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Getting to Healthy Housing in South King County

*Current landscape and next steps toward a Resource and Referral
Network and a Community Health Worker program*



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Executive Summary

Background

The purpose of this report is primarily to expand upon the recommendation from a previous report, *Health and Housing in South King County*, to use community health workers and a resource and referral network to improve the health of housing in South King County (SKC), WA. This paper provides a more detailed proposal as to how this model could be adopted in the region specifically in *unsubsidized* housing. The research conducted here was designed to assess readiness to implement, including potential leadership and funding, as well as policy and advocacy needed to support sustainable programming.

The secondary purpose of this report is to provide useful information to the housing and public planning sectors on the trends, players and complexity of the health sector. The intersection of housing and health is a nascent and growing field. Each sector involved has its own bodies of expertise and lexicon that can be challenging to decode or understand if one is not working in the field day-to-day. This research intends to strengthen cross-sector partnership and innovation by highlighting some of the possibilities specific to community health worker programming during a time of great transition under health care reform.

The four core questions for our research were:

1. How much interest is there among local stakeholders in a community health worker (CHW) program and/or a resource and referral network (RRN) focused on healthy housing?
2. What organization, if any, would be the most suited and best prepared to host these programs? What support would they need to be most effective?
3. What are the most effective and realistic funding mechanisms, with particular emphasis on Medicaid?
4. What are the policy or advocacy steps needed to help achieve sustainability in both funding and leadership?

Summary of Findings

There was a great deal of support across the region for this exploration of the intersection of health and unsubsidized housing. This comes at a time of increased cross-sector work, including stronger ties between health and housing professionals, to better understand social determinants of health and to develop collaborative solutions.

Much like in other areas of the country, health care providers in King County are implementing CHW program models with an understanding that what happens in the community and the home is as important to a patient's health as what happens in the clinic. As we considered how to positively impact the health of residents of unsubsidized housing in SKC, through changes in the home as well as increased access to resources for self-empowerment (such as health education and tenant advocacy), we noted that

there are a number of professionals already working in communities and in homes that help residents with health and housing resources as a major part of their jobs. In addition to CHWs, other job titles include patient navigators or early child and older adult care home visitors. All of these staff make referrals to a wide range of resources, and there was a commonly identified need among them for housing resources. There are a number of referral systems already in place, or in development, that assist direct service staff in accessing resources needed by patients. There is also interest in improving the coordination of both referral mechanisms and care providers working with any given family.

There has been high-level thought at both the state and local levels to understand the roles CHWs play, strengthen their field, fit them into the larger health care system and identify funding models. Regionally, a number of key stakeholders are positioned to deepen CHW initiatives, including the Foundation for Healthy Generations, Public Health – Seattle & King County, the Accountable Community of Health (ACH) and the Housing-Health Partnership and Planning Group (HHPPG), led by Mercy Housing Northwest (MHNW). The ACH is a regional cross-sector collaboration with influence over funding, policy and priorities and is a potential high-impact partner in addressing health through housing. Housing is a clear interest for the ACH.

Funding CHWs remains a challenge. Most projects are grant funded, which is not advised for a long-term, sustainable model. The payment mechanisms for Medicaid will change dramatically in the near future, driven by the “Triple Aim” of improving care, health and cost. The new model will move from a fee-for-service mechanism to Value Based Payment (VBP) for health outcomes, creating a business model that potentially rewards prevention and community-level work. Details of how this will work are still very unclear, and this lack of clarity makes planning any new CHW program using Medicaid a challenge.

Summary of Conclusions

As we sought to answer the four core research questions in this report, we used two frameworks: Are there any emerging *strategies that maximize existing resources* that could be a solution, and, what are the opportunities for *new programs* that would address the need for healthy housing in SKC?

There exists a great deal of interest in CHWs across the health sector, as a key asset in both improving health and positively impacting the financial bottom line. However, due to the broadness and diversity of the region, lack of a current inventory of the relevant CHW-type services available and the shifting funding landscape, the region is not ready to launch a new program yet. There needs to be more planning to better assess where the need is, including identifying the target population, geography and optimal service design. It would be far more fruitful in the short-term to better understand the existing pieces, including the number and capacities of current health workers and home visitors who could potentially assist with healthy housing initiatives. There is a need for more shared learning in CHW approaches or data collection, including mapping the system, assessing needs and learning from the field. Due to the ripeness for collaboration and regional planning, now is a good time to improve coordination, advocate and define regional priorities.

Regarding which entity should host these programs, we found that there is no enthusiasm to create a new regional coordinating body at this time. Rather, existing entities are positioned to act on the recommendations made here. At the systems/planning/coordination level, ACH and King County are the natural leads for much of this work, including shared learning, collecting data, fostering collaboration and long-term planning. The ACH is supporting HHPPG’s work in data integration and sustainability planning. Foundation for Healthy Generations, Global to Local and WithinReach currently play important

roles in supporting CHW or referral systems that could be leveraged. On the direct service level, until we are more precise on need, defined geography, target population and defined desired outcomes, there is no clear programmatic lead to launch a new or expanded CHW program. Depending on design parameters, the community health clinics or hospitals would be logical partners as well and are interested partners.

Under the Affordable Care Act (ACA), including Medicaid payment reform efforts, the entire health care system is in flux right now.¹ As these reforms take shape over the next several years, Medicaid appears to be the best funding option for a sustainable, scalable CHW initiative; however, this is not likely to be a viable option until the system is more settled. Beyond health funding, it is recommended that planning consider other sectors that use home visiting and housing-based interventions to improve health, including early childhood initiatives under Best Starts for Kids (BSK), weatherization programs and older adult programming. It is not recommended to launch a new RRN at this point but, rather, to advance the impact through alignment or coordination of the many RRNs that currently exist. There are some existing resources, including Best Starts for Kids, which may help support this work.

HHPPG, with MHNW, has taken a lead in making the case for long-term funding for CHWs in affordable housing at the policy level. This work can be expanded to include unsubsidized, substandard housing. A long-term joint advocacy plan should be developed to define strategies and roles for this long-term goal, and should include relationships with Managed Care Organizations (MCOs) and the state Health Care Authority (HCA) who are both key decision makers in how Medicaid funding can be used for CHWs. Locally, the ACH is positioned to play an instrumental role in setting the priorities for health care investments and strategies. Strong relationships, advocacy and clarity of solutions for a range of housing options would support the ACH in ensuring healthy housing is included in their policy and strategies.

¹ As of the writing of this report, the 2016 elections had not yet occurred. Therefore, all research and recommendations information on a rapidly changing environment at the time. The uncertainties created by the 2016 elections only underscore the need to track changes and continue engagement with stakeholders, as a Republican President and/or Republican-controlled Congress would likely compound current uncertainties to the Affordable Care Act and Medicaid expansion.

Introduction

This report is a follow up to the June 2015 report, “Health and Housing in South King County,” written for the Housing Development Consortium of Seattle – King County by Andrew Calkins, Andrew Desmond and Andrew Wong of the Daniel J. Evans School of Public Policy and Governance. That report offered an overview of the condition of the housing stock in South King County, focusing primarily on the Washington cities of Auburn, Federal Way, Kent, Renton, Seatac and Tukwila and the impact those conditions were having on the health of their tenants. These cities are not homogenous in their housing profile; however, this report identified data indicating that the quality of private market housing and rental stock in South King County was of specific concern. Data on home conditions collected by the King County Assessor provided evidence that single family homes are of poor condition in South King County relative to other parts of the County. SKC cities reported unhealthy conditions in large, multi-family buildings where mold and deferred maintenance could lead to poor health outcomes.

To address this disproportionate health concern specific to private, unsubsidized housing, “Health and Housing in South King County” issued policy recommendations to increase the health of housing, including adjustment of building codes and inspection standards as well as the use of community health workers (CHWs) and a resource and referral network (RRN). The purpose of this report is primarily to expand upon the recommendation to use a resource and referral network and community health workers in unsubsidized housing and to provide a more detailed proposal as to how this model could be adopted in South King County. It is highly recommended that the aforementioned report be read prior to this one for deeper context and understanding.

Methodology

Secondary research helped us to understand the trends and possibilities from a national perspective as states and health care providers innovated to find programmatic and funding solutions to implementing and improving healthy housing-based strategies. We set the local landscape into these national trends through a series of stakeholder interviews. These interviews were held primarily with professionals working in the health care sector at leadership and management levels. This included the providers from Community Health Clinics, select regional hospitals and Public Health — Seattle & King County (Public Health). We also interviewed health sector experts who have systems level or bird’s eye views of trends and possibilities in the field, including experts at community, county and state levels. A full list of interviews is shown in appendix B. In total, we interviewed 19 individuals representing 13 different agencies for a cross-section of the field.

