Centering Equity in Health and Housing Partnerships in Times of Crisis and Beyond

CSH

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GOAL OF THIS PUBLICATION

- Provide background on the factors that have driven deep racial and ethnic inequities in health and housing that are more apparent than ever in times of crisis.
- Provide recommendations for health and housing system partners to center racial equity in their work together in times of crisis and beyond in order to preventing existing inequities from deepening and to advance health equity.

This paper will focus on ways health centers, other health system providers, and housing partners can **center considerations of equity** in their shared work to address the needs of people most impacted by structural racism and its impact on health and social determinants of health, including Black people, people of color, and Indigenous people. For suggestions on specific partnership structures and activities health and housing partners can conduct together, please see Addressing Health Equity Through Health and Housing Partnerships, released by CSH and the National Health Care for the Homeless Council in 2019.

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INTRODUCTION

Health is one of the most fundamental components of the human experience. It impacts the quality and length of one's life, including the capacity to function independently, as part of a community and our broader society, and the ability of an individual to reach their full potential. 'Health equity' is a term used to describe a situation that should, but does not yet exist, where all people have a fair and just opportunity to access care and be as healthy as possible. When we achieve health equity, neither race nor ethnicity will impact health or the social determinants of health - which constitute the quality and safety of the places where people live, work, learn, and play; housing; justice; employment; income; transportation; child care; and education.[1] Yet, deep racial and ethnic inequities exist, driven by structural racism - the systemic, social, institutional, ideological, and other forces that create and reinforce inequitable outcomes for people of different racial and ethnic groups.[2]

A long and deep history of racially discriminatory policies and practices at the structural level in housing (federal redlining, segregation), justice (mass incarceration; police brutality), health care, voting, employment, education, and other areas has created and reinforced deep racial inequities in health and other factors influencing a person's ability to be healthy.[3] These inequities intersect and compound over lifetimes and generations. A particularly devastating area of inequity is seen in people who experience homelessness: Black people make up 40% of the those experiencing homelessness despite representing only 13% of the total U.S. population, and in every state, Black people are overrepresented among people experiencing homelessness and are more likely to experience homelessness than White people.[4] The experience of homelessness can cause or exacerbate health problems and make it challenging to manage existing ones, giving the homeless system a critical role to play in advancing health equity.

Health centers are also on the front lines of serving people disproportionately impacted by structural racism. In 2018, nearly 63% of health center patients were racial or ethnic minorities, 23% were best served in a language other than English, 68% were at or below the poverty line.[5] Advancing health equity will require health centers, other health partners, the homeless system as well as all intersecting systems and providers that impact health such as justice, education and child welfare, to work together, prioritize the dismantling of structural racism and center equity in their work.

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[1] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? Robert Wood Johnson Foundation. 2017.
[2] Gee GC, Ford CL. Structural Racism and Health Inequities: Old Issues, New Directions. Du Bois Rev. 2011;8(1):115-132.
[3] National Health Care for the Homeless Council. Health, Homelessness, and Racial Disparities. 2019.
[4] National Alliance to End Homelessness. Data Snapshot: Racial Disparities in Homelessness. 2019.
[5] Health Resources & Services Administration. 2018 National Health Center Data.

CENTERING EQUITY

At its core, to *center equity* is to recognize:

- All people *should* have the same opportunity to live a full, healthy life, regardless of race, ethnicity, or other demographic characteristics, but currently, they do not.
- Black people, people of color, Indigenous people, and other groups highly impacted by structural racism experience deep and persistent inequities in health, housing, justice, education, income, and other outcomes.
- Structural and institutional forces have both intentionally and unintentionally driven and reinforced racial disparities, and must be the drivers of equity.
- People - including Black people, people of color, Indigenous people, and other communities that have been excluded from power by structural and systemic racism – should be owners, planners, and decision-makers in the systems that shape their lives.[6]

With these acknowledgments in mind, to center equity is to prioritize an explicit focus on eliminating inequities experienced by Black people, people of color, Indigenous people, and other groups highly impacted by structural racism, using a process that involves the people most impacted by structural inequity in leadership and partnership, both internally (within organizations) and externally (within and across sectors).

