



## **A Case for Health Vouchers: Rental Assistance Vouchers as a Health Intervention**

### **Concept Paper**

**November 17, 2017**

There are tremendous health risks associated with living in high poverty, high crime, lower opportunity neighborhoods. People living in such neighborhoods have higher rates of obesity, depression, post-traumatic stress disorder, asthma, and high lead blood levels.<sup>1</sup> Many Connecticut families suffering from ailments associated with their environments are interested in moving, but are unable to do so due to a lack of affordable housing in health-promoting areas. Decades of explicit and implicit housing policies that generated segregation, such as redlining, and discriminatory lending practices, have created neighborhoods in which Blacks and Latinos are disproportionately isolated from the structures that lead to positive health outcomes and success in life. Research also demonstrates that families who move from high poverty to mixed income neighborhoods see changes in health outcomes.<sup>2</sup>

As a society, we need to invest in communities that present health risks to transform them into areas where all families can thrive, but that is a long term prospect made exceptionally challenging by the dynamics of poverty concentration and disinvestment. Furthermore, decades of research have yet to identify an investment or set of investments that transform struggling communities without involuntary displacement.

What the research has determined conclusively is that low income families – and especially children – are more successful across a range of outcomes when they move from high poverty, high crime neighborhoods to thriving communities with safe streets, high performing schools,

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<sup>1</sup> See Rossen LM, Neighbourhood economic deprivation explains racial/ethnic disparities in overweight and obesity among children and adolescents in the USA, *J Epidemiol Community Health* 2014; 68:123-129. Quynh C. Nguyen, Dolores Acevedo-Garcia, Nicole M. Schmidt & Theresa L. Osypuk (2016): The Effects of a Housing Mobility Experiment on Participants' Residential Environments, *Housing Policy Debate*; Dolores Acevedo-Garcia, Theresa L. Osypuk, Nancy McArdle & David R. Williams, *Toward a Policy Relevant Analysis of Geographic and Racial/Ethnic Disparities in Child Health*, 27 HEALTH AFFAIRS 321, 323 (2008); David R. Williams, Michelle Sternthal & Rosalind J. Wright, *Social Determinants: Taking the Social Context of Asthma Seriously*, 123 PEDIATRICS S174, S181 (2009).

<sup>2</sup> Nguyen, Q. C., Acevedo-Garcia, D., Schmidt, N. M., & Osypuk, T. L. (2016): "The Effects of a Housing Mobility Experiment on Participants' Residential Environments." *Housing Policy Debate* 1-30.

and other “higher opportunity” features. This proposal puts forth a strategy to help children who face the highest environmental health risks – Health Vouchers. Health Vouchers should be considered a complementary strategy to continued efforts to revitalize and invest in struggling communities.

This effort is the brainchild of Open Communities Alliance (OCA), a Connecticut-based civil rights non-profit, which focuses on generating access to opportunity for historically disenfranchised groups, particularly through promoting pathways to housing in thriving communities. Other partners to this project include the University of Connecticut Health Disparities Institute, which brings data analysis and evaluation capacity to this project, Health Equity Solutions, a health disparities advocacy group, the Hartford Knights, a school-based mentoring and community engagement organization, and a team of Hartford community-based doctors.

## Summary

This proposal lays out a multi-step process for creating a pool of “Health Vouchers” – government-funded rental assistance that can, in essence, be prescribed by a doctor, community health worker or social service provider to allow low-income families with children experiencing negative health outcomes due to their environment move to areas likely to generate improvements in health. Versions of this concept have been sketched out by one of our national partners, but to our knowledge this the first proposal for a direct implementation of the concept in the field.<sup>3</sup> This initiative should work in tandem with deep investments to make struggling neighborhoods healthier. While these longer term efforts are underway, Health Vouchers would provide immediate and meaningful relief for low-income families facing health challenges who have an interest in moving to opportunity.