Background

The intersection of housing and health is not a new research or intervention area. In 1992, the Fannie Mae Foundation created the National Center for Lead Safe Housing; this was later renamed the National Center for Healthy Housing (NCHH) in 2001 to broaden its scope. The U.S. Department of Housing and Urban Development (HUD) first launched its Healthy Homes Initiative (HHI) in 1999, in response to growing concerns about children’s environmental health. For well over a decade, housing and its impact

on its tenants' health has been the subject of strong research studies, which have proven that housing issues like mold, pest infestation, poor ventilation, insufficient insulation, lead, radon, asbestos and carbon monoxide are major contributing factors toward various health problems including asthma, cardiovascular disease, developmental stunting, cancer and death. These factors are part of what are often called "social determinants of health," an umbrella phrase that addresses the fact that the housing and neighborhood issues that cause health problems often have an even greater impact on one's health than traditional health care systems. In particular, social determinants of health often disproportionately adversely impact individuals of low-income means and people of color.

One comprehensive definition of the concept of a "healthy home," which will be used as the working definition of the term in this report, was offered in a 2016 report by PolicyLink:

"Healthy housing" is a home where the physical, mental, and socioeconomic environment supports household members in making healthy choices, achieving educational and economic success, and engaging in robust social and cultural networks. It is housing in a neighborhood connected to good employment and business opportunities in the region. It is a home free from toxins and threats from the built environment such as unsafe streets, violence, poor air quality, industrial chemical exposures, allergens, mold, or pests. It does not impose cost burdens that divert household income away from healthy food, medical care, or educational opportunities. It is located in healthy and well-resourced neighborhoods.

While there is conclusive evidence supporting cross-sectoral impacts, as can be seen by the inclusion of health, education, environment, economic well-being and housing in the above definition, there has yet to be a standard intervention model adopted to address unhealthy housing. States, municipalities and nonprofits around the country are all working on this issue, but their efforts have tended to be disparate and siloed, targeting only their specific region or problem of interest. This is a result of various factors, but it seems that, primarily, it stems from both the initial reactive approach that created programs designed to combat individual diseases or issues (i.e. anti-lead groups, weatherization programs) as well as a lack of consistent funding for broader efforts, a result of the issue's precarious positioning in between two well established fields: housing and health care.

The ACA

With passage of the Affordable Care Act (ACA) in 2012, however, there has been a shift toward collaborative efforts. One major outcome is that Medicaid funding has begun to be made available more broadly to managed care organizations (MCOs), who receive a set payment per member per month (capitation). This "Value Based Payment" (VBP) model incentivizes using proactive, preventative, environmental health care models that can keep people healthy in the first place, thus avoiding costlier emergency services after an illness or accident has occurred. As a result, preventative, in-home health care is on the rise. This preventative model has been most successful where it has been a collaborative effort, linking the existing disparate and siloed programs from various fields, including environmental sustainability efforts, child care, disease specific health groups and low-income housing developers, to create a more comprehensive health model.

This “Value Based Payment” (VBP) model incentivizes using proactive, preventative, environmental health care models that can keep people healthy in the first place, thus avoiding costlier emergency services after their illness or accident has occurred.

Another outcome of the ACA is the requirement for non-profit hospitals to conduct a community health needs assessment (CHNA) and corresponding expansion of the community benefit requirement, an amount of money or services that are to be reinvested in the hospitals’ own region. Hospitals are now required to spend a greater percentage of their operating revenue on programs to improve community health, as well as required to conduct an in-depth study of specific needs in their community to be addressed. The combination of these two things has pushed hospitals further into the public health arena than ever before and lends their significant political weight and technical skill as a new resource for groups looking to broaden health interventions in the community, including healthy housing groups.

Issue Integration Models

This seismic shift in the way the healthcare industry is incentivized has opened many doors for government and nonprofit organizations, finally beginning to blur the lines between housing and health care. One model, Breathe Easy at Home in Boston, MA, has created a referral network that allows doctors and other healthcare professionals to make a web referral for a patient to have their residence visited by a city inspector who will check for health hazards in the home. The inspector can then issue a violation notice with a “correction order” directly to the landlord. Not only is this a simple, streamlined way to connect health and housing, it also avoids the potentially large barrier of the landlord – tenant power dynamic, which can create tenant fear of reporting structural issues in their home.

Another example of a model using program integration is the partnership between Opportunity Council Head Start in Bellingham, WA and various local weatherization and home rehabilitation programs. Head Start home visiting workers were trained in asthma trigger prevention and used to recruit families that had children with clinically diagnosed asthma for healthy home renovations. They partnered with the Northwest Clean Air Agency to assess in-home hazards, City of Bellingham Community Development Department to contract for minor renovations, and the Whatcom County Health Department to define target populations and the highest risk families. By leveraging existing weatherization funds from these partners, they were able to make minor home renovations that provided substantial benefits to both health and energy consumption, and by utilizing existing home visitors.

Community Health Workers

National Trends

Many different programs targeting many different outcomes use home visitation as a key component of their outreach strategy. If properly implemented, trusted community members are direct access points, for the families, as trained, skilled employees to assess and diagnose the problems, whether they be structural or behavioral. Both the Boston and the Bellingham models used home visitation, housing inspectors and child care providers respectively, but one emerging field directly tied to health, CHWs, could potentially be the best fit of them all. As defined by the U.S. Department of Health and Human Services (DHHS), CHWs are:

...lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, “promotores(as),” outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.

While this is a rather broad definition, the crucial component of it is that there exists a deep connection with the local community through shared language and life experience. This connection allows CHWs to penetrate communities that are not currently being reached by the health care system either due to fear, a lack of understanding, or often both. By their positioning as neighbors who have a personal understanding of the families’ experiences, they have an existing level of trust from the outset and can more easily access people’s homes and offer assistance that will be more culturally competent and thus more effective than more generalizable, traditional interventions.

Some iteration of community health workers exists in many neighborhoods across the country, and they have for many years. With the ACA-encouraged shift in focus to a VBP model, however, CHWs have begun seeing more mainstream acknowledgement among the healthcare community as a potential tool to further prevention efforts, particularly in difficult to reach communities.

Local Landscape

Local conditions are reflecting national trends. The interviews conducted confirm that there are a number of factors converging to fuel a very high interest in increasing the availability of CHWs in King County. Several things are driving this, including:

- Evidence of the impacts of social determinants of health (social and economic factors that determine the health of individuals and communities) are increasingly clear and compelling.
- Local health care providers increasingly understand that what happens in a hospital or physician's office is only a fraction of what is contributing to the overall health of a patient. From the complications of getting patients into a physician's office for follow up visits to understanding that place matters for overall health, be it neighborhoods or homes, all of the health care providers and systems' partners interviewed placed a very high value on the role of community health workers to support non-clinical aspects of health.
- Providers are keenly aware that the ACA is driving toward outcomes (and ultimately payments) that are holistic in nature – improving the overall health of patients rather than counting visits and treating conditions.

As one provider noted, “the health care team of the future will look different,” and will most likely include some integration of CHWs into care teams. It is clear that there is no obvious roadmap forward, however. The changes in the health system under the ACA – both movement toward more holistic health outcomes as well as redesigning the funding landscape – is in the midst of a massive transition without much clarity about what it will look like once complete. Within this landscape, the health care and community providers interviewed are at different stages of evolution in developing, implementing or funding their strategies for utilizing CHWs. Some programs, particularly the Community Health Clinics (CHCs), have a long history of using CHWs as part of their care model; others are developing programs to respond to current needs and opportunities.

Although most do not focus specifically on healthy homes, there are a number of different initiatives underway in King County that use CHWs as a central part of their strategy. These are roughly organized by location and intent of the service model, and these differences are important considerations for a CHW model that integrates housing and health. A partial snapshot of our current landscape includes:

Community/Neighborhood-Based Approaches

The structure of a community/neighborhood-based program is similar to the Promotore Model. This type of model typically includes CHWs hired from the community who have high degrees of cultural competency in working with diverse populations, are bilingual and/or bicultural, and are most effective when relationships with residents are longstanding and deep.

[The Promotore] model typically includes CHWs hired from the community who have high degrees of cultural competency in working with diverse populations, are bilingual and/or bicultural, and are most effective when relationships with residents are longstanding and deep.

One of the unique features is that instead of (or in addition to) focusing services on individual patients and identifiable health needs (e.g. asthma), activities can directly respond to what the community says it needs to promote health and build community. This may, for example, include starting a walking club, a women's only swim time or cooking classes. Participation is open to members of a group, often those living in a particular geographic boundary, rather than those suffering from a condition or health risk level. Some of the local groups that are using this model include:

- Global to Local (with their partners Health Point, Swedish and Public Health) focuses on the Somali and Latino communities in SeaTac and Tukwila. Global to Local is a nonprofit based in South King County that is focused on developing community support for improving social determinants of health, specifically through the training and coordination of CHWs.
- Neighborcare, a Community Health Clinic (CHC) serving low-income and uninsured families and individuals, has a housing-oriented CHW as part of Seattle Housing Authority's Choice Neighborhoods Strategy at Yesler Terrace. This project will be expanding to their new Meridian Center.
- Sea Mar, serving primarily the Latino communities, uses a site-based care team to provide services in buildings that they own and operate.