Although centering equity is a core value and should be embraced as a standard for all organizations at all times, doing so is particularly crucial in times of crisis and recovery, which often have a disproportionally negative impact for people already most impacted by poverty, housing instability, poor health, and other challenges driven by structural racism. In 2006, Henkel et. al conducted an analysis of how racial factors played a role in the lead up to and aftermath of Hurricane Katrina- a natural disaster in 2005 that was notoriously devastating for Black people in New Orleans. The authors explored how institutional racism and racial discrimination created a situation where Black people in New Orleans were concentrated in areas especially vulnerable to flooding and other impacts from Hurricane Katrina, and offered this central recommendation:

> *"Because race was central to these circumstances, interventions to address the consequences of Hurricane Katrina and policies for future emergency situations cannot be colorblind. Effective interventions and policies should consider the importance of historical and contemporary racial disparities to the susceptibility of different communities to harm, how racial biases may unintentionally influence the actions of decision makers, and how race relations might influence the responses of vulnerable groups to efforts to help."*[7]

This recommendation is deeply relevant to the COVID-19 pandemic in which people of color have disproportionately suffered poor health outcomes because of social determinants of health driven by structural racism.

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[6] Center for Social Inclusion. What is Racial Equity?

[7] Henkel K, Dovidio J, and Gaertner S. Institutional Discrimination, Individual Racism, and Hurricane Katrina. Analyses of Social Issues and Public Policy, Vol. 6, No. 1 (2006): 99-124.

HEALTH EQUITY, HOUSING, AND TIMES OF CRISIS

Times of crisis like natural disasters and pandemics can both highlight and deepen inequities. The COVID-19 pandemic is no exception – although data on race and ethnicity is not always provided, available data has demonstrated that people of color are contracting and dying from COVID-19 at rates disproptionate to their representation in the overall U.S. population.[8] In 2008, Blumenshine et al. laid out a conceptual framework for how racial/ethnic and socioeconomic disparities could lead to unequal levels of illness and death in a pandemic influenza outbreak.[9] The factors outlined in the framework include:

For more on how crises expose inequities, see CSH's Centering Equity in Times of Crisis & Uncertainty

- Disparities in **exposure** (e.g. living high-density households, inability to work from home, reliance on public transportation)
- Susceptibility to **contraction** (e.g. presence of underlying medical conditions), and
- Disparities in **treatment** once the disease has developed (access to medical care, quality of care, differences in treatment).

A year later, in 2009, the factors explored in this framework were demonstrated to have led to racial/ethnic disparities in morbidity and mortality during the 2009 H1N1 influenza pandemic.[10] The framework also provides prescient insight into the ways multiple intersecting disparities have led to the inequities seen during the COVID-19 pandemic.

A lack of stable housing puts people at significantly greater risk of experiencing negative health outcomes, and an unstable health situation can contribute to homelessness. The connections between health and housing are especially apparent in crisis situations. For people experiencing or at risk of homelessness, consider how the lack of safe, stable, healthy housing compounds the challenges from the framework described above:

- Disparities in **exposure** - e.g. shared sleeping and other common spaces in congregate shelters or encampments, inability to safely shelter in place, reliance on crowded facilities like soup kitchens or food pantries for necessities;
- Susceptibility to **contraction**- e.g. multiple underlying and often untreated medical conditions, lack of access to hygiene facilities/supplies, such as soap and places to wash hands, particularly in shelter in place situations where public restrooms and other facilities are closed; and
- Disparities in **treatment** once the disease has developed – i.e. access to quality medical care, reliance on emergency departments or urgent care facilities, inability to access and store medicine.

The compounding effect of homelessness and housing instability on health disparities illustrates why it is critical for health and housing partners to work together to address health disparities.

