



Connecting Public Housing and Health

A health impact assessment of HUD's designated housing rule

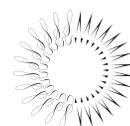
HEALTH **IMPACT**
PROJECT

Overview

A health impact assessment (HIA) was conducted to inform an update by the U.S. Department of Housing and Urban Development (HUD) of its designated housing rule and to illustrate the potential for incorporating health data into federal agency decisions. The designated housing rule allows housing authorities to allocate certain public housing properties, or a portion of them, for occupancy by senior families, disabled families, or a mixed population of senior and disabled families.

A collaboration of the
Robert Wood Johnson Foundation and
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HIAs identify the potential health effects of a proposed policy, project, or program to inform policymakers, those affected by the decision, and others with an interest in the outcome, and to offer practical options for maximizing health benefits while minimizing health risks. This particular HIA—which was conducted by the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts, in partnership with the Oregon Public Health Institute and the Metropolitan Area Planning Council—sought to identify potential health implications that could stem from changes to the designated housing rule. To provide HUD with data to inform the development of an updated rule, the assessment was conducted before the rule-making process began. The HIA examined two scenarios HUD could pursue, developed in consultation with key stakeholders. (See Page 5.)

This assessment was also intended to demonstrate how HIA might be used—in the context of a federal rule-making process—as a tool to advance the National Prevention Council’s goals. HUD is a member of the council, a multiagency federal panel charged with working together to improve the health of all Americans, and chose the designated housing rule-making process for this purpose.

This document summarizes findings from the assessment. The study team conducted a systematic literature review; quantitative analysis of housing and health data; and qualitative research, including interviews and focus groups with a national sample of public housing residents, property managers, resident service coordinators, community partner organizations, and housing or health administrators. This report also outlines recommended actions, arising from the HIA, that HUD could take to optimize the potential health effects of designated housing rule-making.

What is the history and context of the designated housing rule?

The designated housing rule is one of many tools used by public housing authorities (PHAs) to allocate scarce resources and provide housing for seniors and people with disabilities who live in the PHAs’ jurisdictions. HUD is planning to update the rule to align with statutory changes made in 1996 and to clarify and streamline the procedures by which PHAs designate housing for these populations.

The authority for PHAs to designate housing was enacted amid controversy over how best to provide affordable housing for seniors and people with disabilities. Between the early 1960s and 1980s, Congress expanded the definition of “elderly family” to include people with disabilities, and public housing properties that had been predominantly for seniors became available to younger individuals with a range of disabilities. These changes to the definition occurred during the national movement toward deinstitutionalization of people with disabilities in favor of opportunities for integrated community living.

As a result, seniors and younger people with disabilities began living in the same public housing properties more frequently. Concerns among senior and disability rights advocates about access to housing, coupled with dramatic media accounts of alleged violent incidents committed by younger residents with disabilities against seniors, highlighted the challenges PHAs faced in successfully housing these populations together. In response, through the Housing and Community Development Act of 1992, Congress established separate definitions for “elderly family” and “disabled family” and gave PHAs the option to designate certain properties, or a portion of them, for senior families, disabled families, or both. Two years later, HUD released the designated housing rule (24 CFR 945), setting administrative requirements and procedures. In 1996, the Housing Opportunity Program Extension Act significantly revised requirements for PHAs seeking approval to designate housing and reduced HUD’s role in the approval process. Since that time, HUD has continued to issue a series of notices to guide PHAs in their use of the rule until the regulation is revised.¹

One hundred twenty-eight PHAs in 37 states and the U.S. Virgin Islands have an approved plan to designate housing for seniors or people with disabilities. These plans cover 63,806 units—less than 6 percent of all public housing nationwide—of which approximately 91 percent are designated for senior families, 4 percent are designated for disabled families, and 5 percent are designated for a mixed population. The majority (96 percent) of designated units are one bedroom or studio apartments. Urban PHAs that own or manage a large number of units are more likely to use the designated housing rule than are those in rural areas and those with fewer units. Designated housing is located across the country and is concentrated in large metropolitan areas. PHAs that designate housing for disabled families or mixed populations are located primarily on the East Coast and in the Chicago region.