Specific to the goal of improving health and housing outcomes in South King County, this approach has some unique strengths. First, the trust, depth and quality of relationship that can result from increased access to the home and to family and community dynamics, are likely to result in more sustained changes (e.g. behaviors that residents can control to positively affect health). In addition, these programs build the advocacy skills of residents so they can better represent their own needs within existing bureaucratic systems and with landlords. And lastly, the focus on all of the residents in a defined geographic area or building also creates a clearer picture of the quality of the housing stock and potential avenues to improve it through relationships with landlords.

There are challenges to a community-oriented approach, however. Given the primacy of the community-level intervention and its responsiveness to community voices, it is not clear if this approach effectively targets health *behaviors* in the home that could *immediately* impact the health of residents suffering from chronic conditions (e.g. addressing safety risks or reducing asthma triggers that can be done by a tenant). These programs also may not necessarily be tightly tied to a primary care team, which makes coordination of health services less cohesive. Additionally, it is difficult to tie this community-level work to specific health outcomes, which contributes to a long-term funding challenge. This model is typically supported by grant funding and is not likely fundable by Medicaid (see funding section) due to the challenges of data collection and accurately measuring health impact.

Home Visitation Approaches

Some program models use staff trained in health interventions to go directly into people's homes. Service models can vary from promoting general health to targeted health interventions. Some examples of local applications of this model include:

- CHI Franciscan Health's *Health Connections* program combines CHWs and social workers with nurses who assist with assessments and connections on clinical issues. There are two teams of up to 8 staff members. This is called the "ICU" of CHW approaches for high needs patients. Patients are identified through the hospital or emergency room as high risk for re-hospitalization. This team is community-based and does home visits. They accompany patients to follow up visits, offer patients health coaching or advocacy within the health system, and help patients access health and housing resources. Genuine patient engagement, motivational interviewing and patient-identified goal setting are considered essential elements of success.

- Sea Mar does home visits as part of their Maternal Child Health Services that target pre- and post-natal mothers. Their role includes advocating on landlord issues, and it was noted that they “see lots of horrific housing situations” as part of this work.
- Sea Mar partnered with the American Lung Association and other CHCs to use volunteers to provide health education and help identify asthma triggers during home checks. While this project is no longer in operation, leadership noted that they are working with partners to potentially continue this work that would be done through health educators, not CHWs.
- Nurses with Public Health — Seattle & King County (Public Health) do home visits as part of their maternal and infant health services through their clinics.

Specific to the goal of improving health and housing outcomes in South King County, a home visiting approach has some unique strengths. The connection to health care providers and the unique health needs of the resident is usually clear and the focus of the intervention. In addition, the health expertise of the CHW is more specialized (e.g. maternal health or asthma).

The constraint to this approach is that interventions are often time-limited and issue specific. The interventions may not be designed to fully impact the range of relevant social determinants of health that are a foundation for long-term health, including building community connections.

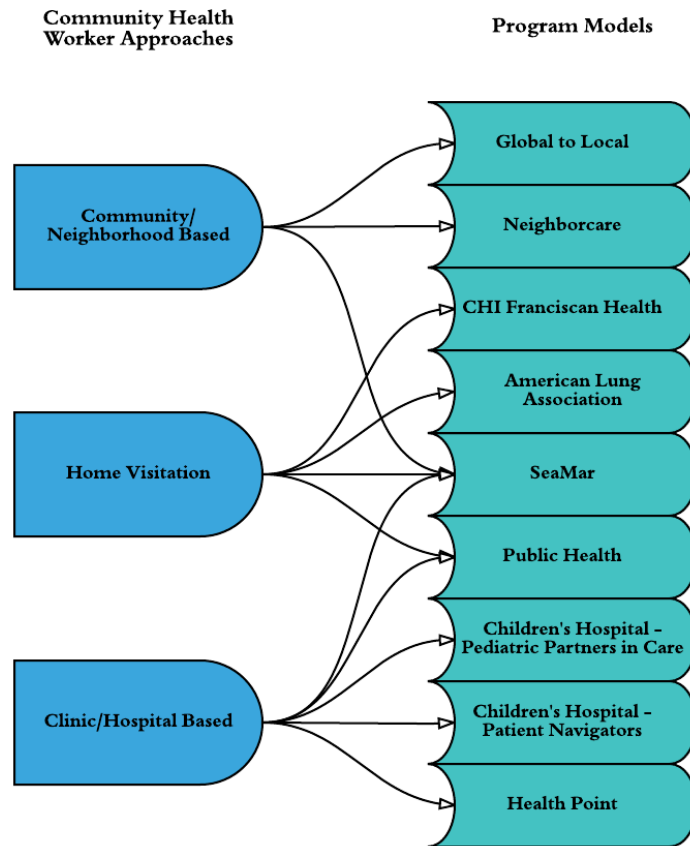
Note that there may be a number of health educators employed by both health providers and CBOs that work in the community or the home that have not been identified as part of these interviews. However, this type of program model may also play a significant role in the network of supports that advances HDC’s intentions on improving health at the intersection of housing. Sea Mar, for example, mentioned that they offer health education programs in some public housing communities.

Clinic or Hospital-Based Approaches

One common method of using CHWs or Patient Navigators is to integrate them into the clinic or hospital setting. Some examples of this model include:

- Children’s Hospital-Pediatric Partners in Care (PPIC) is a Center for Medicare and Medicaid Services (CMS) funded grant targeting all children receiving SSI (who tend to be high utilizers of health care) in King and Snohomish Counties in an effort to improve coordination of care. There are three teams in King County (North, Seattle and South) that provide clinical and resource link support. The South Team operates out of Odessa Brown. This project also includes a mobile mental health team. Patients may or may not be patients with Children’s Hospital, which is a unique element among most CHW programs.

- Seattle Children’s Hospital’s Patient Navigators is a hospital-based group that offers services for families who speak Somali, Spanish, Mandarin, Cantonese, Arabic or other indigenous languages of Mexico or Central America. They are also piloting a program for Alaska Native and Native American families. Children are patients of Seattle Children’s and have medically complex needs or are seen in multiple clinics. They see a number of families who live in South King County and provide resource connections and referrals, primarily through follow up via a phone call.
- Health Point uses patient navigators to connect patients to community resources such as food and housing. They also use care coordinators to assist with ensuring patients enroll in insurance and can access health services available to them.
- Public Health clinics have on-site CHWs that provide services for maternal and infant health as part of a multidisciplinary team with a nurse, social worker and dietician.
- Sea Mar uses care managers in their clinics to attach resources to the needs of their patients.



Specific to the goal of improving health and housing outcomes in South King County, this approach’s strengths include a higher potential to coordinate directly to primary care. The unique health needs of the resident are usually clear and are usually the focus of the intervention, and that the health expertise of the CHW is more specialized (e.g. maternal health or asthma).

Limitations to this approach may include limited time per patient, a focus on predetermined activities or goals during that patient time, constraints on relationship building or community building opportunities that can help build self-efficacy skills, and a limited ability to assess and recommend for home-specific interventions due to the lack of a home visiting component.

Diverse Missions, Diffuse Organization

Broadly speaking, CHWs typically either work to address specific health issues (e.g. asthma or high risk of readmittance) or more generally support health and patient care. Many of the programs discussed in these interviews were issue or disease specific, but there are pros and cons to both approaches. A disease specific program may have deeper specific expertise (e.g. asthma triggers in the home, maternal and infant health, medically complex), but they are also typically strictly limited to serving only patients with that health issue. Broader approaches will also typically have some geographic or other eligibility limitations. Finally, in most, but not all, programs participation is limited to patients of that clinic or health provider.

It is not surprising that there is no unified definition of what a community health worker does. This is consistent with the range of tasks and responsibilities in many of the national models reviewed, as well as the topic of many conversations at the State CHW Task Force. There have also been a few concerns expressed that the push toward a more clinical approach/direct tie to physicians would undercut the value of culturally responsive community-based approaches like the Promotore model.

Our purpose is not overly concerned with having a single definition, however, but rather this report takes a broader approach that is more likely to achieve the intent of the project in the long term. Community health workers should have both health expertise and resident/patient relationships that can potentially lead to:

- Identifying connections between health conditions and/or risks and current home environmental factors.
- Connecting the patient to proper avenues of health care.
- Connecting the patient to resources that support health *specific to the home environment* – specifically the attachment to healthy housing and tenant resources that can improve the physical conditions of the home environment for safety or health.
- Ultimately, changing behavior or environmental factors that improve health, through actions that can be taken in the home by the resident.