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[8] See Cases in the US and Mortality Surveillance on the Center for Disease Control's Coronavirus Disease 2019 webpage

[9] Blumenshine P, Reingold A, Egerter S, Mockenhaupt R, Braveman P, and Marks J. Pandemic influenza planning in the United States from a health disparities perspective. Emerging infectious diseases vol. 14,5 (2008): 709-15.

[10] Quinn SC, Kumar S, Freimuth VS, Musa D, Casteneda-Angarita N, Kidwell K. Racial disparities in exposure, susceptibility, and access to health care in the US H1N1 influenza pandemic. Am J Public Health. 2011;101:285–293.

Strong housing and health care partnerships have a greater chance of improving outcomes for people most impacted by inequities than health or housing interventions on their own.

RECOMMENDATIONS FOR HEALTH CENTERS AND OTHER HEALTH AND HOUSING PARTNERS

Whether or not they intend it to, health, housing, and other social services providers do work that has an impact on racial inequities: their work can either increase or reduce disparities, or reinforce the status quo, in which inequity persists. As such, organizations have the obligation to understand how their work affects Black people, people of color, Indigenous people, and others highly impacted by systemic inequities, and to center equity in their work. This is particularly important as health, housing, and social services organizations work together to manage and recover from the COVID-19 pandemic, and look ahead to prepare for future crises. Doing so, in their own organization's work and in partnership with others, will enable our communities to make meaningful progress toward the goal of achieving equity. Without such deliberate efforts, organizations risk perpetuating or even exacerbating existing inequities, leading to lasting negative impacts for Black people, people of color, Indigenous people, and other historically marginalized groups, such as LGBTQ+ people.

The following sections will provide suggestions for how health and housing partners can center considerations of equity in their work together. For detailed suggestions on specific activities health centers and housing partners can implement on their own and in partnership to advance health equity, see the 2019 joint publication by CSH and the National Health Care for the Homeless Council, Addressing Health Equity through Health and Housing Partnerships.

ASSESS IMPACT ON EQUITY

Understanding how services, programs, delivery mechanisms, policies and procedures might impact people differently based on their race or ethnicity is a critical step in centering equity. This kind of assessment can ensure programs do not deepen existing inequities, but instead actively advance the opportunities and outcomes for people most impacted by structural racism. Race Forward's Racial Equity Impact Assessment Guide and HUD's Equity as the Foundation guide provide overviews of key steps in conducting such an assessment. Any program assessment should include the voices of people who are most impacted, which we cover in Meaningful Partnerships Centered in the Voices of People Most Impacted.

During a crisis, organizations and communities may not have the time to complete as robust a racial equity impact assessment as they might under other circumstances; however, it is of the utmost importance to take the time to consider the potential for both adverse and positive impacts on equity of decisions, strategies, and interventions under consideration. The Central City Concern Case Study highlights how one organization put this into practice in the early stages of the pandemic. The importance of taking time to assess impact is even more critical when making decisions during a crisis related to the deployment of resources, like the funding made available to combat the COVID-19 pandemic through the CARES Act. Without strategic equitable considerations and the voices of people with lived experience at the table, communities and providers risk reinforcing or even deepening existing inequities in health and housing outcomes.

DATA

Data analysis plays an important role in helping stakeholders understand the disparities they can work to address and to measure the progress of work underway. A simple process for using data

to center equity in health and housing partnerships includes the following steps:

