Progress and Opportunities: Integrating Housing and Health Data—August 2016

**Housing Data Integration Planning Grant.** In November 2015, Mercy Housing Northwest received a grant from the Bill & Melinda Gates Foundation to identify what it would take to integrate Washington’s “orphaned” affordable housing data. Our work was intended to build on three years of previous work completed by the Research and Data Analysis (RDA) unit within Washington’s Department of Social and Health Services. That critical effort merged public housing authority (PHA) data into the state integrated database and allowed for reporting on the characteristics of public housing assistance recipients in Washington State ([report available at this link](#)). This update is intended to share what we have learned and where we have found opportunities and progress.

**Housing Data Systems.** Washington’s public and affordable housing falls into two broad categories:

- Public housing authority data reported annually to HUD at the individual level. PHAs across Washington State serve at least 160,000 individuals (2013).
- State and City-Financed Housing—This data is reported to the Department of Commerce and the State Housing Finance Commission (WSHFC) via the Web Based Annual Reporting System (WBARS) for all units receiving capital financing for the two state agencies and six participating city and county housing funders. This data represents about 68,000 units housing 141,000 people (December 31, 2015).

**Initial Progress with PHA-Health Data Integration.** There is some overlap between the two reporting systems due to housing units that are reported in WBARS and also have rental assistance vouchers through one of the PHAs. A notable difference is that the Public Housing data includes details on each individual resident, including name, gender, social security number, and birthdate which facilitates matching of individual identifiers when integrating with other data sets. The WBARS data includes some information on head of household, but not on each resident.

The initial RDA reports that profiled the characteristics and use of state assistance programs demonstrated the value of integrated social services and public housing data as a tool to examine the impact of public housing assistance on its recipients. State and federal partners are putting agreements in place to annually update the Washington State PHA data in the state integrated client database. These agreements will present a great opportunity to further integrate housing, health, and social service utilization information for these residents, across different types of public housing and in comparison to individuals who do not reside in public housing. This work is underway at both the state level and locally in King County.

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For additional information about how you and your organization can support and benefit from this work, please contact Bill Rumpf, President, Mercy Housing Northwest at brumpf@mercyhousing.org.
Assessing Feasibility of WBARS Data Integration.
The effort to scope out the desirability and requirements for integrating WBARS data with health and social service data sets included several months of discussions with leadership and program staff from WSHFC and Commerce, a brief presentation to the Housing Trust Fund Policy Advisory Team, interviews with selected affordable housing owners, and technical analysis by the Center for Outcomes Research and Education (CORE).

An in-depth evaluation was conducted regarding the data elements and reporting structure of the PHA and WBARS data. This information was brought together to guide discussions on field alignment for creating a merged housing data source between the two data sources. Draft technical documents are available that summarize these elements, and could be used in future conversation for assessing development of new data fields and definitions and how to best align with reporting structures.

There was broad support for the utility of having integrated data for program design, evaluation and for encouraging cross-sector collaborations. An oft-cited example is how permanent supportive housing has demonstrated savings and made at least some headway in attracting resident service funds from mainstream health and social service entities, with inclusion in Washington’s proposed Medicaid 1115 waiver to pay for resident services in PSH. However, the modifications and business changes needed to incorporate individual identifiers into WBARS for data-matching were characterized as “a heavy lift” by the State participants in the feasibility effort. Considerations included the need for additional staff and IT costs, training for borrowers, data security, privacy protections, the resident consent process, and a desire for reciprocal use of integrated data. Anecdotally, the impact on borrowers would vary—some already collect the same individual information as PHAs and others do not. A survey would be needed to accurately gauge the burden on WBARS reporting borrowers.

Opportunities to Integrate Housing with the Accountable Communities of Health. The state’s health innovation plan, known as Healthier Washington, created nine regional “Accountable Communities of Health” which combine government, nonprofit and private sector entities to plan and carry out clinical and community health improvement initiatives. Promising opportunities exist at the state and county level to use data to further housing-based health partnerships. Using a federal SIM grant, the Washington Health Care Authority (HCA) is making large investments in data integration, including creation of an interactive dashboard tool for the regional Accountable Communities of Health and local health jurisdictions that combines multiple health and social indicators. One opportunity that could have impact in all 9 ACH regions, would be for the HCA to add integration of the statewide PHA data to the scope of data being combined for this interactive ACH tool. Having public housing and voucher data would enable health and community planners to see the intersection of the low-income housing residents with many other indicators, and track progress and effectiveness of interventions over time.

The current opportunity with the WBARS data is to use address matching to promote immediate access to integrated data at minimal cost. While there is not individual-level information for each resident of the state and city-funded affordable housing units reported in WBARS, it does appear possible to overlay the addresses of individual Medicaid beneficiaries with public and affordable housing sites, with appropriate privacy protections, to assess health needs and measure trends. Washington state has added 500,000 enrollees to the Medicaid program since ACA was adopted, and a high percentage of affordable housing residents now have health coverage.

This address matching—when combined with the PHA/HUD data—would allow comparison of health, housing, and other outcomes for all individuals living in public and affordable housing (with the caveats that Medicaid address data may not always match data in WBARS and other limitations may emerge as the data is reviewed). Additionally, WBARS does not
consistently track housing unit numbers for properties. This may be a simple opportunity for data improvement that could add benefit to testing the address matching approach.

A specific opportunity to test data integration using affordable housing addresses and Medicaid claims data is underway in King County, where Public Health Seattle & King County has received a Robert Wood Johnson Data Across Sectors for Health (DASH) grant. PHSKC intends to integrate Seattle and King County public housing authority data with Medicaid data and has expressed willingness to integrate the WBARS address-information for King County affordable housing residents.

**Testing Housing-Based Health Interventions.** Connecting data is just part of building housing-health linkages. The other critical element is designing and testing interventions to demonstrate effectiveness in improving quality of health and/or savings in preventable health expenditures. A recent study of affordable housing in Portland did just that. Enterprise Community Partners, published “Health in Housing: Exploring the Intersections between Housing and Health Care” done by the Center for Outcomes Research and Education (CORE). The research looked at 148 housing projects that are home to 10,000 residents in Portland, Oregon. The study found a 12% average reduction in Medicaid expenditures after residents moved into affordable housing. Primary care visits and resident health access increased, while emergency rooms visits dropped by 18%.

The King County Accountable Community of Health is hoping to accomplish something similar. The King County ACH has just selected the Housing-Health Partnership as its Regional Health Improvement Project. Partners include Mercy Housing Northwest, Global to Local, Neighborcare Health, Seattle and King County Housing Authorities, and Public Health. The project scope expands on the research from Portland by refining and measuring the impact of integrated health and prevention services in affordable housing and in low-income communities in King County that have disproportionately poor health outcomes. (Leaders from both the ACH Dashboard project and the King County ACH project will work across projects to develop and learn together to best align approaches.)

**Looking Forward.** There is good progress underway related to integrating housing data for some of Washington’s most vulnerable residents, whether through matching affordable housing sites with Medicaid beneficiaries’ address data, or by annual integration of public housing authority data with Medicaid claims. Washington state is leading the way in using cross-sector data-sharing to make effective, non-duplicative health and social service investments. As the efficacy of housing-related health improvement activities is shown, we believe it will be beneficial for the affordable housing, homeless, and health sectors to fully integrate data for the universe of public and affordable housing residents with their health care data, as illustrated by the graphic below.