Parallel Objectives, Collaborative Potential

Given this broader set of goals, we can include a number of common, existing job roles around the region who could play a potential role in positively impacting resident health or increasing access to tenant resources that improve housing conditions. Some typical titles that include components of education, referral and linkage, and advocacy include care coordinators, patient navigators, nurses (particularly those that do home visits) and health educators. In addition to staff who have a job objective in some way related to health outcomes, it is worth noting that there are many other types of jobs outside of health care that have the direct or indirect potential to further impact HDC goals. Early childhood education models include many programs that include home visits that focus on education and healthy development; programs that focus on older adults commonly do home visits where health and safety are part of the services provided. Exploration of these specific services is outside the scope of the interviews conducted for this report but should be considered as an asset to any systems-level strategy going forward.

Everyone in the health care system is at a different stage in incorporating strategies that address social determinants of health that may include a CHW strategy. Health Point, for instance, has been engaging in

a strategic growth phase and expanding services in South King County. They have eight health centers in South King County serving approximately 65,000 people, plus two school-based clinics (Evergreen and Tyee in the Highline School District). They partner with Public Health's mobile medical van and use clinic-based patient navigators to connect to basic needs and services. While they do not have CHWs at this time, they are interested in the possibility and in opportunities for shared learning. The interest in shared learning was mentioned in several interviews, across agencies.

This review was not designed to be a comprehensive scan of the different types of CHWs providing services in South King County. However, other CHW programs were mentioned during the interviews that may warrant further research as to their potential. Public Health — Seattle & King County has a grant funded initiative on asthma and diabetes that utilizes CHWs. A few of the Managed Care Organizations (MCOs) - Molina and Coordinated Care - have hired their own CHWs, and Molina is reaching out to partners for CHW services to connect patients with health homes (differentiated from healthy homes). There may be great benefit to conducting a more complete inventory of who does what in South King County to better determine opportunities and gaps in services, but this was not within the capacity of our current research.

Each of these different models and locations of services has a different set of assets and limitations. The point is not that they can all equally provide a set of services that also meets the HDC dual aims of affecting health and housing quality. Rather, it makes sense to have a mix of strategies that meet client needs, be they intensive or minor. This incomplete list points to two possible directions for next steps.

1. By nature, the scale or scope to how much CHW-type work is currently going on in South King County, and who is being served by them, is a challenge to fully understand. It is very difficult to know where to start for greatest impact at the intersection of housing while having a limited view of what is happening already, where it is occurring, and where the potential gaps are. This information would be incredibly helpful.
2. There is a benefit to having a variety of approaches to patient health that are responsive to individual needs, from major to minor forms of assistance. We have a web of services that is both broad and deep, spanning a wide range of needs across the whole spectrum of intensity. However, there does not appear to be anything resembling a continuum of care or a cohesive way to transition or coordinate services. Coordination of services from a patient experience would be beneficial, yet also complex and challenging to implement.

There are different approaches on how to move forward with growing a CHW model. As noted above, there are differences, both positive and negative, between preferred approaches – community- or provider-oriented. There are passionate feelings among some providers about the overall, long-term benefits of a community-oriented approach as a long-term, population-level strategy that best responds to community need. However, there is a general acknowledgement that this approach is difficult to fund and that the future model will more likely require tighter coordination with the health provider. There is general consensus that, at least initially, most CHW work will have a disease or condition focus (treating asthma or reducing hospital readmissions, for example), but there is also hope that more general, preventative approaches will be fundable and effective as health care reform evolves.

There are also different approaches to how to pilot or test models. With so many efforts that are seemingly disconnected, leadership at Public Health wondered if there were ways to streamline programs to show

fidelity to a model and demonstrate impact. Both CBO and provider partners, on the other hand, are interested in small scale pilots with clear goals and time to build the partnerships that can be grown and sustained over time. To a large degree, most interviews see the community health clinics (CHCs) as the natural health partner for a housing-health CHW initiative.

Trends in Data Collection

Several health care providers expressed an interest in knowing what is working for their patients. Providers are at different stages in collecting and using data that incorporate social determinants of health. As is noted in the Funding Landscape section, making a strong data case will support funding for CHW or other innovative solutions, with health care dollars, by demonstrating cost savings and health outcomes. In addition to funding, the data will be helpful in conducting proper formative and summative evaluations to assess need and future direction at both a provider level and at a systems or geographic level. This will help strengthen the programs and their interventions over time.

...making a strong data case will support funding for CHW or other innovative solutions with health care dollars by demonstrating cost savings and health outcomes.

In general, programs that include CHW components do not include their work in electronic medical records (EMRs). And since many CHW programs have been funded by time-limited, specific grant dollars, many of these projects have had their own specific data requirements or data systems. This is an incomplete inventory of efforts to demonstrate effectiveness and/or improve services:

- Health Point, to date, has not been tracking data beyond basic factors such as homelessness or English Language Proficiency, but they are moving quickly in this direction. They are partnering with the National Association of Community Health Centers, Next Gen and Epic to use a tool that better collects data on a range of social issues.
- CHI Franciscan is using TAV Health for the Health Connections program. This system is used to track care (progress toward goals) as well as barriers or patient circumstances that help paint a more holistic or comprehensive picture of what is happening. In addition, this system generates possible resource links based on barriers/needs, which is helpful for staff on the ground.
- Public Health has system-wide data sets, as well as evaluation data, on specific CHW-type programs they operate.
- Mercy Housing Northwest (MHNW) is leading a data integration project which seeks to integrate health data for all Medicaid recipients living in any housing that gets public funds. This would include public housing, vouchers, and state- and city-financed housing that report through HUD and WBARS (Washington State Web-Based Annual Reporting System) data systems. See Funding Landscape section for more details.

With the exception of Mercy Housing Northwest, these projects do not as *their primary purpose* have the lens of health and housing. However, there may be very rich data sources within these models that will advance decision making for future project design, including geographic or target population focus. In addition, the different approaches, as well as data systems, being used could potentially point to interest in increased collaboration across partners for shared learning.

Community Health Workers -- Common Themes and Summary

- *Generally, most interviewees were excited to hear about HDC's interest in the intersection of health and housing. While they have a lot of questions on what this means, there are opportunities right now (into the next few years) to support the development of systems or funding mechanisms that incorporate a housing-health model that includes CHWs.*
- *The health system is recognizing that they are only a piece of the health puzzle and most impacts on health happen in the community or home. This is a big partnership opportunity, and there is a lot of interest in shared learning or planning, but no one is fully clear in how to engage in the conversation beyond individual organizations or initiatives.*
- *There is a great deal of interest in increasing the number and use of CHWs among health providers, even if the details and the business model are not yet clear. Most programs are either exploring or implementing different models of care that include CHWs.*
- *There are a number of good ideas on how we could potentially proceed with a dedicated CHW program to focus on residents of unsubsidized housing, while there is recognition that we would need to work out critical details such as health outcomes, intent, geographic focus and basic approach. There is a great deal of interest among several providers, including Neighborcare, Health Point and Global to Local, to explore possibilities.*
- *Hospitals operate using a different business model from the clinics and are doing innovative work. They are future partners in any exploration.*
- *Most interviewees see the need for a convener with vision and leverage to help fill in the gaps and to help create a shared framework for expanded and quality CHW services that includes social determinants of health. King County in general, Public Health or the Accountable Community of Health (ACH) were most commonly identified as the logical player to improve coordination and help forward a vision at a large or systems level.*
- *In addition to CHWs, there are a number of different job titles and roles that directly work with individuals and families to address both health needs and the social determinants of health through linkage, referral, care planning or home visits.*

Resource and Referral Networks

A resource and referral network (RRN) is a system in which people in need can either directly, or indirectly, through a professional, be connected to the services and support that they require. As assistance programs have proliferated nationwide in response to specific issues and causes, they have also become a tangled web that is difficult to navigate. Many of those who are most in need do not know the support that is available to them, or, if they do, they cannot access it. RRNs help connect disparate programs and services that usually operate independently, both acting as a compass for individuals in need and helping the programs themselves find and more efficiently serve one another.

National Trends

Various RRNs already exist around the country for various purposes. Some focus on a specific resource that they can refer to, such as child care or counseling, while others work more broadly to cast a net over a variety of available services, to assist people with many needs. One of the first successful national RRNs was the 2-1-1 network. 2-1-1 is a short number, similar to the better known 9-1-1, that immediately connects the caller to information and referrals for health and human services. It began in the late 1990s as a regional number developed by the United Way to assist people in need and has grown to cover over 90% of the population of the United States and 100% of Washington State.

One of the more common RRN models at the statewide level has been for childcare resources. One such program is Oregon's Central Coordination of Child Care Resource and Referral (CCCCRR), which acts as a center point for 13 CCR&R programs around the state. This works to both connect families with child care resources and knowledge in the state, as well as to advocate for policies enhancing the quality of and access to child care services statewide. By giving families one point of contact, this simplifies the process and gets families the help they are looking for faster and more effectively than the individual groups could do on their own.

Even more granularly, some groups at the county level have taken up the mantle of developing a RRN network for childcare. One such group is the Family Resource & Referral Center (FRRC) of San Joaquin County, California. California is a large and diverse state, and FRRC believed that working at the county level would provide the best level of support for families in need by having more cultural competency and awareness of the unique issues in their region with which parents most often need support. They work with parents not just to offer child care referrals but also to help subsidize that child care, to provide nutritious meals and snacks for food insecure children, and even to host workshops and training for parents looking to gain work skills.

