DESIGNING HEALTHIER COMMUNITIES:

Key Lessons from Housing and Wellness Discussions

2023 - 2024

ULI Orange County/ Inland Empire

ULI Randall Lewis Center for Sustainability in Real Estate

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EXECUTIVE SUMMARY

This study is part of OC/IE ULI's 2021 Building Healthy Places Initiative which led to a meeting on "Health, Healing and Affordable Housing" on January 26, 2023. Breakout groups at the meeting discussed the critical components of healing centers, funding, and stakeholder support. The discussion was guided by the social determinants and vital conditions of health framework(s) that go beyond the traditional biomedical model to examine the health and wellbeing impacts of social, political, and cultural factors such as economic stability, health care access, transportation, education, housing, and the built environment.

The discussions yielded several insights on the role of housing, particularly the importance of supportive services that address both physical and mental health onsite. Participants emphasized the need to be creative with respect to funding and "stacking funding" as different sources (e.g. tax credits, grants, private capital, govt. funds) each have drawbacks but can be combined or stacked to develop different components (e.g. buildings, infrastructure, services, equipment, etc.) of wellness centers. Attendees underscored the importance of evidence-based approaches that combine secondary data (e.g. Census, Pt. in Time, Health Assessments and Utilization) with primary data gleaned through consistent community outreach during design and implementation phases.

Seeking to expand upon these initial discussions, OC/IE ULI, funded by a grant from Randal Lewis, commissioned a semi-structured survey of local experts with significant experience in public health services, health care access, affordable housing development, local government, community-based services, food systems, homeless services, mental health and substance abuse.

Kendra Chandler (ULI Executive Dir.) emailed prospective interviewees to introduce the purpose of the study and Abhishek Tiwari, the PI conducting the interviews.Survey questions were developed by Abhishek and the ULI Study sub-committee (Kendra Chandler, Matt Romero and David Smith) and focused on four areas: Existing Wellness Centers, Needs Assessment and Outreach; Siting, Funding and Operations; and Wellness Center Exemplars.

The findings discussed in this report are distilled from conversations Abhishek had with the following respondents:

- **George Searcy - Jamboree Housing,** City of Irvine (Affordable Housing)
- **Rosalie Zoll - Be Well OC** (Mental Health and Substance Abuse)
- **Kelly Bruno-Nelson - CalOptima** (MediCal/Medicare, Health Care access)
- **Sandra Lozeau - City of Anaheim** (Local Govt)
- **Milo Peinemann - American Family Housing** (Affordable Housing)
- **Gina Cunningham – Home Aid** (Homelessness)
- **Dora Barilla - Hc2 Strategies** (Public Health)
- **Madelynn Hirneise – Families Forward** (Homelessness)
- **Joe Perez – City of Anaheim** (Local Govt)
- **Esperanza Pallana – Food and Farm Communications Fund** (Food Systems)
- **Dr. Clayton Chau – Former OCHCA Director** (Public Health and Govt)

DISCUSSION

Interview results converged on a few common themes though respondents approached the questions, unsurprisingly, through their professional experiences and institutional roles. For example, housing and homeless services providers focused on the transformative role of affordable housing coupled with supportive services for mental health and substance abuse; community development officials emphasized the provision of services and other resources (e.g. food) through both mobile and "brick and mortar" facilities; public health experts emphasized outreach to the most medically vulnerable and health promotion activities.

Irrespective of their background, almost all respondents asserted that health and wellness centers should be community specific, i.e. there is "no one size fits all" approach: consistent community engagement during all phases of development and implementation from conception, needs assessment, funding, design, launch and operations was a recurring motif. Many, however, simultaneously emphasized the importance of secondary data on demography, health need, or service utilization in determining relevant services. This combination of emic (insider, first person) and etic (outsider, deductive, theory driven) epistemologies was a hallmark of the interviews. One respondent admonished providers to "not hold those they serve in contempt." This statement, perhaps, is the lens through which the other insights can be best distilled.

Many of the comments implied inherent tensions or opportunity costs in choices about services and resources provided, populations served, funding for development and operations, and fee structure. For example:

- A narrowly focused center that provides specific services for the most at-risk populations would serve the greatest need and simplify data collection but would exclude many in the community-at-large; however, one with a general community focus would be more inclusive, build more social capital though at the cost of measurable health or other outcomes.

- A center with onsite services would improve compliance and collect better usage data than one that relies on referrals; however, a center located in a resource rich area with an excellent referral system could serve a larger population and broader spectrum of needs.