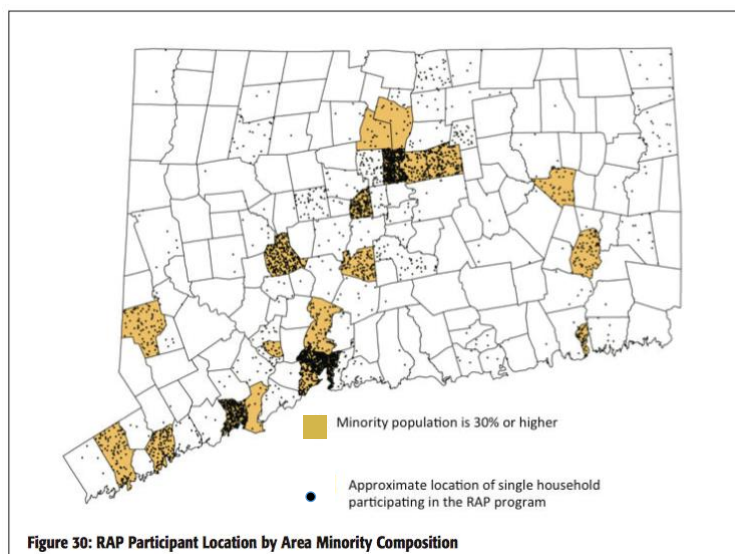


Figure 1: Rental Assistance Program Certificate Location by Area Racial and Ethnic Composition (source: 2015 State of Connecticut Analysis of Impediments to Fair Housing Choice)

<sup>3</sup> See “Prescription for a New Neighborhood? Housing Vouchers as a Public Health Intervention” and accompanying policy briefs at [www.prrac.org/projects/healthdisparities.php](http://www.prrac.org/projects/healthdisparities.php).

## **Connecticut Rental Assistance Program**

The Rental Assistance Program (RAP) is the Connecticut's largest state-funded program providing tenant-based housing subsidies to low income families and individuals. Families given RAPs are able to take what is functionally a housing voucher on the open rental market to search for an apartment. The family is expected to pay 30-40% of its income towards rent and the program pays the remainder up to a certain cap.

Due to a variety of factors, 75% of RAP participants live in racially concentrated areas of poverty – areas where the poverty level is three times the regional average and is 50% or greater minority. These are all areas which also have the lowest access to “opportunity” in Connecticut using a census tract analysis ranking every census tract along five levels of opportunity access (very high, high, moderate, low and very low) considering factors like school performance, crime rates, job access and more. In fact, 57% of RAP households live in the 2% of the land area of Connecticut categorized in the lowest of the five opportunity levels.<sup>4</sup>

In essence, this state voucher program, like its federally-funded analogue, the Housing Choice Voucher (HCV) Program, currently functions to limit housing choices for low-income families to areas with levels of concentrated poverty associated with negative health outcomes.

## **Poverty Concentration, Racial Isolation, and Health Outcomes**

A growing body of research indicates that families that move into higher opportunity areas experience positive health outcomes. An opportunity-based housing voucher program in Baltimore has achieved tremendous success since it was established in 2003. According to survey data, nearly 80% of participants in the Baltimore Housing Mobility Program reported that they feel safer, more peaceful, and less stressed after moving into mixed-income neighborhoods. Sixty percent say they feel more motivated and nearly 40% say they feel healthier.

Additionally, Moving to Opportunity, a randomized housing mobility experiment sponsored by the U.S. Department of Housing and Urban Development, showed evidence that housing mobility may reduce health disparities. Findings from 10 to 15 years of data show that families that were given housing vouchers to live in less distressed communities demonstrated improved physical health including lower rates of obesity and diabetes. These families also demonstrated improved mental health including depression and psychological distress.

Most recently, research by Raj Chetty and his colleagues at Harvard found that children in families who moved from higher poverty to lower poverty areas experienced lower rates of single-parenting and teen pregnancy, were more likely to attend college, and earned higher

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<sup>4</sup> Erin Boggs and Lisa Dabrowski, Out of Balance: Subsidized Housing, Segregation and Access to Opportunity in Connecticut, September 2017, available at [https://d3n8a8pro7vhmx.cloudfront.net/opencommunitiesalliance/pages/360/attachments/original/1506957824/Out\\_Of\\_Balance\\_Report\\_-\\_Final-rev.1.pdf?1506957824](https://d3n8a8pro7vhmx.cloudfront.net/opencommunitiesalliance/pages/360/attachments/original/1506957824/Out_Of_Balance_Report_-_Final-rev.1.pdf?1506957824)

incomes. While not part of the Chetty study, these findings suggest that improved health outcomes likely accompanied the other positive outcomes assessed. Health outcomes improve as income improves, so the positive income outcomes in the Chetty study logically extend to health improvements.

### **Creating Health Vouchers**

What if Connecticut's state Rental Assistance Program or federal Housing Choice Voucher Program could be transformed from programs that generate segregated housing patterns and contributes to negative health outcomes to one that provides true housing choices and leads to healthier children?

A Health Voucher program would involve identifying doctors, community health workers or social workers interacting with populations that are income-qualified for voucher programs and have children experiencing any number of identified environmentally-triggered negative health outcomes. In the course of providing treatment or other assistance, the provider could educate the patient's caregiver about the connection between environment and health and inform them of the availability of a Health Voucher and associated mobility counseling, a counseling intervention assisting families with better understanding their housing options in healthy, higher opportunity areas.