Local Landscape

Our interviews explored elements of both the current, existing RRNs as well as the potential RRN proposed in *Improving Health and Housing in South King County* that would identify people with health challenges that appear to be the byproduct of unhealthy housing and link them to services such as CHWs,

home repair, code enforcement, or medical services. There are two different programmatic components to the RRN that may be integrated, but can also be separate functions.

First, there are wide ranging mechanisms and systems to identify people with illnesses that can be tied to housing conditions and refer them to specific services. Health systems, school personnel, firefighters, landlords, other social service workers and others are typical referral sources into specific services that have expertise in housing or health interventions.

Second, once a person is receiving health services in connection with someone in a CHW-type role there is very commonly a need to make a wider range of referrals for additional services that are available in our regional health and safety net.

Interviewees were primarily health providers, which leads to a natural focus on patients already receiving health care. Therefore, we cannot speak in detail to the status of a referral into health/housing resources from other sectors such as schools or fire safety. It is certainly likely that this link happens, particularly in structured programs that have an existing cross-sector approach (for example, school-based health clinics). However, one provider noted that she felt that health resources were not very well known, and it is very likely that the non-health sectors experience the same sense of fragmentation and disconnect with referral networks that the health system noted. This may be an area to explore in future research.

All CHWs, as well as patient navigators, social workers and others serving in the health ecosystem provide referrals to other services as part of their daily jobs. Often, this is a core function of their role. This is done through providing patients with resources to contact as well as “warm handoffs,” or facilitated referrals where the CHW helps directly make the link or assists with eligibility and paperwork. Common connections include insurance eligibility and enrollment, access to food and education resources.

None of the programs interviewed had a specific target of residents of unsubsidized, substandard housing, but nearly all see patients living in substandard housing, and many go directly into those homes. Providers specifically mentioned that they often see bad conditions within the homes they visit that they recognize as potential health or safety hazards. Housing was frequently identified as one of the most needed resources, both in terms of access to housing for homeless patients and for safer, healthier housing for others. Many interviews specifically noted that this is one of the biggest challenges - not having adequate resources in housing to meet the need.

Given that we interviewed high-level program management or leadership staff, our information lacks some detail of street-level experience by CHWs. As a result, this report does not explore the evidence-based research to determine the degree to which tenant or landlord resources that could improve housing quality are used, or, if they are used, their efficacy; it also cannot make a recommendation as to whether the approach and skill of providing resident education (directly or through referral) to mitigate health triggers through behavior change in the home is effective. These questions would be better answered by CHWs themselves or through specific data requests of providers who track referrals. There was general consensus, however, that CHWs are not in a position to change landlord behavior and that this vision would be difficult to accomplish without regulatory muscle. There was a general feeling of not knowing where to start to influence landlords.

We explored the question of how CHWs learn about and access housing resources. There are a number of initiatives and methods for centralized referral networks, but it was repeatedly noted that the referral

networks in this region are fragmented. Coordination could lead to improved services. Some existing RRNs in the region include:

- CHI Franciscan's Health Connections uses a program from TAV Health, a software group, as a client tracking (e.g. activities and goals) and referral system. As CHWs put patient barriers or issues into this system, possible resources are generated. This database is updated every six months by TAV Health. CHI Franciscan representatives expressed that they would be very open to using a more comprehensive regional system if it existed.
- CHI Franciscan representatives also mentioned that they use the Area Agency on Aging as a comprehensive resource for anyone over 18 with a disability. It was not clear if this was in King or Pierce County, as the program discussed operates in both.
- WithinReach is part of a Centers for Medicare and Medicaid Services (CMS) grant that would expand resource coordination as an extension of their partnership work with Global to Local. While this will be a very competitive grant, WithinReach has expertise and infrastructure on health, food and child development resources and is a system asset to be explored.
- As mentioned earlier, 2-1-1 is a major RRN nationally, and it is as well in this region, but it was only mentioned in one interview. We would not interpret this absence as meaning that 2-1-1 is not a useful tool for CHWs and others in the field, but rather a function of the interviews being conducted primarily at a management and not a direct service level.
- King County recently funded its Regional Access Points (RAPs) for coordinated entry to the homeless system. There may be larger interest and potential for additional resource coordination with these once they are more firmly established.
- The Washington Department of Health (DOH) has a CDC grant to pilot the integration of CHWs into their care model in five regions (King County is not one of those regions). This pilot includes the development of an electronic tool with modules for CHWs that will generate health or referral information. The intention is that the tool could be customized to meet local needs. This project is at a very early stage.
- Best Starts for Kids (BSK) is beginning a planning process for Help Me Grow Washington, a framework that is part of the BSK early childhood investment. This RRN model includes a network of "Navigators [who] will be community health workers or trusted community messengers" (BSK implementation plan). Significantly, the intention is to deepen multi-directional/multi-sector service linkages that include health providers, CHWs and home visitors, among others. Discussions with BSK staff highlight that this framework is envisioned to be a "connective tissue" system for everyone ages 0-24 and may be a way to coordinate all of the various subgroups working on RRNs. Leadership at Public Health is also exploring this potential.

None of these resource links are specific to housing and health but all include housing and health resources as part of their network. Also note that some systems are wider in geographic reach than others. There are pros and cons to each approach. One provider noted that, given the dynamic complexities of understanding and making appropriate referrals, tighter regional geographic RRNs may be a more effective option in some cases.

Note on Regulatory Tools for Improving Housing Quality

It was noted repeatedly in the interviews that both finding safe housing for patients and knowing the resources available when someone lives in unhealthy housing (such as tenant advocacy or landlord improvements) were very significant gaps. While the affordable housing industry's regulatory or policy influence is not the emphasis of this report, HDC is working to expand the use of rental registration and inspection programs and enforcement of the National Healthy Housing Standards across SKC cities and spread renter right and resources information to SKC housing stakeholders. HDC has also been working with cities to create and implement stronger healthy housing policies within city comprehensive plans.

The state Growth Management Act (GMA) sets rules that each city's comprehensive plan track and inventory its affordable housing stock, project future needs, including number of units needed, and establish goals for development and land acquisition. The Countywide Planning Policies (CPPs) were created with the acknowledgment that affordable housing is a regional issue, not constrained to one city. They set affordability criteria and housing stock affordability expectations for the individual cities. Many see the GMA and CPPs as incentives to not improve older housing, which is more likely to contain hazards like radon or lead paint, because these regulatory frameworks focus on managing growth (of new housing) and due to fears that upgrades to or renovation of older housing will increase its market price. This market dynamic means low-income individuals or families are faced with the burden of choosing between paying unaffordable rents or living in unsafe, unhealthy homes that further impact their lives in a negative way.

The four largest cities in South King County are Auburn, Federal Way, Kent and Renton. See Appendix C for the policies that these cities have currently committed to or enacted for housing stock preservation and quality, which we are using as a rough measure of methods to improve the health of housing as well. We also included the city of Tukwila in the table, as they are somewhat of an outlier and have many policy levers in place to assist in healthy home maintenance, including a strong licensing and inspection program as well as a commitment to develop their preservation and maintenance programs, weatherization, rehabilitation and long-term preservation of existing housing resources. Their policies could be a model for the other cities of SKC to emulate if they wish to improve the health of their housing stock.

Resource and Referral Networks - Common Themes and Summary

- *Regardless of where the service was provided or if it was tied to a specific health concern/chronic issue, most providers noted that part of the role of their team was to connect to housing resources and to provide some level of advocacy for their patients.*
- *In addition to relying on the relationships and expertise of CHWs, there are a number of different ways providers learn about or access resources to support their patients.*
- *There is currently confusion, gaps and redundancies in the regional RRNs and ample interest in more coordination. There seems to be little appetite, however, for an additional, separate RRN.*

- *A new RRN would likely add to what is an already fragmented system. While there are possibilities and interests in better streamlining existing RRNs, there is no clear pathway yet to do this. There may be opportunities to participate in conversations that improve this coordination or to leverage another group's efforts (e.g. BSK).*
- *Many interviews noted that it is likely that any given patient or family has multiple, perhaps competing, professionals providing care management, case management, resources and referrals or other services that are confusing or redundant to the patient. Service coordination happens to various degrees within a single provider/entity, and perhaps informally on the ground, but no system-wide approach to coordination of services was identified.*
- *The breadth of CHWs working in some capacity, in SKC, with families living in unsubsidized housing, remains unclear. There is also currently no clear pathway to help transition individuals or patients or to provide housing-specific interventions. As one provider reflected of her clinic-based care team – “to have a community health worker they could refer to [at discharge to help with home-based care support] would be great.” Individual providers may have developed a continuum of care for providers, but there does not appear to be a system-wide continuum to meet resident and patient needs over time.*
- *Regardless of location of services, nearly everyone noted that appropriate housing (whether safe housing or any attainable housing) was a major need for their patients.*
- *It is not clear how well-understood resources, designed to improve housing quality, including in ways that specifically improve health, are used.*
- *There is little clarity on how CHWs can use existing resources to influence landlord behavior to make improvements or how effective those resources are.*

Infrastructure and Support Systems

The local providers to whom we spoke operate their businesses within a larger context that has a significant impact on the possibilities of expanding CHW programs. These systems and the infrastructure supporting CHWs are important assets to consider in developing a healthy homes strategy. At a systems or coordination level, there has been a growing body of work to professionalize and standardize the CHW field, develop skills, and generally build the credibility of the CHW workforce. There are also key players who are already leading cross-sector innovation and collaboration who are natural partners in reaching HDC's goals.