Key Definitions

HUD uses the following terms to refer to its target populations:

“**Person with disabilities** means a person who:

- (i) Has a disability, as defined in 42 USC 423;
- (ii) Is determined, pursuant to HUD regulations, to have a physical, mental, or emotional impairment that:
 - (A) Is expected to be of long-continued and indefinite duration;
 - (B) Substantially impedes his or her ability to live independently, and
 - (C) Is of such a nature that the ability to live independently could be improved by more suitable housing conditions; or
- (iii) Has a developmental disability as defined in 42 USC 6001.”[†]

“**Disabled family** means a family whose head (including co-head), spouse, or sole member is a person with a disability. It may include two or more persons with disabilities living together, or one or more persons with disabilities living with one or more live-in aides.”[‡]

“**Elderly family** means a family whose head (including co-head), spouse, or sole member is a person who is at least 62 years of age. It may include two or more persons who are at least 62 years of age living together, or one or more persons who are at least 62 years of age living with one or more live-in aides.”[§]

* Based on feedback from members of the advisory committee for this HIA, the terms “seniors” and “senior families” are used in lieu of “elderly” and “elderly families,” where possible.

† 24 CFR 5.403.

‡ Ibid.

§ Ibid.

Who is eligible for or living in designated public housing?

Nearly 5 million low-income households, comprising more than 10 million individuals, live in HUD-subsidized housing in the United States.² Approximately 22 percent, or 1.2 million, of all HUD-subsidized units are public housing.³ In addition to public housing, PHAs are also responsible for managing and administering the Housing Choice Voucher program, which provides vouchers for subsidized housing to help very low-income families afford housing in the private rental market. Nearly 800,000 senior families (more than 450,000 of which have a head of household or spouse with a disability), and more than 830,000 younger disabled families, receive housing assistance through either public housing or the voucher program.⁴ Ninety-one percent of designated public housing units are for seniors only, so the majority of designated housing residents are seniors. Because studies have not examined the demographics or health status of designated housing residents specifically, the HIA team used two types of relevant data as a proxy for those who could be eligible for or residing in designated housing, including research on public housing residents, generally, and low-income seniors and people with disabilities living in counties where housing authorities operate.

Families in public housing typically have incomes below the federal poverty line.⁵ Public housing residents are also less likely than the general public to have attained education beyond high school. For example, a study using data on public housing residents from the Boston Behavioral Risk Factor Surveillance System found that only 36 percent had attained an education beyond high school, compared with 76 percent of other area residents.⁶ Households with heads who have lower levels of education are more likely to remain in or move deeper into poverty than are those with heads who have higher levels of education.⁷

People who are eligible for or residing in public housing have higher rates of physical and behavioral health issues than does the general population.⁸ Residents in public housing are more likely to report being in fair or poor health compared with other area residents.⁹ Limited mobility or the need for assistance with everyday tasks, such as toileting, eating, bathing, dressing, household chores, and arranging and getting to appointments, are common challenges for low-income seniors and people with disabilities and are also more common among seniors in public housing than among other seniors in the community.¹⁰ For example, one study reported that 40 percent of seniors in public housing had limitations in activities of daily living compared with 19 percent of senior homeowners.¹¹ An analysis of population health data for low-income individuals in counties where housing authorities operate found that 66 percent of low-income seniors were overweight or obese, and 25 percent had diabetes—and, among low-income people with disabilities, 72 percent were overweight or obese and 27 percent had diabetes.¹² By comparison, national statistics report that among adults in the general population, about 65 percent are overweight or obese and fewer than 10 percent have diabetes.¹³

How does the designated housing rule relate to health?

The HIA focused on six factors important to health that could be affected by designated housing rule-making: housing affordability, housing discrimination and choice, housing as a platform for supportive services, resident social environment, housing design and accessibility, and neighborhood characteristics. These factors were selected based on strong evidence of their effect on health outcomes and on stakeholder priorities. Because one of HUD's goals is to clarify and streamline the procedure that PHAs must follow to designate housing, the analysis also considers the implications of this regulation for PHA administration and financing.

