Investment to Increase Production of Affordable Housing

  Between 2013 and the close of 2019, including projects scheduled to close in 2020, the Minnesota Equity Fund has supported the production of 2,032 affordable housing units. Of those, 57% (1,158 units) are work force and senior housing units; and 43% (874 units) are supportive housing. In total, the fund raised $185.2 million for equity investments, with $105.5 million of that creating supportive housing.

- ### Social and Financial Returns for Investors

  Investments through the Minnesota Equity Fund generate returns for investors by creating a double bottom line for investors: financial returns through tax credits and tax losses, and social benefits through the creation of needed affordable housing units. The requirements of the tax credits commit the developer to maintaining affordability by imposing rent limits and resident income limits for a minimum of fifteen years, and longer if state allocating agencies require.

  By focusing UHG's investments in projects that address Health and Housing connections in supportive housing, like Steve O'Neil Apartments in Duluth and Fort Snelling Upper Post Veterans' Homes in Minneapolis, special high-need populations have been assisted by UHG's investments: homeless veterans and families of veterans, homeless youth, and homeless individuals and families.

[1] UnitedHealthcare has invested over of $400 million in affordable housing linked to health care with MEF and UHG's other investment partners nationally. Learn more...

Minnesota Case Study

Minnesota Equity Fund

IMPACT INVESTMENT FUND STRATEGY

Goal & Purpose	Address health disparities for vulnerable populations, and relieve critical affordable housing shortages, by investing in housing for cost burdened low and very low income renters and formerly homeless persons and persons at risk of homelessness.
Strategy	Work collaboratively to assemble investment capital from health sector investors, targeting investment to improve health outcomes through permanent supportive housing with services, affordable housing with improved access to primary care, and housing for cost burdened low and very low incomes families and individuals.
Health & Human Service	• UnitedHealth Group as a health sector investment partner and program design collaborator • Veterans Administration, CHUM Shelter, and various social service, mental and behavioral health organizations
Housing Partners	• **Housing Developers:** Center City Housing Corp., Community Housing Development Corporation, CommonBond Communities, Beacon Interfaith Housing Collaborative, Southwest Minnesota Housing Partnership, Itasca County Housing and Redevelopment Authority, and others • **Housing Finance Intermediaries:** Greater Minnesota Housing Fund (GMHF), Minnesota Equity Fund (MEF), and Cinnaire • **State and Local Housing Agencies:** Minnesota Housing, Greater Minnesota Housing Fund, Duluth Housing and Redevelopment Authority, St. Louis County Housing and Redevelopment Authority, Metropolitan Council, Dakota County Community Development Agency, Headwaters Housing Development Corporation, Beltrami County Housing and Redevelopment Authority, Red Lake Nation, Leech Lake Band of Ojibwe, Bi-County Community Action Programs
Target Population	Persons with significant medical disabilities experiencing homelessness, targeting veterans, homeless youth, single mothers, and persons working toward chemical health, cost burdened low and very low income renters, and formerly homeless persons and persons at risk of homelessness.
Geography	Cities throughout Minnesota, Wisconsin, Michigan and several other states.
Funding Sources	United HealthGroup (Tax Credit Equity), State and Local Housing Agency programs (from funding partners listed above)
Timeframe	2013 and ongoing
Key Outcomes	Production of a total of 2,032 affordable housing units: • 871 Permanent Supportive Housing (PSH) units • 124 Senior Housing with Programming units • 794 Affordable Work Force Housing units • 243 Mixed income units
Lessons for Replication	• Combining funds through an investment specialist, such as a Community Development Financial Institution (CDFI), increases the ability to target and select appropriate investments, increase impact outcomes and target specific project types.

Minnesota Case Study

Hennepin County Housing Navigation Program

Frequent User Service Enhancement (FUSE) Strategy

PROJECT PARTNERS:
HENNEPIN HEALTH, HENNEPIN COUNTY MEDICAL CENTER, HENNEPIN COUNTY HUMAN SERVICES AND PUBLIC HEALTH DEPARTMENT, MINNEAPOLIS PUBLIC HOUSING AUTHORITY

TIMETABLE:
2012 TO PRESENT

OVERVIEW

Hennepin County's Housing Navigation is part of a broader strategy spearheaded by Hennepin Health to take an innovative, integrated approach to addressing the behavioral, social, and economic conditions that impact health outcomes and costs.

Hennepin Health is Hennepin County's wholly owned and operated Health Maintenance Organization (HMO) that operates an accountable care model for Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members.

Housing Navigation began as part of a Medicaid demonstration project, a collaborative effort between Hennepin Health, Hennepin County Human Services and Public Health Department, NorthPoint Health and Wellness Center, and Hennepin Healthcare. Members in need of housing stabilization are identified through an assessment and are referred by clinic care coordinators and social services staff to Housing Navigation.