Washington State Trends

At the state level, the Health Care Authority and the Washington Department of Health convened a Community Health Worker Task Force, which met five times from August 2015 to December 2015. This group, which included 55 representatives from local stakeholders including hospitals, Tribes, legislators and community-based associations as well as 18 CHWs, focused on three main issues: 1) CHW skills and qualities (or attributes); 2) Training and education; and 3) Financing.

As will be further explored in the Funding Landscape section of this paper, the Task Force did not answer the question of how to fund CHWs. It is not likely that this question will be answered as a standalone, but rather it will be folded into the overall strategy for Medicaid payment reform. Much of the work at the state level has been to develop competencies and training standards, and while the state level work was not a focus of this research, it should certainly be acknowledged. Note as well that it has been an intentional choice in Washington to not highly define or structure the role of a CHW. This leaves open the possibility for more cultural responsiveness and innovation. The logic is that by standardizing CHW work, CHWs will lose their most important characteristic - the intrinsic relatability that comes through their connection with their neighborhoods.

As mentioned in the RRN Section, the DOH is implementing a CDC grant to pilot systems to support the connection of CHWs and primary care. Among other elements, this project will document what is needed when CHWs are placed in clinics, including charting requirements, and includes a learning collaborative. The Foundation for Healthy Generations is part of this project.

Supporting and advancing a strong CHW strategy statewide is a core competency for the Foundation for Healthy Generations. Their expertise and leadership will be germane to the intent of this research in a few immediate areas, including involvement with a statewide CHW training protocol and their coordination of CHW networks in several regions, including King County. They work directly with CHW programs, including ones integrated with housing, in other areas of the state and play a key role in the state CDC grant that looks at the mechanics of the intersection of CHWs and care, providing a forum for best practices and a learning lab for any future work.

The Foundation for Healthy Generations also has a thumb on the pulse of funding models for CHW programs, including a well-developed financial/business plan that blends funding sources to create a centralized CHW hub where CHWs can be deployed by language or geography to wherever they are most

needed. This system could function like a brokerage that supports culturally appropriate deployment of CHWs to communities or providers. Exploration of this model is outside the scope of this project but is an interesting model to understand and could be a good focus for future research.

There are five CHW networks around the state that are supported by Foundation for Healthy Generations, including a network in King County. These networks have collectively prioritized inventorying the roles and locations of CHWs, which would fill a significant knowledge gap in understanding our system statewide.

Local Landscape

The creation of Accountable Communities of Health (ACH) is one of the requirements of ACA health care reform. There are nine ACHs in Washington that align with the state's Medicaid Regional Service Areas, including one that covers King County. Staff support for the ACH is provided by Public Health — Seattle & King County. These are cross-sector regional partnerships charged with an understanding of social, economic and physical environments affecting health as well as the quality and availability of health care.

King County has had an interim ACH leadership council since its beginnings in 2015 and is currently revamping its governance structure. The leadership structure to date has included representatives from community health clinics, hospitals, local governments, health plans, philanthropy, human service organizations and others and includes representation from the housing sector. While it is still in a formative stage, the ACH is envisioned as a future key entity in the region to both strengthen the infrastructure for integrating social determinants of health into the health system as well as act as a catalyst for driving innovation. One of its key priorities thus far has been developing Communities of Opportunity (COO), using a dual geographic and cultural lens to impact systems and policy change. So far, this work has included housing-health partnerships, an integration of physical/behavioral health, and Familiar Faces, an anti-recidivism program targeting high users of the justice system.

The ACH will have significant influence over some of the Medicaid spending in the region, in alignment with state and federal plans and guidance. The ACH will be in an excellent position to act as a convener or leader to advance a more systematic, coordinated approach to the web of CHWs working both in health care settings and in the community.

MHNW has been convening the Housing and Health Partnership Planning Group (HHPPG) since 2014 with the goal of identifying a sustainable and scalable model for doing housing-based community health work. This team has been preparing the state's key stakeholders for the creation of ACHs and the move to integrate housing and health. Active participants have included the Seattle, King County, Tacoma and Spokane housing authorities, Global to Local, several of the managed care plans, Public Health — Seattle & King County, the Boeing Company, the Gates Foundation, Pacific Hospital Preservation and Development Authority (PHPDA), Washington State Health Care Authority and the state Department of Health. They have also been leading a subset of that group comprised of CHW programs that work in affordable or public housing or in very low-income communities, including Neighborcare, Global to Local, Foundation for Health Generations, King County Housing Authority and Seattle Housing Authority.

Global to Local has played a coordinating role since 2009, primarily in the Tukwila and SeaTac areas, developing program models that are highly responsive to community health needs. They currently focus on the Latino and Somali communities with a community-based CHW model. Their role includes training

CHWs. They have helped to coordinate a range of services and partners in this subregion that includes partnerships with Swedish, Public Health — Seattle & King County, WithinReach and HealthPoint. As a future strategy, Global to Local would be interested in being a training lead.

Note on the WA Low Income Housing Alliance and Permanent Supportive Housing

While it is outside of the scope of this report, we would also like to acknowledge the immense amount of thought, energy, and work that the Washington Low Income Housing Alliance has done to enable Medicaid funds to be used for permanent supportive housing services. Their 2016 Washington State Legislative Agenda states that the Medicaid Supportive Housing Services Benefit would, “allow housing providers to bill Medicaid for supportive services provided to eligible residents. This would help individuals with severe and chronic health conditions get off the streets and into a healthy home.” It is a fantastic example of using advocacy to gain Medicaid eligibility for a program targeting social determinants of health. This is a sizable portion of the Medicaid waiver that will likely be used for this worthy purpose, and we believe it is worth applauding in this report.

Infrastructure and Support Systems - Common Themes and Summary

- *At all levels there are existing bodies that have taken lead roles in developing different elements that support a strong CHW field or strategy. This is a fast evolving field.*
- *Tackling issues in unsubsidized housing is incredibly challenging to address, particularly without landlord partners, as it increases the complexity of the housing-health challenge. The energy right now, particularly with MHNW, is on using subsidized and affordable housing as a more accessible starting point, with a clearer data set and access to willing landlords. This is a platform for additional strategies in unsubsidized housing.*
- *Healthcare providers/practitioners and individuals working at state or regional systems levels have a different understanding and range of knowledge of both the status of Medicaid reform and regional actors. Many interviewees below the system-level organizations recognized that they personally had limited knowledge of the initiatives underway outside of their organization or sector. They know of pieces of work, but are not fully connected or clear, and are highly supportive of increasing the cross-sector collaboration.*
- *We are at what appears to be a very nascent stage, where the intersection of health and housing is part of a number of cross-sector conversations or at least interests. There are formal and informal opportunities to join those conversations.*
- *The interest in social determinants of health, as well as the trend toward more cross-sector partnerships, opens up options for potentially important political alliances built around shared goals of healthy, safe and adequate housing. The health care system is very large and influential. Looking to the future, a strong alliance with the health care system to address regional housing challenges could wield significant impact.*

Funding Landscape

Funding CHWs is challenging for several reasons. Consistent and long-term financing will be one of the major cogs in the system that will decide whether using CHWs for housing interventions becomes a reality.

National Trends

A number of models have been developed across the nation that have creatively found the dollars to fund CHW efforts. Some of these efforts include the following:

Maximizing Existing Medicaid Authority

Medicaid is a complex system of health care funding. While there has always been the possibility of using the current Medicaid Authority for CHW work, it required modifying or reimagining the rules of the existing system and using the funding for new purposes. To change these rules requires extensive advocacy and support at high levels of influence and often also necessitates some compromise as a result. However, it is a large pot of money that is enticing to tap if possible, and several places have met with some success after a concerted effort to do so.

An example of this is the Minnesota CHW Alliance. The state of Minnesota standardized a CHW curriculum and then used strong advocacy tactics to push their legislature to pass a bill in 2007 to allow CHWs to be covered by Minnesota Health Care Programs (MHCP), including Medicaid, if they met certain standards. CHWs had to be certified through education and training, as well as supervised by one of a set number of defined provider types, including physicians, advanced practice nurses, dentists, certified public health nurses and mental health professionals who are enrolled as MHCP providers. They are specifically defined as NOT providing social services, but rather a diagnosis-related medical intervention.