Scenarios

This HIA assessed two possible scenarios HUD could follow in updating the designated housing rule. In the first, the majority of designated housing plans would continue to seek designation for senior-only properties, and HUD would clarify its policies regarding how the rule interfaces with financing mechanisms, such as the Low-Income Housing Tax Credit and Rental Assistance Demonstration programs. In the second scenario, HUD would use the rule-making process to encourage coordination of resources and collaboration among affordable housing and supportive service providers and those implementing state and local initiatives to address fair housing and homelessness. These two approaches are not mutually exclusive, and HUD could implement select actions from each.

Housing affordability

Limited affordable housing can force households to make difficult trade-offs that can negatively affect health. Adults who have unstable housing (e.g., who are behind on their rent or mortgage or are homeless) are more likely to report being in fair or poor health and to experience anxiety or depression than are those who have stable housing.¹⁴ A lack of affordable housing not only affects people's ability to acquire and maintain adequate shelter, but it also limits their ability to meet other basic needs: Financial constraints can force individuals to choose among paying for rent, utilities, food, or medical care.¹⁵ These trade-offs, termed material hardship, have implications for health through food insecurity, exposure to extreme temperatures, housing instability, or forgone medical care and medications. In focus groups, residents talked about facing difficult budget choices in their efforts to meet basic needs and stay healthy, such as paying for medications or healthy foods.

Affordable housing needs among both senior and disabled households have increased nationwide. The demand for federally subsidized rental housing is far greater than the supply. Only 1 in 4 low-income renter households that qualify for federal housing assistance is receiving it, and typically only after a lengthy wait.¹⁶ Income eligibility criteria vary among the federal housing assistance programs; in general, households must have incomes at or below 80 percent of the area median income, and some programs limit eligibility to incomes at or below 50 percent of the area median.¹⁷ However, a majority of households receiving rental assistance have incomes at or below 30 percent of the area median (roughly equivalent to the poverty line, on average, nationally). In 2012, for example, 73 percent of all public housing households earned an average of 25 percent of the median income in their respective communities.¹⁸

Nearly 7 million renter households earning less than half the median income for their areas are senior families without children or families with younger people with disabilities.

Nearly 7 million renter households earning less than half the median income for their areas are senior families without children or families with younger people with disabilities. Of these, HUD considers approximately 2.75 million households as having “worst-case” housing needs—renters with very low incomes (50 percent or less of the area median) who do not receive government housing assistance and who either paid more than half their monthly incomes for rent, lived in severely substandard conditions, or both. Nationally, these account for about 1 in 3 of all households with worst-case housing needs.¹⁹ Between 2009 and 2011, the number of worst-case households increased significantly.²⁰ This was especially true among households with younger people with disabilities.²¹

Moreover, nearly all data on worst-case and affordable housing needs, including those discussed here, underestimate the unmet need because they do not include those who are homeless or living in institutions, such as nursing homes or assisted living facilities. To be considered chronically homeless under the HUD definition, the individual or head of household must have a disabling condition, making it critical to include the homeless population when estimating the number of disabled households in need of housing.²²

As previously noted, PHAs predominantly designate properties as senior-only (91 percent of designated units). In focus groups conducted for this HIA, younger designated housing residents with disabilities voiced concerns about the implications for availability of affordable housing supply to younger disabled households if PHAs continue the trend of seeking approval for senior-only designations. On average, approximately 3,237 public housing units were newly designated for seniors each year between 2011 and 2013, compared with an average of 68 mixed and disabled designated units, combined. If the rule-making process does not result in changes to the average number of units designated for these populations, as many as 16,185 units would be newly designated for seniors over the next five years, compared with 340 or fewer allocated to younger people with disabilities.