Participation in the Health Voucher program would be completely optional for the patient-families and, when the program is fully implemented, new Health Vouchers would be prioritized for use in neighborhoods likely to promote positive health outcomes. As part of a pilot effort, current participants in the RAP program with children fitting the project's medical criteria would be offered moving and security deposit assistance if they made a successful move to a neighborhood likely to produce better health outcomes for their children. The progress of moving families would be assessed using standard social science procedures to allow outcomes to inform the potential of an expanded Health Voucher program.

### **Mobility Counseling**

Spurred by the positive outcomes of moving to higher opportunity areas and, in some cases, as the result of litigation, a number of "mobility counseling" programs exist around the country.<sup>5</sup> These programs provide counseling services to families using tenant-based subsidies interested in moving to higher opportunity communities. The counselors provide information on why neighborhood is so important to life outcomes, assist with finding units, interface with landlords, and help connect program participants to neighborhood resources like transportation, schools, and other amenities. It is important that mobility counseling be incorporated into a plan for Health Vouchers.

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<sup>5</sup> See [www.prrac.org/pdf/HousingMobilityProgramsInTheUS2015.pdf](http://www.prrac.org/pdf/HousingMobilityProgramsInTheUS2015.pdf).

## Creating a Health Voucher Pilot Program

Open Communities Alliance recommends that the efficacy of a Health Voucher program be demonstrated initially through a pilot program working with existing voucher holders, as described below. If successful, this would be followed by a full-fledged program with dedicated health vouchers and resources to support moves. This would allow families with the most serious environmentally-triggered negative health outcomes to participate even if they are not currently benefiting from the RAP program. This plan will be honed during a four-month planning period.

A Health Voucher pilot program could be administered as follows:

- (1) Source of Vouchers.** In the pilot phase, this program could be tested by working with households participating in the Department of Housing's existing RAP program. There are several strategies for identifying potential program participants that are detailed under item #3 below, "Identifying Clients." Ideally, in the fully-implemented iteration of this program new vouchers would be set aside specifically for use in this program.<sup>6</sup>
- (2) Health Opportunity Areas.** During both the pilot phase and fully-implemented program, it is important to designate communities that promote positive health outcomes where the program benefits, such as moving and security deposit assistance, will be provided. In a fully-implemented program, the dedicated Health Vouchers would also be restricted to these areas.

OCA suggests that our opportunity mapping, which considers factors like crime, school performance, poverty levels, vacancy rates and more, be compared to indicators of environmental health such as the presence of lead in the housing stock, pollution emitting plants, elevated levels of crime, and air quality. We suspect that such an analysis will reveal that "high" and "very high" and potentially some "moderate" opportunity areas will be found to be "healthier" communities. The opportunity mapping designations are already used by the Department of Housing for several of its programs, including the Mobility Counseling program, so continuing with this metric would be helpful if it aligns with health indicators. With technical assistance from Health Equity Solutions and OCA, the UConn Health Disparities Institute would develop and map a set of health indicators and compare them to OCA's existing Opportunity Mapping. Ideally, the maps would correspond. If not, the project would focus its efforts on creating access to healthy areas as identified by the health indicators map.

When considering indicators of healthy neighborhoods, OCA cautions against the use of indicators that can become "unhealthy" under certain conditions. For example, "walkability" is sometimes used as an indicator of healthy neighborhood conditions because presumably if a neighborhood is "walkable," with the availability of sidewalks and nearby amenities like shopping and schools, residents will walk more and thus be

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<sup>6</sup> Each RAP certificate costs the state approximately \$9,000 a year.

healthier. Typically such indicators do not consider personal safety in the scoring. If a neighborhood has a high level of crime it can quickly become unhealthy to walk around the block. Likewise, proximity to a park has in the past been used as a positive neighborhood indicator. This is only true in the absence of high levels of crime and poor air quality.

For the purposes of the pilot program, OCA recommends concentrating the effort in the Hartford region because the rent levels will be most feasible there and many of the potential partners are located nearby.

### **(3) Identifying Clients.**

- a. Health Criteria:** OCA will seek the input of health professionals in developing the best system for identifying the most appropriate health indicator criteria to select clients for this program. To qualify for the Health Voucher program, OCA recommends that the selection criteria be children in families with incomes at 50% of AMI or below (the RAP and HCV eligibility criteria) who are experiencing negative health outcomes due to their environment. We suggest that the ideal patient will have a health condition that can relatively quickly be addressed by a change in environment, but turn to the input of health professionals to identify the appropriate health conditions. Some possibilities include asthma, Post Traumatic Stress Disorder (PTSD) or other selected mental health issues, high lead blood levels, and diabetes.