- A "brick and mortar" center could provide a multitude of services and different types of spaces (e.g. recreation, classes, medical) to different populations at different times (e.g. seniors in the morning and teens in the later afternoon); however, a mobile center would significantly reduce barriers related to transportation, mobility (e.g. disability) and other factors (e.g. childcare).

- A center using a sliding scale, fee-for-service structure would be more self-sustaining but income verification would be potentially difficult and even nominal fees may act as a deterrent to many. A center open to all, irrespective of ability to pay, is more inclusive but would have to rely on other sources for ongoing operations.

These tensions notwithstanding, certain general themes or "take aways" emerged from the conversations. Even those who did not articulate these explicitly, their comments about how to identify needs, what a wellness center is (i.e. its ontology), what it should look like and emphasize (i.e. its design, services and resources offered), how it should be funded and whom it should serve (i.e. specific clients or community-at-large or both) resonated with these themes. A summary of these themes is provided in the following section along with supporting quotes.

THEME

Solicit community input consistently and through a variety of means.

Respondents articulated the tension between top-down, needs assessments based on secondary data and the identification of needs based on community input. In emphasizing the importance of community engagement, respondents discussed the challenges in soliciting input but also validated the importance of consistent outreach through multiple avenues as not only necessary for identifying needs but also, perhaps, more importantly, to build rapport, trust and long-term community capacity.

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“Listen to the community in a meaningful way. Maybe compensate community members for their time. CHIDLA, for example, helped develop community listening sessions.” - (MH)

“City conducts needs assessments every other year. Users at community centers are asked to fill out surveys. City also does door to door canvassing and sets up tables at schools. Build rapport with local residents though this takes several visits and points of contact.” - (JP)

“Conduct community outreach, talk to local leaders and community members.” - (RZ)

“No cookie cutter approach. Wellness approach will be neighborhood specific. Achieve things that the community sees as a win and not just what the public health data are saying ”- (KBN)

“Identify number one calls in the community, i.e. what people are seeking care for.” - (DB)

“Use demographic and other relevant data but also interview key stakeholders and cross reference needs with community assets.” - (GS)

“Provide a digital platform for the community to articulate its need and solutions.” - (DB)

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Resources and services for housing and food are critical.

Several respondents mentioned the importance of housing, including transitional and long-term, affordable units, and food related resources and services. High housing costs compel many to make choices between housing and other necessities or live in crowded conditions. Additionally, other services such as childcare, job training, or case management that enable family stability and social mobility can be part of an affordable housing strategy. Food needs started to increase during the pandemic and were further exacerbated by high inflation. Housing and food related resources and services can be combined to enable access to healthier food and build economic capacity (e.g. onsite food pantries, communal food gardens, training to work in the food industry).

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“Complete overhaul of affordable housing model. Not a lot of investment or innovative thinking in the types of services that can be provided in a multifamily development. Ideally families should become independent and transition out” -(MH)

“Housing assistance is important. People will forgo basics like food and utilities so they can pay rent” - (SL)

“Affordable housing can be a touchstone for health and well-being in a community” - (GS)

“Food needs have increased significantly post-pandemic. Housing need is severe. Many are living in crowded conditions and will not seek services for fear of losing parking spaces” - (JP)

“Bridge housing can be important depending on population served. A robust housing strategy is important” - (RZ)

“Support aggregation and marketing of local farmers and food producers” - (EP)

“Permanent housing solutions with services are important” - (GC)

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Centers should provide synergistic services, trauma informed care, wrap-around services, and case-management.

Respondents emphasized that services and resources at the center should reflect community need but also complement each other. Many warned against using a “potluck” approach that simply provided services or resources that were easiest to marshal without any thought as to how they fit together to create health and wellness in the long-term. Some discussed the use of trauma-informed care coupled to case-management and wrap-around services as these would help address acute issues while building long-term self-sufficiency.

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“Use trauma informed design for shelters, and wrap around services so that clients have someone they are working one-on-one with” - (GC)

“Use trauma informed care models that address the most vulnerable.” - (SL)

“Services should be synergistic. Do not use a “pizza party” or “kitchen sink” model” - (MH)

“Not just provide a basket of social or health services but a place that helps people address their determinants (long term) enablers of health”

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Many respondents stated that though wellness centers can provide typical medical or clinical services, they should, ideally, address other important social determinants and vital conditions that foster long term health and well-being. These can include the provision of housing assistance, job training, cooking classes, spaces for recreation and restoration, and health education. Centers should encourage the development of social capital, or community cohesion, by providing welcoming, nurturing environments for different groups in the community such as the elderly and teenagers or different SES groups. Centers should be inclusive and not associated with any one group, particularly those with negative social constructions as this may increase community opposition.