Housing discrimination and choice

Housing discrimination can affect health by limiting people’s opportunities to live in affordable and accessible housing units and in neighborhoods offering high levels of economic and social resources. For example, practices such as “geographic steering,” where potential renters or purchasers are intentionally directed by property owners or others in the housing industry to highly segregated racial and ethnic minority and poor neighborhoods, can affect households’ access to resources and opportunities that are essential to health (e.g., education, employment, opportunities for physical activity, healthy foods, and medical services).²³ Data suggest that participants in the Housing Choice Voucher program may face housing discrimination, often based on their source of income or whether they are families with children.²⁴

Research that directly examines how housing discrimination affects health is limited, but analyses of the relationship between racial discrimination and health can help to illuminate the effects of housing discrimination. One systematic review of published studies found that racial discrimination is associated with a number of negative health outcomes, including poorer mental health, more intimate partner and interpersonal violence, poorer self-rated health, worse physical functioning, less use of preventive health services or medication adherence, higher rates of smoking and substance use, and physiologic responses consistent with stress, including changes in cortisol levels, blood pressure, and heart rate.²⁵

Housing discrimination remains a common problem for many population groups, including people with disabilities, despite policies designed to prevent it. Between 2008 and 2013, HUD’s Office of Fair Housing and Equal Opportunity filed 27,239 fair housing cases against rental property owners, real estate offices, public housing authorities, and others in the housing industry. Forty-eight percent involved allegations of

discrimination based on disability.²⁶ Furthermore, the number of such cases as a share of total fair housing cases filed increased in each of those years.²⁷

The designated housing rule operates at the intersection of several laws and policies that aim to decrease housing segregation and discrimination, including Title VI of the Civil Rights Act of 1964; the Fair Housing Act of 1968; Section 504 of the Rehabilitation Act of 1973; the Fair Housing Amendments Act of 1988; the Americans with Disabilities Act of 1990; and *Olmstead* case law and guidance.²⁸ One challenge HUD must address is how the designated housing rule can best operate within these laws and policies to decrease housing segregation and discrimination. If the rule-making improves collaboration between PHAs and agencies and nongovernmental organizations implementing state and local initiatives to address fair housing and homelessness, access by younger people with disabilities and frail seniors to public housing units and therefore to more affordable housing choices could increase.

Housing as a platform for supportive services

When housing is coordinated with supportive services, it can benefit the health of seniors and people with disabilities. Housing that is coordinated with services ranging from transportation to medical appointments to assistance with daily tasks such as cooking or bathing can increase housing stability, decrease behaviors such as substance abuse that are detrimental to health, improve medical care outcomes and treatment adherence, enhance quality of life, and facilitate community integration and housing choice. Evaluations of various models to coordinate supportive services with housing also indicate the potential for cost-avoidance or savings. For example, a 2005 survey by the Centers for Medicare & Medicaid Services estimated that if 165,276 nursing home residents who indicated that they would like to return to their communities received Home and Community Based Services waivers to do so, the public could see annual savings of \$2.6 billion.²⁹ These figures, however, do not consider the ability of respondents to successfully return to their communities. For example, one study estimated that 30 percent of seniors in long-term care facilities would be able to independently perform most everyday tasks.³⁰



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In focus groups and interviews, PHA staff, resident service coordinators (RSCs), and residents indicated that RSCs were a critical aspect of PHAs' efforts to support the housing and health needs of seniors and people with disabilities.

Providing housing as a platform for improving quality of life is a strategic goal for HUD. Service coordination—a bridge between housing and an array of available services and providers—is integral to successfully combining supportive services and affordable housing.³¹ In the early 1990s, HUD created the Service Coordinator Program and the Resident Opportunities and Self-Sufficiency Program to link public housing residents with resident organizing and leadership activities, supportive services, and assistance in becoming economically self-sufficient.³² In focus groups and interviews, PHA staff, resident service coordinators (RSCs), and residents indicated that RSCs were a critical aspect of PHAs' efforts to support the housing and health needs of seniors and people with disabilities. Several property managers indicated that these coordinators were essential to helping residents maintain tenancy, independence, and neighborly relations at their properties. If the rule-making promotes alignment of affordable housing and health resources, more senior and disabled families living in designated housing could gain access to supportive services that benefit health.