In order to ensure fairness for families currently on the RAP waitlist, some of whom have been on the list for years, it might be wise to devise a system for identifying waitlist families who might qualify for the Health Voucher program perhaps by doing a mailing indicating the program criteria and/or offering the family a free health evaluation.

- b. Connecting to Clients.** In the pilot phase there will be three strategies for recruiting clients, all of which can also be employed when the project is in full implementation, along with the involvement of any number of state agencies.

In the pilot phase the role of community partners is particularly important since their involvement is essential to identify existing voucher holders living in areas that are producing negative health outcomes. The three ways to connect to voucher holders with children experiencing negative health outcomes include:

- i.** A partnership with DOH and participating physicians working with low-income populations to identify patients experiencing the identified environmentally-triggered negative health outcomes whose families already participate in the RAP program.

- ii. Outreach through school-based programs, such as the Hartford Knights, who would identify families who fit the project's criteria. Hartford Knights has already agreed to be a partner in this project.
- iii. An affiliation with community health workers who would help identify candidate families.

Once client-candidates are identified, they would have to undergo an initial health assessment and then be referred to a state-funded mobility counseling program. During the pilot phase, Open Communities Alliance would coordinate the project's administration and, with assistance from UConn Health Disparities Institute, the assessment of outcome data. At the end of the pilot phase the partners would determine if a similar role is necessary should the program be implemented fully.

- (4) Health Provider Role.** There will be several important interactions health providers and community health workers in this program. First, in the pilot and full implementation phases, both community health workers and clinic physicians are important conduits to potential clients. Second, before a family is admitted to the program there needs to be a baseline assessment of the family's health. The partners will need to determine who provides this assessment. Lastly, once the project is in full implementation, there will need to be ongoing engagement with medical providers to educate them about the availability of health RAPs and develop systems for referral.
- (5) Referral to Mobility Counseling.** After a medical assessment, the client is then referred to mobility counseling, which provides a housing needs assessment, unit search assistance, and post-move counseling. The project partners need to determine the best way to involve community and medical partners, which have been involved with the client at earlier stages in the process. It may be that this project will work most effectively if the trust relationships that developed in the early stages of the relationship with the client are important to maintain as the project moves forward.
- (6) Monitoring and Follow Up.** A mobility counselor-medical research team coordinated by Open Communities Alliance will follow the progress of each client family to monitor results. A set of measurable outcomes and follow up protocols will be designed to ensure results-based accountability. The time period by which to expect positive results should be determined by health professionals based on anticipated outcomes for the health conditions identified as the focus for this pilot.

Some of the health outcomes that could be measured include:

- Did patients experience a decreased rate of emergency room visits for due to asthma attacks after moving to a higher opportunity neighborhood?
- What mental health changes were experienced by the patients pre and post move?

- If elevated lead-blood levels were present prior to the move, has the patient experienced a drop after the move?

These will be more fully developed during the planning period of this grant. It would also be useful to collect data on other life circumstances that have been affected by a move to higher opportunity in other parts of the country. These include educational performance and employment.

## The Planning Period

During the planning period, OCA will work to more fully develop several components of the project and answer specific questions. These include:

- Health Criteria – Working with a team of health experts from the UConn Health Disparities Institute, Health Equity Solutions, academic institutions, and national organizations with expertise in health and housing policy, we will work to answer the following questions:
  - What negative health indicators are most appropriate for this project, considering the need to show health improvements within a year or two of implementation?
  - How should “healthy neighborhoods” be defined?
- Identifying Clients - In partnership with neighborhood groups, mobility counseling agencies, community health workers, and, ideally, the state of Connecticut we will explore:
  - How best to recruit clients to this program?
  - How best to keep clients engaged with the program?
  - How best to communicate with clients about how moves to opportunity could impact health outcomes?
- Role of Partners – In consultation with the partners to this project, during the planning period we will work to fine-tune their role, especially with regard to client interaction. We will try to address:
  - How to best provide case management, particularly once a family has moved, when clients may have a trusting relationship with their original contact to this project in their neighborhood of origin?
  - Which partner is best situated to provide post-move counseling?
  - How should medical information be kept private when multiple partners are involved in providing services to clients?
- Outcome Measures – Again, with the assistance of local and national partners with expertise in health and housing policy, during the planning phase we will answer the following questions:



- What move-related outcomes should be measured to demonstrate project success? E.g. moves to particular types of neighborhoods.
- What health-related outcomes should be measured?
- What non-health-related outcomes should be measured? E.g. educational and employment outcomes.