1. **Seek out information related to the work you want to engage in or the problem you want to solve**. Health centers and other health sector stakeholders have a great deal of data on the health status/outcomes and service utilization of their patients. Homeless system and housing providers have robust data on housing status and other social determinants of health. To identify disparities and disproportionality, the health sector and homeless system can analyze data by race and ethnicity, comparing groups to each other and/or to representation in overall population figures. If race and ethnicity information is not available, change the way data is collected to ensure that it is. Matching data can help both systems identify the people in greatest need of joint interventions (such as supportive housing coupled with intensive health support).[11] All data matching efforts should include the ability to break data down by race and ethnicity. When matching data between systems, look at racial disparities both within the systems separately, as well as together.
2. **Ground data analysis in an awareness of structural racism, along with other contextual factors.** For example, as described in the example shared above (see Centering Equity) researchers studying Hurricane Katrina recognized that the disaster was particularly harmful to Black residents because they were concentrated in particularly low-lying areas prone to flooding because of historical discrimination and institutional racism. In health and housing work, partners should consider how structural racism influences access to resources, experience in systems, accessibility of services, and other factors. Another contextual consideration is how intersecting experiences such as poverty, disability, gender, sexual orientation, experiences of homelessness, etc. can lead to particularly complex, compounded disparities.
3. **Use the data and context as a starting point from which to begin to develop goals and solutions.** The information is a good start, but a critical next step is to engage with partners to identify target goals (see Goal-Setting, Monitoring, and Quality Assurance) and develop appropriate strategies to address the challenges identified. When sharing data with people with lived expertise and other stakeholders without formal training in data and analytics methods, take the time to educate them about the information being shared and how it can be used to drive decisions, shape programs, and influence the allocation of resources.

GOAL-SETTING, MONITORING, AND QUALITY ASSURANCE

In partnership with each other and on their own, health and housing providers should set goals around reducing inequities. In a virtual learning hour organized by the Institute for Healthcare Improvement (IHI), recapped in '3 Lessons COVID-19 Teaches us about Addressing Health Equity', panelists stressed that building equity into quality accountability (by stratifying data by race and ethnicity and holding institutions accountable for inequitable care) is necessary in order to make progress towards equitable health. Naming specific goals establishes accountability and creates a

[11] For more on data matching, see Data Matching: Understanding the Impact and Potential for Health Centers.

way to measure progress. Centering equity in your work is not possible without such accountability. Health and housing partners working together on new projects can set goals and then engage in work to develop joint interventions, partnership strategies and structures, programs, and impact reporting designed to achieve the target outcomes. This should be done in partnership with the people most impacted by the programs and the challenges they are designed to solve – see the next section. Establishing goals is important, but even more so is evaluating progress regularly and frequently, so course corrections can be made to ensure the effort is on track.

Health and housing partners should also consider how to build equity-focused outcomes tracking and objectives into work they are already doing together, if it did not previously have a focus on equity. They can start by assessing the current outcomes and progress against goals by race and ethnicity, to see if there are differences in impact and outcomes by group. If so, they can work together to redesign or tweak the intervention, processes, etc. to better address the needs of people being left behind.

MEANINGFUL PARTNERSHIPS CENTERED IN THE VOICES OF PEOPLE MOST IMPACTED

Health and housing providers working to effectively serve and improve outcomes for Black people, people of color, Indigenous people, and other communities most impacted by inequities, should work to develop meaningful, diverse partnerships with individuals and organizations that are embedded in and representative of those communities. Inclusion of these diverse, representative voices must not be limited to special equity-focused discussions – they should be integrated into all levels of leadership and decision-making. In times of crisis, this means ensuring the people most impacted by inequities are included in emergency management command structures to maximize the speed at which decisions can be made without sacrificing equity considerations.[12]

PARTNERING WITH CULTURALLY-SPECIFIC ORGANIZATIONS

Health and housing systems in the United States have traditionally focused on serving individuals rather than specific communities, an approach that has contributed to the depth and persistence of inequities, particularly among communities of color. In recent years, public health experts have emphasized the need to focus on communities (instead of individuals) in order to more effectively address racial and ethnic disparities.[13] Building or deepening partnerships with culturally-specific organizations is a critical step for health and housing agencies looking to focus on certain communities (and in doing so, center equity in their work). Culturally-specific organizations:

- Serve a majority of clients from a specific culture (often people of color who may be underserved by mainstream institutions);
- Have staff, boards, and leadership that are reflective of the community served; and

[12] National Innovation Service. An Equitable Systems Transformation Framework for COVID-19. 2020.
[13] Prybil L. Scutchfield D, Killian R, Kelly A, Mays G, Carman A, Levey S, and McGeorge A. Improving Community Health through Hospital Public Health Collaboration: Insights and Lessons. Health Management and Policy Faculty Book Gallery. 2014.