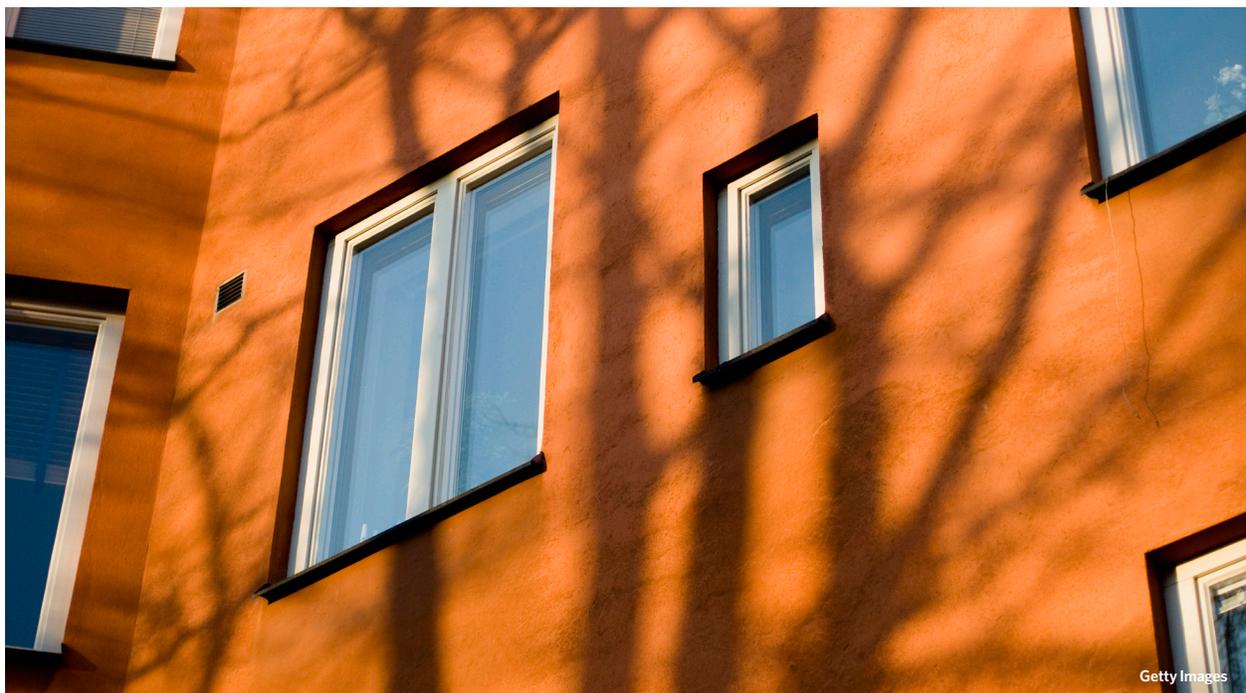


Resident social environment

For residents in designated housing, the social environment—the connections, relationships, and interactions among occupants—can have a substantial impact on health and quality of life. Strong social support networks and social participation can improve people's functional skills and quality of life and can help seniors live longer. Conversely, stressors such as crime, violence, and social isolation can negatively affect mental and physical health.

Some focus group participants noted that a sense of safety and connections with neighbors in their own building can decrease isolation and improve participation in physical and social activities. Conversely, many people described the health implications of experiencing conflict among neighbors, including stress, sleeplessness, and exacerbated asthma. Several participants indicated that they remained isolated in their apartments rather than socializing or participating in activities with other building residents because of real or perceived resident conflict and safety issues. Furthermore, many residents expressed concern about crime in their buildings and the safety and security of building entrances.

Residents also expressed differing preferences about living in public housing designated for seniors only as opposed to public housing designated for mixed populations. Some seniors said they would rather live in a senior-only environment where other residents have common interests and come from the same generation; others favored living with a mixture of age groups and appreciated intergenerational learning opportunities. Several younger people with disabilities shared concerns about being segregated into properties based on their disability status and conveyed the importance of mixed-population housing as an option for integrated community living. The impact of designated housing rule-making on the resident social environment and associated health outcomes is likely to be mediated by other factors discussed in this HIA, including housing discrimination and choice, property accessibility and availability of community space, and neighborhood characteristics.



Housing design and accessibility

The design of the housing development and residential unit can help residents maintain independence, reduce the risk of injury or death, and improve public safety. Accessibility features can reduce the risk of injury related to falls, support independent living, and promote mobility and socialization, all of which are important for good health.³³ Community space within a public housing development is also an important consideration for seniors and individuals with disabilities. In focus groups, many designated housing residents expressed concerns about the accessibility of their units and of the development as a whole and how it affected their health and safety.