"Centers should be places of healing and connections. They can provide typical resources but should focus on health promoting, group exercises" - (DB)

"Environmental or social determinants are of paramount importance as little things can sometimes derail people. How can someone address their diabetes if they are unemployed." - (KBN)

"Centers should be friendly and inclusive. Places need to feel inviting." - (GC)

"Development of social capital and support networks is just as important as provision of resources and services"(MP)

"Not just provide a basket of social or health services but a place that helps people address their determinants of health and not just the immediate health problem." - (KBN)

"A wellness center from a public health perspective is a place for at-risk populations. However, others such as single parents, youth, elderly should, ideally, be able to procure resources and services and connect to each other" - (CC)

"Community health and wellness spaces including those for community gatherings or faith-based, multi-cultural. Spaces not just for clients but the general community." (RZ)

Centers should connect service and resource providers with each other and help integrate them, when possible, with the local community at other sites including businesses.

Several respondents framed the center's as not only providers of resources and services but facilitators or conduits that enable integration between other services and resource providers and the community. To achieve this, center's would need to identify and organize communication and collaboration between different entities – public agencies, private businesses, health and social service providers—serving the community. This would enable both collection of needs data, collaboration, sharing of funding resources and prevent duplication. By becoming a hub, center's could help create the economies of scale that increase the quantity and quality of services and resources available to their community.

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“Develop partnerships among various types of providers (e.g. churches, food providers, etc) so they can share needs data, funding opportunities and provide referrals to each other.” -(JP)

“Multiple providers in once place, some for emergency and others focused on long-term services. Providers can consult with each other.” - (RZ)

“Support aggregation and marketing of local farmers, food producers” -(EP)

“Provide a navigator for clinical and other resources that are not provided at the center” - DB)

“Offer services onsite at local businesses” - (CC)

“Staff can come from a variety of agencies (health clinics, educational programs, housing, etc.) - (GS)

“Collaboration is difficult. It took us almost 10 years to get everyone on the same page for our system of care (i.e. govt, providers, for-non-profit, etc.)” - (SL)

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Mix and match brick and mortar facilities with a mobile/virtual component and address transportation related issues.

Many respondents mentioned mobile centers as one response to transportation or mobility related barriers such as lack of personal automobile or disability. A mobile strategy allows centers to build rapport with their target communities which improves both needs assessments and resource and service provision to those who may otherwise by unable or unwilling to engage the center at their “brick and mortar” facility. Similarly, a virtual strategy can greatly expand the center’s reach to those who with access issues. The center’s can also improve access by providing alternative transportation (e.g. vans or bus service) options to and from their catchment areas or integrate the center with existing multimodal options.

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“Cannot expect people to come to the center, especially those with critical needs. A mobile component is necessary as many are more comfortable in their neighborhoods. For example, we are thinking of partnering with others to provide a street medicine program” - (SL)

“Center needs to make systemic (case management, referral) and literal (web based, transportation) connection to those providing services/resources.” - (MP)

“Mobile strategy is important. Need multimodal access for the center” - (RZ)

“Centers don’t need to be big and can provide specific services inside existing facilities such as a community center or multifamily complex” - (MH)

“Safety and transportation are important issue and center doesn’t need to provide actual medical services as long as there are transportation options to these services” - (CC)

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Centers should enable long term self-sufficiency and community capacity by identifying and strengthening community assets which includes people, facilities, and local resources.

Most respondents emphasized the importance of building long-term individual, household/family and community capacity. The centers should, ideally, identify individual, household/family and community strengths or assets and leverage them to build long term self-sufficiency. A center based on a top-down, deficiency model that casts itself as the provider or expert and its target populations -- individuals, households/families or communities -- as irrevocably broken or permanent clients will be unsustainable. Though some services and resources (e.g. rent assistance, medicines) may be needed for stabilization in the short-term, the long-term plan should focus on empowerment and transition out of the "acute care" programs.

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"Create community leaders who are able to access and navigate the system" (EP)

"Centers need to improve neighborhood stability and empower the community and not long-term dependency. Provide support so people can connect themselves by providing referrals, transportation to needed services and resources" (MP)

"Empower individuals to take charge of their wellness. If an individual or household is experiencing a crisis, stabilize them, and then develop a long-term plan for stability. No long term dependency" - (JP)

"Help people by helping them find purpose in life even if they have issues" - (RZ)

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Funding will come from multiple sources and depend on the characteristics of the center. Its important to leverage in-kind contributions of land, services and resources and provide a way to funnel general donations from residents and the business community. For long term sustainability, an "anchor tenant" or one high capacity organization is important.