Funding for Housing Navigation services comes from the capitation rate that Hennepin Health receives for operating PMAP/MinnesotaCare programs. Beginning in 2019, Hennepin Health and Hennepin Healthcare have used the learnings from the housing navigation program to launch an award-winning program that has been documented to reduce hospital readmissions among Hennepin Health members who are inpatient at Hennepin Healthcare and experiencing homelessness.

KEY PROGRAM COMPONENTS

- ### Integrated Care Coordination for Health Care and Human Services

  Members experiencing or at high risk for homelessness are referred to Hennepin Health by clinics, including Northpoint, Hennepin Healthcare, the Access Clinic and the Coordinated Care Center; by internal Hennepin Health staff; and by self-referrals. The Hennepin Health social service navigation team connects engaged members to primary care and behavioral health services through a multidisciplinary team that Includes both health and social services. The team also works to find engaged Hennepin Health members housing in the tight housing market and resolve legal and eviction issues.

- ### Alignment of Departmental Resources and Incentives

  The broader strategy by Hennepin Health as an accountable health model to more effectively address housing as a social determinant of health leverages all the relevant County departments and creates financial incentives for a more coordinated and comprehensive care model. The members of the collaboration share in the financial benefit of health cost savings achieved through distribution of a portion of the savings and targeted reinvestment into initiatives that drive innovation and further improve the quality of care. Together with a shared governance model, the aligned financial incentives have encouraged increased collaboration and alignment of resources.

Minnesota Case Study

Hennepin County Housing Navigation Program

FREQUENT USER SERVICE ENHANCEMENT (FUSE) STRATEGY

Goal & Purpose	Reduce preventable hospital admissions and emergency department visits for frequent users of health services to lower costs and improve outcomes.
Strategy	Increase access to preventive care; provide stable housing and enhanced services needed to maintain housing stability for high risk members.
Health & Human Service Partners	**Hennepin Health (Health Maintenance Organization)**: Provides coverage to integrate health and social services; assesses members for homelessness and other needs; and refers to provider and county partners. **Hennepin Healthcare and North Point**: Provides health care services that integrate the social determinants of health with health care and refers to Hennepin Health social service navigation teams. **Hennepin County Human Services & Public Health Department**: Provides intensive case management, financial support, and housing navigation services to stabilize the health and housing of high risk members.
Housing Partners	**Nonprofit Housing Providers & Various Private Sector Landlords**: Provide housing for program clients.
Target Population	Homeless Medicaid enrollees and MinnesotaCare enrollees who are adults between the ages of 21 and 64 and their dependent children.
Geography Served	Hennepin County, including Minneapolis.
Funding Sources	Existing State and County Human Services funding, including Housing Supports, supplemented by health plan using Medicaid savings.
Timeframe	Navigation system since 2012, ongoing.
Key Outcomes	• 55% reduction in emergency department use by Medicaid clients in the study • 52% reduction in emergency department costs by Medicaid clients in the study • 29% reduction in hospitalizations by Medicaid clients in the study • 72% reduction in hospitalization costs by Medicaid clients in the study
Lessons for Replication	• Medicaid savings can generate funds for housing stability and other services. • Outcomes are most pronounced in a tight housing market where access to housing is most constrained. • Use of data is key to maximizing cost savings and health outcomes by targeting resources where they are most needed and make the most difference. • Funding stability is key. By re-investing health savings, a virtuous cycle emerges which must be sustained to continue to have impact.

ENDNOTES:
Aligning for Health. (2020). "Integration-in-Action: Best Practices and Research" Retrieved online February 6, 2020: http://aligningforhealth.org/integration-in-action/best-practices-and-research/

Sandberg, S., Erikson, C., Owen R., Vickery, K., Shimotsu, S., Linzer, M. Garrett, N., Johnsrud, K., Soderlund, D., DeCubellis, J. Publisher: Health Affairs: Vol. 33, No.11: Collaborating for Community Health. (2014). "Hennepin Health: A Safety-Net Accountable Care Organization for the Expanded Medicaid Population." https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0648

Minnesota Case Study

Beyond Backgrounds Program

Frequent User Service Enhancement (FUSE) Strategy

PROJECT PARTNERS:	TIMETABLE:
HOUSINGLINK, EAST METRO CRISIS ALLIANCE, MEDICA FOUNDATION, VARIOUS LANDLORDS	JAN 2018 TO PRESENT

OVERVIEW

HousingLink is a non-profit organization based in the Twin Cities formed in 1997 to expand access to affordable housing by providing information about rental vacancies and housing resources.