A majority of public housing developments were built before the passage of key federal laws and are not accessible to people with disabilities. Laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA) require that housing developments be accessible to all people regardless of age or ability. HUD has made investments through programs such as HOPE VI and Choice Neighborhoods that have supported accessibility improvements in public housing. But research suggests that PHAs have room for improvement with regard to the accessibility of their developments. For example, a 2008 study assessed the physical accessibility of 14 public housing developments and concluded that many were not compliant with ADA requirements. The authors called for better enforcement of accessibility regulations.³⁴

In general, most U.S. housing stock does not have optimal accessibility. One study estimated that the vast majority (roughly 90 percent) of the housing units in the United States are inaccessible to people with physical disabilities.³⁵ In focus groups and interviews, PHA staff noted that seniors and people with disabilities who hold Housing Choice Vouchers often face challenges in finding accessible units in the private market. Construction and rehabilitation are the primary opportunities for making housing units accessible. If the rule-making does not change the number of senior-only designations done in conjunction with mixed-finance development, as many as 6,775 accessible public housing units could be available to senior households within five years.



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Neighborhood characteristics

Neighborhood characteristics such as availability of public transportation and grocery stores, levels of racial and economic segregation, crime rates, and perceived safety are important factors in the health of seniors and people with disabilities. PHAs that use the designated housing rule tend to be located near transit and community health centers but also in more racially and ethnically segregated neighborhoods and in counties with higher levels of violent and property crime compared with PHAs that do not use the rule. However, in focus groups, several residents mentioned that limited or costly public transportation makes it difficult to access medical care.

The findings also suggest that there may be differences between the neighborhoods surrounding predominantly mixed and disabled properties compared with senior-only and other property types within a given PHA's portfolio. For example, this analysis suggests that mixed and disabled properties may be more likely to be located in neighborhoods with a greater share of racial or ethnic minority residents, higher poverty rates, and fewer opportunities for employment compared with senior-only properties. However, due to small sample sizes, these findings should be interpreted with caution. If the rule-making encourages PHAs to use readily available data regarding neighborhood characteristics in their designated housing plans, it could help them connect residents to local resources and services and select properties for designation. However, the rule-making is unlikely to directly affect the characteristics of the neighborhoods surrounding public housing properties.

Public housing administration and financing

The designated housing rule intersects with several affordable housing financing mechanisms and trends. No federal funding has been authorized to increase the total number of public housing units since the early 1990s. HUD has tried to slow the loss of public housing units resulting from poor maintenance and lack of capital improvements through programs such as the Rental Assistance Demonstration (RAD) program, which allows PHAs to convert public housing properties to long-term, project-based vouchers or rental assistance contracts with nonprofit or for-profit property owners.

The Low-Income Housing Tax Credit (LIHTC) program also supports rehabilitation and redevelopment of existing affordable housing. Through the program, tax credits are allocated to states based on their populations. Developers apply and compete for these credits and then sell them to investors to raise capital for their projects, which reduces the debt required to build or rehabilitate housing and makes it financially feasible to provide units at lower rents. PHAs frequently partner in the development of LIHTC properties to facilitate the rehabilitation or replacement of public housing units in their jurisdictions.

In focus groups and interviews, PHA staff noted that approval of a designated housing plan for public housing units within a mixed-finance development, particularly for senior-only housing, can help PHAs secure investors and optimal pricing. Several also said that they were exploring options to convert public housing properties under RAD as described above, including those designated for seniors or younger people with disabilities. Although additional analysis is needed, preliminary research suggests that some stakeholders have concerns regarding potential changes to the rule as they relate to RAD conversions and to the timeline for applying for tax credits.

For residents in designated housing, the social environment—the connections, relationships, and interactions among occupants—can have a substantial impact on health and quality of life.

Recommendations

Based on these findings, HUD could take a number of actions to optimize the health effects of the designated housing rule-making. Although designated units make up less than 6 percent of public housing nationwide, these recommendations could be used more broadly to support the health of more than 1.6 million senior and disabled families that PHAs assist through the public housing and voucher programs. Designated housing rule-making offers substantial opportunities for HUD to engage in interagency collaborations at the federal level and to support PHA efforts to offer more choices in integrated community living; expand partnerships that bring together housing and supportive services; and create environments that help seniors and people with disabilities remain in home and community-based settings as they age.