- Are recognized as culturally-focused by the population being served and have established, successful engagement with the community[14]

While the types and variety of services they offer vary by organization, these organizations all have key knowledge about cultural norms, languages spoken and read by the community, effective communication strategies, community gathering places, and concerns of the population that come from years working within the specific community.

Health and housing providers must be willing to share power with culturally-specific organizations in order to create meaningful partnerships to achieve a goal of advancing equity. Power sharing, in this context, can be defined as the ability to decide what is (or is not) a problem, what needs to be done about it, who will be involved and in what capacity, and what resources will be used.[15] In times of crisis and beyond, how health and housing partners can meaningfully engage with culturally-specific organizations include:

- **Assessing and Understanding Need.** Culturally-specific organizations can help health and housing providers get a deeper understanding of the needs of communities most impacted by crises, health and housing disparities, barriers to access, or the gaps in and other problems with existing services and resources. They can provide timely information and feedback about what is going on in their community and lift up the voices of people most impacted.
- **Designing Services, Processes, Access Models, etc.** Health and housing providers can work with culturally-specific organizations to adapt or create new programs to effectively serve the community. Planning and decision making should be done through an ongoing partnership with the culturally-specific organization. To truly center equity and respond to community needs requires openness, transparency, inclusive engagement, and meaningful power-sharing, especially resource sharing.
- **Communications**. Culturally-specific organizations can be particularly helpful in sharing important information about services, programs, resources, etc. with members of the targeted community. Institutional racism and past harms perpetrated on Black people, people of color, Indigenous people, immigrants, and other groups, including in recent times of crisis like Hurricane Katrina, have led to significant issues with how impacted communities seek out information, who they trust, and how they may receive or interpret communications, especially in times of crisis. As a result, providers may have more success sharing critical information (e.g. changes in operating hours and patient-facing processes of a health center during a pandemic; emergency housing supports and services available; etc.) with a target group if that information is shared by a trusted culturally-specific organization than if it is only distributed through the organization's regular communication channels, or by sources such as local government.

[14] Curry-Stevens A, Deloney G, and Morton, M.. "Rethinking Services with Communities of Color: Why Culturally Specific Organizations Are the Preferred Service Delivery Model. Sociology Mind (2019): 183-206.

[15] Starr, R.W. Moving from the Mainstream to the Margins: Lessons in Culture and Power. Journal of Family Violence. (2018): **33,** 551–557.

ELEVATING THE VOICES OF PEOPLE WITH LIVED EXPERTISE

Another important way health and housing partners can center equity in both times of crisis and normalcy is to elevate the voices of people with lived expertise into leadership, decision-making, evaluation, and other areas of work. People with lived expertise are those who have experience with the agency's programs and/or of the issues it is working to address (e.g. homelessness, chronic illness).

These individuals bring unique and invaluable expertise – they understand the reality on the ground of the services and interventions provided, and the challenges they are designed to address. Engaging people with lived expertise can make service interventions more relevant and responsive to needs, and more effective in advancing equity.[16] Inclusion and elevation of the voices of people with lived expertise must go beyond tokenism and inclusion only for the purposes of meeting funder requirements. Helpful resources offering guidance and information on engaging, supporting, and meaningfully partnering with people with lived expertise include:

- HUD: Integrating Persons with Lived Experiences in our Efforts to Prevent and End Homelessness (2020)
- TAC: Tips for Continuums of Care Working to Include People with Lived Experience of Homelessness (2018)
- National Health Care for the Homeless Council: Recruiting and Retaining Consumers Experiencing Homelessness in Health Center Governance (2018)

TARGETED UNIVERSALISM

Another key approach for health and housing partners working to center equity is that of 'targeted universalism,' an outcome-oriented policy approach rooted in an understanding that different groups of people come from different sets of circumstances (particularly in relation to society's resources, institutions, etc.); therefore, in order to reach a universal goal (such as good health for all), policymakers must deploy a variety of strategies tailored to meet the unique needs of each group.[17]