Since the passage of the ACA, many more states have begun applying for and adopting Medicaid waivers to change the way they can use the money. This will be discussed in more detail later in this section.

Health through Non-Health Funding

The method that is currently most frequently used by CHW programs is drawing on funding sources not specifically targeted for health. This has created a patchwork financing model that is challenging to sustain. This includes grant funding, in-kind contributions, and resource-sharing among program partners. Generally, programs funded in this way are operated by a group invested in an issue tied to social determinants of health who sees an opportunity to impact their target indirectly through a health intervention.

An example of this type of funding model being used is found in South L.A.'s Esperanza Community Housing Corporation. This group leveraged an existing team of promotores de salud, trained in healthy homes interventions, with a collaboration with St. John's Well Child and Family Center (St. John's) and Strategic Actions for a Just Economy (SAJE). Families were recruited with referrals from St. John's, tenant-organizing activities were conducted by SAJE, and door-to-door outreach was done by Esperanza.

Advocacy is also a cornerstone of the program – pushing the concept that access to good housing and healthcare is a fundamental right. Collaboration with tenant organizations is a crucial component of the process as well. The physician contacts promotores to assess housing conditions, and promotores report back after their home visit. If an intervention is needed, the physician will send a letter to the landlord stating the effect of housing conditions *only* if tenant organizers have established a relationship with the family in question. This is to limit the threat of retaliatory eviction by ensuring the family is aware of any risks and consents to the program's assistance.

This pipeline of action, with many handoffs and groups involved, is not generally the most efficient means of generating the desired outcomes. However, by combining community outreach and home visitation, tenant rights, and population health groups, Esperanza was able to access a far wider variety of funding sources than they would ever have been able to commit to independently. The program was funded by grants from HUD to support healthy housing and in-kind services from project partners who could use existing employees as support; it also leveraged financial support from the three partner groups' own resources, ensuring that it was a shared burden that would not overwhelm any one organization. Thus by incorporating so many different parties, Esperanza was able to create a sustainable patchwork of funding for their community health program model without any direct funding for health.

Reinvesting Return on Investment

Molina Health Care's efforts in New Mexico were referenced repeatedly in local interviews as a possible model that supports prevention and upstream interventions. The program is based on the understanding that if the basic needs of food, shelter and clothing are not being met, it is too hard to focus on health care needs. However, the way it is sold politically is centered on return on investment (ROI).

Table 1

New Mexico Molina Health Care's CHW Model		
Functions	Activities	Financing
Outreach	Educating referred members about alternatives to ER use	Direct employment with the MCOs
Coaching	Locating members to obtain Health Risk Assessments	Contracting with agencies or groups that employ CHWs (especially effective for Native American CHWs)
System navigation	Ensuring members have the basic life necessities to remain healthy and safe	Contracting directly with independent CHWs
Connector to care	Assisting members with making and keeping health care appointments and setting up transportation if needed	Covering CHW costs as part of a care team (flat fee or pmpm*), PCMH**, etc.
"Eyes and ears"	Referring members to local resources found within communities (e.g. food pantries, utility or housing assistance)	Fee-for-service
Increase access to primary care	"Wellness support"	
Decrease pharmaceutical and hospital-based utilization	Locating "unreachable" members for care coordination	
	Providing Translation Services	

* per member per month
 ** patient-centered medical home

The government pays for the program through cost savings from a decrease in the prior average number of costly, avoidable actions (i.e. ambulance trips or emergency room visits). They constructed a clearly defined plan with roles for each of their CHWs. Those roles are summarized in Table 1.

Local Landscape

The interviews that we conducted primarily explored the local strategies to fund a housing-health CHW strategy for unsubsidized housing. Exploration of tapping Medicaid funds as an option was a primary theme of the discussions at three distinct levels:

- How likely is it that current providers would use the current Medicaid authority to fund a CHW program?
- Is the Medicaid Waiver a practical funding mechanism at this time?
- What are the long-term prospects of funding a CHW program at scale once the details of Medicaid payment reform are finalized?

The general consensus was that it does not seem fruitful to look at the current Medicaid authority at this time. Without both a strong program design and key partnership in place that can quickly launch a project that will demonstrate cost savings in the very near future, looking to the Medicaid waiver seems premature and possibly counter-productive. While a great deal is still unknown about what Medicaid will look like in the future, strategic planning, including partnership development and establishing shared goals, is the next step to create a viable, long-term funding strategy for an unsubsidized housing CHW strategy.

The ACA is dramatically changing the landscape, but it is not fully implemented yet. Washington is still, to a large degree, operating out of the historic Medicaid business model - what is essentially a fee-for-service model. In other words, specific types of medical visits are paid for specific types of medical professionals and types of treatment per patient. At a provider level, this forces a choice in how to spend limited dollars within a financial model where CHW-type of work is not directly reimbursable. There is nothing inherent in the Medicaid requirements that stops a provider from using their dollars to fund CHWs, but the payment incentives work against this possibility.

Locally, it is unusual to use core Medicaid funding for CHWs, although a few providers have done so. However, most providers use grant funding or, in one conversation, Health Resources and Services Administration (HRSA) funding that is distributed across all FTEs at the agency. It is very unlikely that providers in the very short term will look for creative ways to use the current Medicaid billing mechanisms at their disposal to fund a CHW program that is focused on housing at any scale. Many interviewees addressed the limitations of trying to stretch the current Medicaid dollars to cover the cost of care. Everyone interviewed also noted, however, that they are at some level of planning for the future state of Medicaid payment structures.

Both among the programs identified here and others that have been implemented over the past several years in King County, the core funding source has often been grant funding. HUD, National Institute for Environmental Health Services, and foundation grants have been a few of the sources accessed for CHW projects in King County. Often, the core of this work has been to pilot effective models in improving health

outcomes to demonstrate the financial cost savings case that can be made to support the use of CHWs as part of a health care model. In general, there was a recurrent theme in many conversations that these have been wonderful programs, but there is frustration in the reliance of time-limited, narrowly defined grants. Countering this, there is also hope that because the evidence base is strong and compelling it will help to support more sustainable CHW models under the ACA in the future.

The Future of Medicaid

The landscape of Medicaid funding is changing dramatically, which could open up significant new possibilities to fund services like an integrated housing-health model. The “Triple Aim” of health care reform—to improve the experience of care, improve the health of populations, and reduce per capita costs of health care—will drive this change.

There are many players and decision makers involved in how current Medicaid dollars are spent at the service level and how they will be spent under the ACA. All of the system stakeholders listed below (the HCA, MCOs, ACH and providers) have different roles in crafting what this landscape will look like in Washington. These key stakeholders include:

- The Health Care Authority (HCA), which negotiates the state’s overall agreement with Centers for Medicare and Medicaid Services (CMS) to establish parameters for spending. Under health care reform, this includes taking a lead role in prioritizing and negotiating the priorities for the Medicaid Transformation Waiver, an opportunity to demonstrate health outcomes and cost savings through innovative, time-limited projects. The HCA also negotiates contracts with Managed Care Organizations (MCOs).
- MCOs are the payer to health clinics per patient. It is in their interest to maximize enrollment and control costs. There are five MCOs in Washington State. In King County, Molina and Coordinated Care are the largest per enrollment.
- Health care providers such as clinics and hospitals provide direct health care and receive reimbursement payments from insurance companies and government programs, including Medicaid.
- Recently established ACHs that will oversee cross-sector collaboration as well as influence local funding decisions, including awarding some of the Medicaid Waiver funding.

It is widely anticipated that the reimbursement and payment mechanisms that will result from the Triple Aim’s requirement to reduce overall health care spending will be significant and will seismically change the health care service model. Simplistically stated, the current payment system of “per visit” reimbursement for a particular service performed by a limited number of health care professionals that are “reimbursable” will change. Reimbursement will transition to paying for health outcomes through Value Based Payments, which will incentivize more effective, holistic strategies that include wider definitions of a care team and more prevention or community-based work. As there is strong evidence that CHWs promote longer term healthier outcomes, there could be an opening for funding for these kinds of programs. To be clear, this is moving existing money around, not freeing up new dollars for CHW services.

As noted above, providers are already exploring steps to include CHWs or patient navigators. Most providers see Medicaid as the potential long-term funding for this CHW role, although there is a wide array of views, from skepticism to optimism, on the timeline and the mechanisms possible. For example:

- Two interviewees noted skepticism that the health system will demonstrate the cost savings that are anticipated. This would reduce the likelihood that dollars will be shifted to CHWs at scale.
- Several interviewees expressed concern that the MCOs, which play a huge role in the payment mechanisms for providers, are not in a position to fundamentally change their contract structure. These are large, often national businesses, and decisions are made at very high levels that are challenging to customize to local needs. Another interviewee made the point that strong evidence has supported the case for CHWs for a long time, but the MCOs have still yet to be convinced. However, the interviewees also noted that things may be changing under the ACA.
- The MCOs will pay a key role in the funding options for CHWs, but it is not yet clear how. While there is some pessimism that we will see significant change from the MCOs to structure payments to support CHWs, some interviews noted that the MCOs “have been at the table” to grapple with the questions of innovative payment reform that could lead to the increased use of CHWs. While they are not there yet, there is some optimism that the MCOs will increasingly value CHWs as part of their health strategy. Note that Molina’s work in New Mexico (see Table 1) was frequently referenced as a model to consider.
- One provider expressed they were “...not skeptical of the value of the idea [that Medicaid will fund CHWs] but mindful that there will be some significant bumps in the road as things start to get implemented,” and that it could be at least ten years before the cost savings are realized for this kind of work.