The recommendations highlighted below are those likely to have the greatest impact on the health of seniors and people with disabilities. A complete list of recommendations is available in the full HIA report.³⁶ Many of these recommendations speak to opportunities to support the health of senior and disabled households beyond those living in designated units and therefore may be optimally addressed as a part of regulation or guidance instructing broader PHA efforts. Successful implementation of these recommendations would probably require additional financial and staffing resources for HUD and other federal agencies.

- 1. Expand efforts to use housing as a platform for supportive services.** In HUD's 2014-18 strategic plan, one of its goals is to "Use housing as a platform to improve quality of life" by improving housing stability and health outcomes.³⁷ Housing that is coordinated with supportive services can benefit health and help state and local governments contain public service and health care costs. For many seniors and younger people with disabilities living in designated housing, supportive services help facilitate mental and physical health and the ability to meet lease requirements and maintain housing. HUD requires PHAs to describe in their designated housing plans the supportive services they plan to provide or coordinate. In updating the designated housing application requirements, HUD could:
 - Provide guidance and incentives to PHAs to collaborate with state Medicaid redesign efforts to support the coordination of housing with supportive services, including medical services, assistance with daily tasks, and social services, such as food and nutrition programs. Such initiatives could include formal relationship agreements with Medicaid programs, including Home and Community-Based Service waivers or the Money Follows the Person program, and co-location of designated housing properties with Federally Qualified Health Centers or Community Mental Health Centers.
 - Expand the scope of the HUD and Department of Health and Human Services (HHS) Housing Capacity Building Initiative for Community Living or form an additional advisory committee to bring together stakeholders on an ongoing basis to discuss alignment of housing, supportive services, and public safety systems for residents in HUD-assisted properties.
- 2. Promote fair housing initiatives to support choice in integrated community living.** People with disabilities have significant unmet affordable housing needs. Despite federal fair housing laws and policies, these individuals are likely to experience discrimination in their attempts to find housing. To support PHA efforts to develop and implement fair housing initiatives that offer people with disabilities a choice in integrated community living, HUD could:
 - Require that PHAs, when submitting a designated housing plan, certify that it is consistent and in compliance with the forthcoming Affirmatively Furthering Fair Housing rule and Section 504 of the Rehabilitation Act of 1973.

- Provide guidance and incentives to PHAs to consult or demonstrate consistency with state *Olmstead* plans or settlement agreements (where applicable), state agencies responsible for implementation, and local plans to end chronic homelessness by:
 - Demonstrating an affirmative marketing strategy for people with disabilities by targeting potential tenants, such as those transitioning out of institutions, who are least likely to apply for housing.
 - Developing memorandums of understanding with area affordable housing providers (e.g., Section 811 and Section 202 providers), and using project-based vouchers (i.e., Housing Choice Vouchers dedicated to specific housing projects) to assist in the creation of a supportive housing environment.
- Promote integration of residents with disabilities by encouraging designation of disabled units distributed throughout public housing properties and the inclusion of more mixed-population units in PHAs' designated housing plans. This could be achieved by offering funding flexibility, expediting processes for designated housing plan approvals, or providing additional points in the formula for determining operating subsidies for these properties. Successful implementation of this recommendation would require sustained access to supportive services and service coordination for these residents.

Although designated units make up less than 6 percent of public housing nationwide, these recommendations could be used more broadly to support the health of more than 1.6 million senior and disabled families that PHAs assist through the public housing and voucher programs.