As an example, A Way Home America is a national initiative with a universal goal of preventing and ending homelessness for all youth and young adults. It is employing targeted universalism by focusing on first developing solutions for two groups more likely to experience youth homelessness and dies as of result - LGBTQ+ youth and youth of color. Recognizing that these groups experience homelessness differently than other groups, the initiative is engaging in collaborative problem-solving processes with communities targeted at improving outcomes for these particularly impacted groups. The goal with this approach is it will lay the groundwork for ultimately meeting the needs of all groups to end youth homelessness universally.[18]

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[16] HUD. SNAPS In Focus Message: Integrating Persons with Lived Experiences in our Efforts to Prevent and End Homelessness. 2020

[17] powell j, Menendian S, and Ake W. 2019. Targeted Universalism: Policy & Practice. Berkeley, CA: Haas Institute for a Fair and Inclusive Soceity, University of California, Berkeley.

[18] A Way Home America. About the A Way Home America Grand Challenge. 2019.

Health and housing providers can develop and implement a targeted universalism approach in times of crisis and beyond by:

- Defining your goal. For example, health system stakeholders, the homeless system, and other local partners might set the goal of ensuring that all members of the community have access to testing and treatment in the case of a disease outbreak, such as COVID-19.
- Assessing where your community's overall population is relative to the goal, then break data down by race and ethnicity and other key groups relevant to the goal (e.g. insured vs. uninsured, age, etc.) to flag areas of differential progress.
- Working to understand why groups are at different places – what are the barriers that are driving the differences? Similar to data analysis, this assessment should be rooted in an understanding of structural racism and other contextual factors.
- Creating targeted strategies tailored to the groups most impacted by disparities, closely monitor outcomes, and make changes to the targeted strategies as necessary in order to ensure that all groups can meet the universal goal.

CASE EXAMPLE: CENTRAL CITY CONCERN, PORTLAND, OREGON.

Central City Concern (CCC), based in Portland, Oregon, provides a wide range of housing (including supportive housing and recovery housing), health care, and services for more than 13,000 people each year. CCC is a Federally Qualified Health Center and a Healthcare for the Homeless grantee. The case study below explores how the organization approached its COVID-19 response with an equity focus, and details some on-the-ground examples of response work done in partnership by the housing and health arms of the agency, including how this work was driven and/or influenced by the lens of equity.[19]

STRATEGIC FOCUS ON EQUITY

At the beginning of the COVID-19 pandemic, Central City Concern leaders made a deliberate decision to be extremely intentional about creating an equity and social justice-informed response to COVID-19. A focus on equity wasn't new for Central City Concern, but the organization felt it was especially important to center equity in their crisis response. Key elements of their strategy included:

- Taking time to assess how decisions could impact certain racial and ethnic groups differently;
- Weaving a focus on equity into decision-making structures, including through a multi-department 'Incident Management Team' focused on the COVID-19 response; and
- Consulting with their in-house culturally-specific programs to understand how the experiences of the populations they serve may be different than others and to be responsive to their needs.

[19] Information gathered from a 4/13/20 interview with CCC's Chief Equity Officer and a 5/27/20 interview with CCC's Director of Supportive Housing, Senior Director of Housing and Recovery Support Services, and Health Services Administrator.

In an interview on April 13, 2020, Central City Concern's Chief Equity Officer, Freda Ceaser, provided a powerful summary of the approach and the thought behind it:

> "I'm really proud of the agency's response. Proud that we have the types of leaders that will pause and explore. Equity is something that can easily be pushed aside and thought of as a luxury. There is so much opportunity to prevent systemic, long-term negative impacts for people of color. We know that we need to think about how our decisions might negatively impact these groups. We need to ask the questions, add a data point or two, and connect the right people. Even if we can't create the very best solution, the fact that we paused and talked about it is super powerful. People are going to remember what we did, the decisions we made, what we prioritized. After all this is done, hopefully the story will be good."