All respondents discussed the importance of using multiple sources of funding particularly given the changing landscape in non-profit funding. Some were wary of using government funding given the onerous reporting and other requirements. Furthermore, to ensure long-term viability, some emphasized using a single, permanent organization to spearhead the project and serve as the main fiduciary. Others mentioned the importance of using small and large in-kind resources and services as some organizations, like Churches, may be able to provide space or land whereas others may have staff for services or resources but need space and access to clients. A flexible center that can mix and match donations and existing service and resource providers will leverage assets and resources more effectively and become less reliant on external sources of funding. Additionally, its important to provide a mechanism such as an auxiliary foundation that can receive and allocate general donations or contributions for specific causes. This increases fundraising capacity and builds trust among non-traditional funders such as businesses or smaller donors who would also receive a tax deduction for their giving.

"Leverage in-kind contributions, especially land (Churches or local govt. agencies)." (GS)

"Donors need a mechanism that allow them to target their funding to specific causes and gives them some assurance that funds will be used wisely" (SL)

"Center staff can come from a variety of organization, but its better to have one organization that will stand the test of time running the center" (GS)

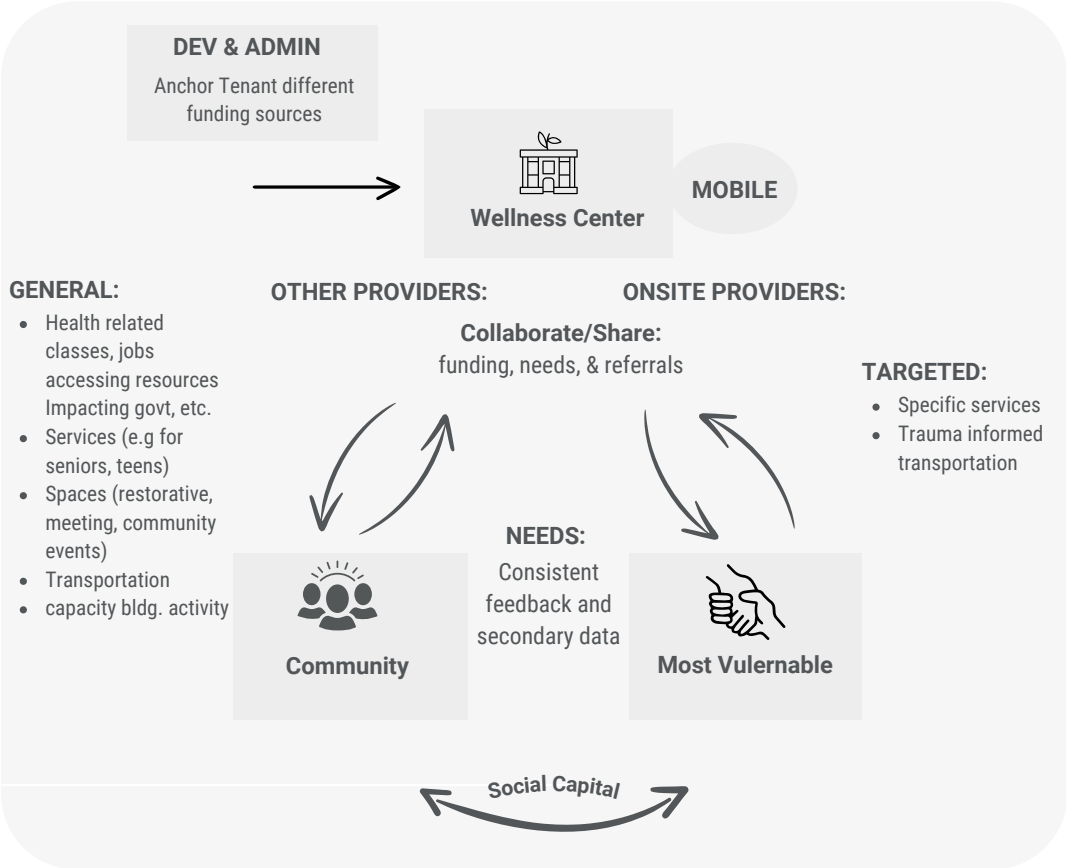
"Mix private and public funding though this requires a lot of sophistication" (GC)

"Get funding from health plans, government, or other sources such as EAP programs at businesses. Be creative but don't use only one type such as grant funding which may expire. Also fee for service has limited utility as you may be competing with other providers" (CC)

"Use a heat map of resources to target resource rich areas for housing and/or use funding measures that target specific populations" (MP)

"Identify an anchor tenant, possible the main funder such as the govt, hospital or a non-profit" (MH)

FIGURE 1. WELLNESS CENTER CONCEPTUAL MODEL



SUMMARY

The following section provides a summary of the interview results organized by four areas: needs assessment, services, funding and design. These results are the basis of the themes in the preceding "discussion" section.