In 2018, HousingLink launched the Beyond Backgrounds Program, which pairs housing stability services with an innovative Landlord Risk Mitigation Fund to incent landlords to accept renters with troubled rental history. By expanding access to stable housing for individuals with chronic or complex health conditions, the program also seeks to drive down health costs and improve health outcomes. The Beyond Backgrounds program has attracted the attention of health sector partners, and is now expanding with grant support from Medica Foundation in partnership with East Metro Crisis Alliance (EMCA). The partnership with EMCA links mental health and addiction recovery services expertise with HousingLink's housing placement and stability services to create more sustained positive health impacts and housing stability.

KEY PROGRAM COMPONENTS

- ### Housing Navigation & Stability Services

  EMCA collaborates with Regions Hospital, United Hospital and HealthEast Hospital to make referrals to the Beyond Backgrounds Program. Beyond Backgrounds leverages HousingLink's extensive rental housing database, rental market expertise, and relationships with public housing agencies, private landlords, and non-profit housing and human service providers to offer robust housing placement and stabilization services including help finding housing, assistance with lease-up including any subsidy eligibility processes, and links to other services to address health conditions or behaviors such as substance abuse that may jeopardize housing.

- ### Landlord Loss Mitigation Guarantee

  When a landlord agrees to rent to a household referred through Beyond Backgrounds, they receive a loss mitigation guarantee of up to $2,000. The $2,000 can be used for damage to the unit, unpaid rent, or court filing fees in the event an eviction occurs. With the increased interest in the program both in the East Metro as well as in Greater Minnesota, HousingLink has set a goal of increasing the Landlord Risk Mitigation pool to accommodate 160 new renter households in the Beyond Backgrounds Program over the next two years.

- ### Landlord Recruitment

  HousingLink maintains a Landlord Liaison to recruit landlords to match with Beyond Backgrounds renters. The Landlord Liaison works to increase housing options in settings that work best for the renter. Landlord recruitment is a critical piece of a broader strategy to overcome barriers to accessing affordable units for low-income households and has potentially positive ripple effects as landlords adopt more inclusive methods of tenant screening.

Minnesota Case Study

Beyond Backgrounds Program

FREQUENT USER SERVICE ENHANCEMENT (FUSE) STRATEGY

Goal & Purpose	To reduce costs and better serve homeless or precariously housed individuals with complex health needs by decreasing emergency room use and hospital admissions and shortening the length of stays.
Strategy	Pair housing stability services with a Landlord Risk Mitigation Fund to address the root causes of housing instability and expand access to housing in the community by incenting more landlords to accept individuals with a troubled rental history.
Health & Human Services Partners	**East Metro Crisis Alliance:** Provides mental health and addiction recovery services. Works with hospitals to identify referrals for Beyond Backgrounds Program.
	Regions Hospital, United Hospital, HealthEast: Provide targeted patient referrals for the Beyond Backgrounds Program.
	Medica Foundation: Provides grant funds to operate the program.
Housing Partners	**HousingLink:** Administers Landlord Risk Mitigation Fund, provides housing stability services, and conducts landlord outreach. **Various non-profit housing providers and private landlords:** Provide rental housing for participants of the Beyond Backgrounds Program.
Target Population	Homeless persons identified through Continuum of Care entry points. High users of emergency rooms, persons with chronic medical conditions or serious and persistent mental illness; those with substance abuse disorders; and those with histories of homelessness.
Geography Served	South and East Metro currently.
	Potential future expansion to St. Cloud and Rochester; funding requests pending.
Funding Sources	**South Metro:** South Metro Continuum of Care Funding via Minnesota Housing, Ramsey County, and Pohlad Foundation. **East Metro:** $200,000 Medica Foundation.
Timeframe	Jan 2018--Beyond Backgrounds launched with South Metro Continuum of Care.
	Jan 2020–Beyond Backgrounds expanded to East Metro with grant from Medica Foundation.
Key Outcomes	***In the first 21 months:*** • 109 Beyond Backgrounds participant households were placed in housing. • Two claims received from landlords for Risk Mitigation Funds. • 95 percent of households that signed a lease through Beyond Backgrounds is on track to stay housed after the first year in their unit.
Lessons for Replication	• Collaborative partnership with health sector partners allows enhanced impact by expanding the targeted population beyond Continuum of Care entry points. • Program impact is highest in markets with low vacancies where housing options are most limited. • Participation in this program mirrors racial inequity in homeless population with 44 percent of participants identifying as Black or African American.