EXAMPLES OF COVID-19 RESPONSE WORK DRIVEN BY EQUITY CONSIDERATIONS

Equity considerations were woven into the strategy and decision-making processes for the organization's entire COVID-19 response. Below are just a few of the many examples of how specific equity considerations were addressed.

Equity Consideration	CCC's Response
Immigrant communities have expressed fear and hesitancy about seeking necessary medical diagnosis and treatment, including during the COVID-19 pandemic, because of concerns about the "Public Charge" rule.[20]	Communications targeted to immigrant communities about COVID-19 and services available were translated into multiple languages and customized to include information about public charge implications of seeking treatment.[21]
Systemic racism and past harms done to Black people, people of color, Indigenous people, and other marginalized people including LGBTQ, HIV+, and immigrant communities, may impact how they seek out information, which sources they trust, and how they experience communications.	Used multiple channels to distribute important information about COVID-19 and services available, including engaging culturally-specific programs, and tailored messages as appropriate. Deliberately used simple, trauma-informed, non-stigmatizing language in communications.

[20] The Inadmissibility on Public Charge Grounds final rule (84 FR 41292) details how immigrants or others seeking admission to the U.S. or a status change may be deemed a 'public charge', and thus inadmissible to the U.S. for receiving certain public benefits over a set threshold.

[21] U.S. Citizenship and Immigration Services (USCIS) has announced that testing, prevention, and treatment related to COVID-19 will *not* be used against immigrants or those seeking an extension of stay or change of status in a public charge test (for more, see USCIS's Public Charge webpage)

Many front-line staff come from populations that are highly impacted by structural racism and disproportionately affected by COVID-19 and its impact on health, the economy, logistics (lack of child care due to closed schools, public transportation disruptions), etc.	Channeled information to staff as well as clients in regular distribution of lists of resources and services available in the community Aggressively worked to obtain, distribute, and train staff on personal protective equipment (PPE) to protect health workers as well as housing staff. Conducted regular staff surveys to understand experiences during the crisis. Intentional virtual community building to support staff and increase engagement
The use of phone or video conferencing technology can exacerbate challenges in communicating and understanding providers for tenants that do not speak English or for whom it is not their first language.	Ensured that translation services were available for telemedicine appointments just as they would be for in-person appointments.
Lack of access to equipment including phones (or having limitations on minutes), computers, internet, or other necessities for tele-communication prohibits some tenants from accessing critical services, including tele-medicine, as well as virtual visits with the justice system, child welfare, and other social services agencies.	Hired a leader to focus on tele-connections. Worked to ensure that clients had access to the equipment they needed to attend appointments. Also working to develop physical tele-suites in residential buildings, where tenants can access the technology needed to attend virtual appointments.
People with hearing, visual, or communications-related disabilities may be unable to participate or fully engage in tele-appointments without specialized equipment.	Ensured that people who need it have access to appropriate hardware to facilitate tele-medicine and other virtual appointments
When clients live in multi-generational households with many family members in small spaces, it is impossible to find private space or to speak freely in appointments, particularly around mental health or other sensitive subjects.	Provided options for off-site meetings or other solutions so clients can access appointments without having to worry about privacy concerns.

CONCLUSIONS

In partnership, health and housing systems have enormous potential to advance equity and improve the lives of people whose potential for health, housing stability, and quality of life has been limited by the impacts of structural racism. Just as the lack of a home or housing stability negatively impacts health and compounds racial disparities in health outcomes, the provision of housing and supportive services, when coupled with access to quality health care and targeted to the people who need it the most, can compound positive outcomes and set people and communities down an entirely new trajectory of good health and all the benefits that flow from it.

Dedicating time, resources, and effort to center considerations of equity in planning and operations should not only be a focus during times of crisis, but also adopted as the standard operating procedure for all organizations moving forward. Only by doing so will organizations, and the communities and systems they are part of, be able to make the profound changes needed to combat inequities and move toward a day when all people truly have a fair and just opportunity to be as healthy as possible.