3. **Improve data availability and accuracy.** Affordable housing needs have risen significantly over the past few years, but they are underestimated because current data sources do not capture those who are homeless or living in institutions such as nursing homes or assisted living facilities. Additionally, data on senior and disabled households' ability to successfully use Housing Choice Vouchers to rent a unit, known as success rates, are limited. To address this, HUD could:
- Strengthen collaboration with HHS to develop metrics and a data-collection protocol to provide a more accurate picture of affordable housing needs among people with disabilities and seniors, and equip PHAs with improved data about their jurisdictions. Available datasets for such an analysis include: the Comprehensive Housing Affordability Strategy; special tabulations of the American Community Survey, including information on residents in group quarters; and the Homeless Management Information System.
 - Strengthen tracking of Housing Choice Voucher success rates among senior and younger disabled households. This could be accomplished through improved guidance to PHAs on capturing demographic data when reporting to HUD and by encouraging PHAs to consider the rates for seniors and people with disabilities when developing designated housing plans.
 - Request that PHAs delineate, as part of their justification for the designation, HUD-subsidized and other affordable housing programs in their jurisdictions that are available to serve seniors or people with disabilities, such as Section 811, Section 202, and Continuum of Care permanent supportive housing providers, in their applications to designate properties. Currently, HUD only considers housing resources in the PHA's portfolio when examining the availability of alternative housing resources. This will allow for a more accurate assessment of affordable housing supply and availability of alternative housing resources.

HUD could also improve coordination of public housing, Section 811, and Section 202 funding and eligibility criteria to facilitate partnerships between PHAs and other housing providers, which can improve efforts to meet local affordable housing needs.

4. **Equip PHAs with data to inform strategies and actions to improve neighborhood resources.** PHAs that use the designated housing rule are typically located in urban areas that are more densely populated and more diverse, and have higher poverty and crime rates than PHAs that do not use the rule. The HIA analysis also suggests that there may be differences in the characteristics of neighborhoods surrounding predominantly mixed and disabled properties compared with senior-only properties within a given PHA, such as fewer resources and opportunities for employment. Easily accessible data regarding neighborhood resources and service needs for designated housing residents (e.g., transportation, medical clinics) could inform PHAs as they develop designated housing plans. To address this, HUD could provide guidance to PHAs on incorporating neighborhood metrics into their designated housing plans, such as those already established under the Healthy Communities Transformation Initiative and associated Healthy Communities Index, the Affirmatively Furthering Fair Housing indicators, and the eCon Planning suite.³⁸

Additionally, in the short term, HUD could take a number of actions to help ensure alignment of the designation process with trends in public housing financing, streamline the plan review and approval process, and improve tracking of rule use, including:

- Establishing an internal working group and an external advisory committee to examine the intersection of the designated housing rule and broader trends in public and affordable housing finance, including LIHTC and RAD. These groups could be charged with, for example:
 - Developing strategies for coordination and alignment of program goals, implementation requirements, and accountability measures.
 - Establishing monitoring systems to track affordable housing needs and supply.
 - Training PHA staff to blend the requirements of the public housing and LIHTC programs.
 - Engaging with community partners regarding fair housing concerns and tenants' rights.
- Developing and implementing a simplified application form that clearly delineates examples of the data sources PHAs could use to respond to the questions HUD staff use in reviewing designated housing plans.
- Increasing efforts at both the national office and local field offices to achieve accurate and regularly updated surveillance of designated housing rule use, including data on specific PHA properties with designated units.
- Developing and implementing a plan for improving the accuracy of data on mixed-population properties to enable a comprehensive analysis and ongoing monitoring of their number and distribution. This could include encouraging PHAs to routinely use data fields already available to them in HUD's Inventory Management System/Office of Public and Indian Housing Information Center data system to report the number of designated units in their portfolio and clearly communicating why these data are important and how they will be used.

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Andrew Sperling, director of federal legislative advocacy, National Alliance on Mental Illness; co-chair, Consortium for Citizens With Disabilities Housing Task Force.

* The advisory committee for this HIA was a group of organizations and individuals who advised the HIA project team during all phases of the HIA and reviewed and provided feedback on project documents before public release. The committee informed this HIA by bringing expertise and a diverse range of experience or perspectives on public housing policy and issues that may affect seniors or people with disabilities. Individual members were invited based on the breadth of their current and former experience; their professional affiliations have been listed for identification only. The committee for this HIA was not a decision-making body; although the HIA team placed substantial weight on input and advice from the advisory committee, the Health Impact Project had final authority and responsibility for the HIA process, findings, and recommendations.

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