NEEDS ASSESSMENT

- Use both secondary data (e.g. statistics on morbidity, mortality, "call data" or what people are seeking care for, focus groups) and primary data (e.g. needs articulated by community members). Use multiple (e.g. schools, senior centers, churches, door-to-door, town hall) and consistent outreach methods, or "listening sessions", to develop trust/rapport and reach isolated populations.
- Use the most current secondary data (census, land use, economic, etc.) and combine with primary data collected at regular intervals
- Needs assessments should look at multiple needs, how these needs intersect and immediate needs (e.g. housing, food, child-care and transportation as these are related and impact ability to address other longer term health and wellness needs)

> ***"Health is based on the lived experiences of the community. We need to go beyond the medical model".***

- Discussions with key stakeholders (community members, providers, leaders) to understand the community including the most vulnerable and community priorities.
- Address things that the community identifies as important (and not just improvements in health metrics).
- Use a digital platform that allows community members to voice needs and collaborate on solutions.
- Cross reference needs with community assets to provide what is needed and what can be addressed using existing resources and services.

SERVICES

- Mix and match resource and services providers, volunteers and staff from multiple organizations and backgrounds. For example, some providers only need space or use community volunteers for certain staffing needs (this also builds social capital).
- Provide wraparound/ case management / navigator (at the center and virtual) services to address cooccurring conditions, ensure follow-up, provide referrals and leverage resources/services in the community.
- Services should be available to all in the community (no fee for service).

- Address immediate needs to stabilize individuals and households. Financial assistance can be important but don't provide cash. Build self-reliance and not long term dependency.
- Services should be available to all in the community (no fee for service).
- Consider community characteristics when designing services (e.g. don't do a health education class on a school night in a community with families and small children)
- Less emphasis on traditional medical services and greater focus on wellness promotion (e.g. exercise, cooking, support groups, story telling by the elderly who are living libraries, mentoring and life skills). Services should help people feel empowered even if they have issues.
- Services should help create community capacity by developing leaders who know how to navigate the system, change policy and engage lawmakers
- Activities should by synergistic (i.e. don't provide a mixture of unrelated services that don't reinforce each other), culturally appropriate, reduce social isolation and build social capital.

LOCATION, DESIGN

- Ideally build in resource rich areas and enable access (literal and virtual) to the center and to the resources.
- Assess the area you wish to serve to plan the center (i.e. what should be in the center vs. what resources/services can be accessed in the community).
- Plan for transportation (multimodal) to the center and to resources/services in the community.
- Flexible, multi-functional spaces that are inviting, inclusive but also durable (e.g. a senior focused space that becomes a youth focused space after school hours)
- Spaces should facilitate healing, restoration and sense of community (i.e. spaces should not feel like a hospital)
- Evaluating access for different population groups to the center and to services/resources in the community is paramount especially for the elderly, disabled or those with reduced mobility (virtual delivery can play an important role, though many may not have the required devices or internet access at home).
- Embed services in housing (e.g. charter school in an affordable development) or provide services (e.g. an NP who holds office hours) in existing facilities (e.g. senior centers) or businesses.

FUNDING

- No ideal funding source. Each has pros and cons. For example, government funding often comes with onerous requirements (e.g. reporting, prevailing wage) and foundation or private funding may not be sustainable as priorities change.
- Combine different funding sources (federal, state, local, private)
- Portal or one stop shop for different funding sources (e.g. Super NOFA)
- Create a local foundation that can solicit donations and funding from a variety of sources. This allows private entities to donate to causes that also have public funding, allows for smaller donations, and provides assurance that funds will be used for specific causes important to the donor.
- Leverage in-kind donations (e.g. land donated by Churches for housing).
- Physical development should ideally be owned by a stable entity. Identify long-term anchor tenants (e.g. govt agency or established non-profit)
- Develop local provider networks that share funding sources and actual funding. The network or collaboration can also raise funds for different members and projects.
- Address the political environment as this impacts funding by using lobbyists, advocates, community members, etc.
- Seek funding from health plans or businesses (e.g. through Employee Assistance Programs) as wellness programs will reduce utilization of healthcare resources and decrease employee absences and improve productivity.