Minnesota Case Study

Minnesota Medicaid Expansion for Housing Stabilization

Public Policy & Funding Alignment Initiative

PROJECT PARTNERS:
MINNESOTA DEPARTMENT OF HUMAN SERVICES, HOUSING STABILITY SERVICE PROVIDERS, HEALTH PLANS

TIMETABLE:
START 2020

OVERVIEW

The Affordable Care Act and subsequent Medicaid expansion opened the door for states to extend coverage of health and related services to a broader segment of vulnerable populations. In 2015, the Centers for Medicare and Medicaid Services (CMS) issued a bulletin intended to help states design programs that acknowledge the social determinants of health and foster more holistic approaches to individual health and wellness. The Minnesota legislature subsequently directed the Minnesota Department of Human Services (DHS) to explore expanding Medicaid eligible services to include housing support services and in 2017 a bill was passed authorizing DHS to seek federal approval to pay for housing support services under Medicaid. DHS submitted its request to CMS and received federal approval for expanded coverage of housing support services in mid-2019 with reimbursements for expanded services expected to commence in mid-2020. This initiative will provide a consistent, predictable, and reliable source of funding for housing assistance for Medicaid-eligible individuals. The specific types of activities that will be eligible for reimbursement are extensive and includes services that are currently available but limited by a lack of consistently available and adequate funding.

KEY PROGRAM COMPONENTS

- ### Expanded Funding to Transition Clients from Homeless to Stably Housed
  One category of expanded services that are eligible for coverage under the newly expanded Minnesota Medicaid program is up to 150 hours per transition for services that help find and move clients to stable housing in the community. These services include developing and updating crisis plans; resolving barriers to accessing housing including applying for financial support such as ongoing rent subsidies, funds for deposits and moving expenses; assisting with the housing search and application process; and helping to coordinate the move.
- ### Expanded Funding to Help Clients Maintain Stable Housing
  Another type of expanded services that are eligible for reimbursement under the expanded Medicaid program is up to 150 hours per transition for services that help maintain stable housing in the community. These include services to help prevent behaviors that jeopardize housing; provide education to help maintain lease compliance; assist with benefit compliance requirements to maintain financial support for housing; coach to improve or develop skills building key relationships, such as with property managers and neighbors; and help build natural supports in the community.
- ### Expanded Funding for Person-Centered Consultation Services
  The third type of expanded services that are eligible under the expanded Medicaid program include a one-time per year consultation for person-centered planning services to help access support services. This will fund services that provide Medicaid-eligible clients with a consultant to create a person-centered plan that may include referrals to other needed services based on the plan.

Minnesota Case Study

Minnesota Medicaid Expansion for Housing Stabilization

PUBLIC POLICY & FUNDING ALIGNMENT INITIATIVE

Goal & Purpose	The purpose of this initiative is to increase access to housing stability services for Medicaid recipients to improve health outcomes and increase opportunities for integrated community living.
Strategy	By expanding the types of services that are eligible for reimbursement by Medicaid, more funding will be provided to support services that are intended to increase both the quality of services and the system capacity to deliver housing stability services.
Human Services Partners	**MN Department of Human Services:** Sets service standards and processes to implement expanded Medicaid billing procedures and engages new providers of eligible services to expand access. **Service Providers:** The existing housing stability provider network will be encouraged to participate to ensure broad access to services and service funding.
Health Partners	**Health Plans:** Health Plans may help facilitate billing process for service providers lacking experience with Medicaid billing.
Housing Partners	**Affordable Housing Providers:** Various non-profit housing organizations and private landlords will be engaged by service providers seeking housing options for their clients.
Target Population	Medicaid-eligible individuals who meet the following criteria: 1. Enrolled in Medical Assistance 2. Have a certified disability or disabling condition 3. Are experiencing or at risk of housing instability 4. Have a qualifying housing-focused, person-centered plan
Geography Served	Statewide.
Funding Sources	Medicaid funds.
Timeframe	Legislative Action--Started 2017. Implementation of Expanded Medicaid Reimbursement--Expected 2020.
Key Outcomes	Expected outcomes include: • Improved housing stability for Medicaid recipients. • Increased opportunities for integrated community living. • Improved health and well-being for Medicaid recipients experiencing housing instability. • More efficient use of health systems and lower health care costs for target population. • Reduced system complexity by establishing standard services & reliable funding mechanism. • Reduced racial and ethnic disparities in housing stability and access to services.
Lessons for Replication	Preliminary lessons include: • Housing stability service provider network has varying capabilities. • Many service providers are organized around a set of grant funded activities rather than a fee for service model like Medicaid which provides for billing in 15-min increments. It may take time for some providers to adapt to a different payment model. • Linking service providers with health plans that can facilitate Medicaid billing for them may provide a path forward for some organizations.

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We hope to leave you informed and energized to join our community of health & housing organizations working together to make a better life for all Minnesotans.

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