Health + Housing

Goal: Address the dual challenges, especially acute in low-income and predominantly BIPOC populations in our service area, of

1. Lack of access to safe affordable housing and
2. Poor health outcomes due to social determinants of health and access to healthcare – especially culturally competent healthcare services.

Health + Housing

Concessionary Capital

Investment from healthcare payor to bridge affordable housing financing gaps and create more housing for low-income households in and for economically distressed communities

Healthy Buildings

A focus in the design and construction of affordable housing on the impact the built environment can have on health

Healthcare Access & Culturally Competent Healthcare Services

Partnership with healthcare provider to create on-site and/or easily accessible healthcare services and integrated, culturally competent care within a housing community

Data Driven

Intentional focus on data from project conceptualization through ongoing operations, both in the creation of health metric goals (regularity of screenings, etc.) and in support of meeting those goals, as well as in the ongoing evaluation of the effectiveness of the initiative for all stakeholders involved (health outcome impact for residents, financial impact for healthcare investors, etc.).

Health + Housing

Real Estate Developer

to provide development and property management services

Healthcare Payors

typically Medicaid Managed Care Organizations

1. provide concessionary capital to fill financing gaps that prevent affordable housing developments from moving forward and
2. work to support healthcare provider(s) and impact evaluators with data and add-on services

Healthcare Providers

typically Federally Qualified Health Centers

to provide access to healthcare services and culturally competent connections to care via community health workers and navigators

Health Outcome Evaluators

to guide health intervention metric benchmark creation among involved parties and lead ongoing health impact evaluation

Social Service Providers

and other community groups

to provide additional social and supportive services

Evaluation Questions & Associated Measures

How does living at the H3C improve the clinical health of its residents?

- Oral health screenings
- Diabetic Hemoglobin A1c Control
- Comprehensive Diabetes Care
- Inappropriate emergency department utilization and follow up
- Adult BMI Assessment
- Depression Screening and Follow-Up for Adolescents and Adults
- Appropriate Depression Screening Follow-Up for Adolescents and Adults
- Controlling Blood Pressure
- COVID vaccination status
- Fluoride varnish
- Hepatitis screening and medication
- Well-Child Visits (WCV)
- Child immunizations - 0-3 year old; 10-13 year old
- Breast cancer screening
- Cervical cancer screenings
- Colorectal Screening
- Reduction in avoidable in-patient visits

How does living at the H3C reduce the total cost of care and utilization for its residents and overall?

- Total cost of care

How do healthcare costs and utilization compare to similar populations in New Orleans who are not H3C residents?

- Average total cost of care

How does living at H3C improve the overall quality of life for its residents?

- Social isolation measures
- Resident satisfaction/quality of life measures SDOH Screening Assessment and follow-up (closed-loop)
- SDOH Screening Assessment and follow-up (closed-loop)

H3C

192 Senior and Family Units + On-site FQHC

New Orleans, LA

Expected to serve over 4,700 patients annually with primary and preventive health care, pediatrics, immunizations, chronic disease management, pre-natal care, behavioral health, optometry, health and wellness training, pharmacy and laboratory services, and social services

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The Pearl

Jackson, MS

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