The Role of the Accountable Community of Health (ACH)

The ACH is described in more detail in the Infrastructure and Support Systems section, but in addition to its essential role as a catalyst and innovator, it will also have a great deal of influence over large sums of direct Medicaid spending.

The HCA has made the commitment, contingent on receipt of the Section 1115 waiver, to having 90% of their provider payments linked to quality and value through VBP models by 2021. The primary tactic used to create this linkage is lump-sum incentive payments, known as population-based payments (PBP) or global payments. The HCA will give providers a lump-sum payment up front, based on the number of patients they are responsible for, and the providers will accept responsibility for the health of that group of people. The logic behind this model is that providers will be incentivized to provide more preventative health measures, as it would avoid costlier ambulance rides and emergency procedures for their catchment area and thus allow them to make a profit by not using all of the funds allocated to them by the HCA. To ensure quality care is still a focus, beginning in 2026, there will be regular reviews of the payments being made to providers, and high-performing ones will be given higher-annual payments. Some of these lump-sum payments are likely to go through the newly formed ACHs. In addition, currently the ACH is also in a lead role in the distribution of local Medicaid Transformation Dollars, which is a very significant, but short-term, funding opportunity.

Medicaid Transformation Waiver

Section 1115 of the Social Security Act gives states the opportunity to apply for a Medicaid waiver. The waiver effectively strips most of the regulations that are usually tied to Medicaid dollars and allows the approved state to experiment with alternative, innovative programs in an effort to realize cost savings. The waiver is “budget-neutral,” meaning no more money is given to the state than it would have spent without the waiver. States are allowed to reallocate their funds in ways that can test pilot/experimental programs or demonstrations of delivery models that could provide cost savings, contingent on CMS approval of their plan. Washington State submitted an application for a \$3 billion waiver, which was recently awarded at \$1.5 billion. Some of these waiver funds will flow to King County over the six-year grant period, for innovative projects that show a return on investment. While this is a very significant amount of money in the context of traditionally underfunded healthcare innovation, it should also be stressed that there are high pressures to show documented cost savings in this period of time.

In addition to the waiver, we can anticipate in the long run that the ACH will have some control, or at least influence of resources, but at this point it is not clear how this will work. This will include influence over contracting, which has the potential for influencing MCO collaboration or support for CHW or other prevention initiatives.

There are a number of organizations in the King County ACH region that have applied for transformation dollars for CHW programs, although none (besides the MHNW project noted earlier) were specifically targeting healthy housing. Organizations that have applied include the WA Asthma Initiative, MHNW, Public Health, Seattle Children’s Hospital, CHI Franciscan, Neighborhood House, Sea Mar, REACH, King County DCHS, City of Seattle Office of Sustainability and Environment, Seattle Indian Health Board, Anti-Hunger & Nutrition Coalition, WA State Medical Association, WA State Hospital Association, Clarion Healthcare Consulting, Seattle Children’s Research Institute and Washington Families.

We explored the possibility of waiver funding for a possible housing-health CHW program. This is a great deal of money that will be used to advance innovation with a clear directive of demonstrating cost savings in a short period of time. It is also not sustainable funding, as it is designed to demonstrate concepts in its six-year time frame.

It is not recommended at this time to look to the waiver as a possible funding stream for the type of project envisioned. At the most basic level, while there are potential health care providers that might be interested in the idea in concept, there is no clear lead or program design, including partners, location, target population or program objectives. This is a great deal of groundwork that isn’t in place that could be a distraction from the longer-term goal of a sustainable program model. Even if this was a project much further along in readiness to implement, pressures of demonstrating cost savings in a new program in such a short timeline would be very challenging, especially one with a naturally longer time frame such as combatting chronic illness or prevention-/community-level work.

Rather than a short-term funding strategy, it may be more fruitful to partner with the ACH on its role in advocacy, strategy and systems building opportunities that support the goals of a health-housing strategy. At the time of this writing, the governance structure of the permanent ACH is still being developed. The permanent ACH may be in place by the end of 2016. This will likely include representation from the housing sector. Some interim members articulated that the ACH was a valuable forum for cross-sector

learning, including meeting people with expertise in housing. A clearer strategy can be developed after the new ACH's scope and priorities are clearer, and this should be tracked.

It is important to note that despite the ambitious agenda and potential of the ACH, this entity itself has a funding challenge. There are minimal staffing dollars for the King County ACH currently through Medicaid.

Going from Good Idea to Funding Model

While there was a state CHW Task Force in 2015 that looked at options for funding CHWs, it is clear that this question will not be answered in isolation from the much larger question of overall payment reform. As another potential factor, a State Innovation Model (SIM) grant, which ends in 2020, is looking at payment reform through the lens of public employees. It is not clear if or how this will roll out to the local level.

MHNW has taken a lead in laying the foundation for a long-term, sustainable funding mechanism for housing-based CHWs through Medicaid. This strategy has included supporting CHWs in publicly funded, subsidized affordable housing, developing the Housing and Health Partnership and developing an integrated housing and health data strategy to perform the cost-benefit analysis for the use of Medicaid dollars for housing-oriented CHW programs.

This work was selected by the King County ACH as a cross-sector innovation project. While this does not include direct service dollars for CHWs, this award will provide funding for project management staffing that will provide support for community health centers toward increasing both regular primary care visits and prevention screening as well as facilitating prevention treatments for people at risk of chronic health conditions. The goal of this three-year project is to develop a sustainable, scalable model for the use of CHWs in affordable and public housing. A significant part of this model is to track quality and cost measures of housing-health strategies.

As mentioned earlier, the data integration project seeks to integrate health data for all Medicaid recipients living in any housing that has received public funds. Current technical discussions of the data integration status can be found in MHNW's August 2016 report, *Progress and Opportunities: Integrating Housing and Health Data*. See sidebar for more detail. For the purposes of this report, the primary focus is on potential strategic opportunities to expand this work to include funding a CHW strategy for unsubsidized housing.

CORE (The Center for Outcomes Research and Education) in Portland, OR, has a model of how this kind of data integration can demonstrate to stakeholders and policy makers the benefits of pairing affordable housing with health care services, and is referenced frequently in relationship to the MHNW efforts in King County. CORE met with the HHPPG to present their "Data for Strategy" approach to the group, highlighting their success with the tactic in integrating data from various social determinants of health and explaining how that has helped them to develop more effective and more efficient cross-sector interventions. They then offered suggestions on how a similar model would work in Washington, primarily focusing on the creation of an Integrated Data System similar to the one that they helped establish in Oregon.

There are differences between both the approach and the orientation of the MHNW and HDC inquiries. MHNW looks at the health outcomes that come with attaining stable housing that is subsidized, while HDC takes that question further to look at the health outcomes of residents who are already housed, but in substandard housing. The MHNW project is focused on affordable housing data, and, as a result, it will not *specifically* shed light on the outcomes or health issues facing residents of unsubsidized, substandard housing. However, it should make the advocacy case that healthier housing has a direct impact on health outcomes through improved data, which will in turn make a clear argument for housing-health partnerships. Additionally, this project is looking at outcome measures that are more aligned with prevention than acute care, which could also support community-based, upstream work that CHWs are well positioned to provide.

The technical nature of the work (data integration) complements and builds on the last several years of relationship building, to better inform a conversation on Medicaid reform that includes a housing-health intersection. *This goal envisions CHWs as part of the Medicaid billing system.* The foundational work to date has been a heavy lift, and is still in its infancy with regard to a long-term strategy. There are a number of places where a compelling data story (CHWs save money and get better health outcomes) needs to continue to be told to influence the future systemic payment structure of Medicaid - be it through the state contracting methods with the MCOs or the MCO contract structure with providers. To date, MHNW has taken the lead role at the state level with both the MCOs and the ACH. The ACH (as the funder and convener) and Public Health (as a key partner) are directly invested in this project, making this a key partnership.

Implications of Medicaid Funding Changes on Program Design

Funding parameters will inform program design possibilities if Medicaid is considered as a foundational funding stream for housing-focused CHWs. Keeping track of how the funding mechanisms play out will be important. At this point, due to the primacy given to return on investment, it looks more probable that funding will move toward health services that can demonstrate a shorter-term cost savings. This has implications on program design and goals for any future housing-health CHW program, including potential challenges to geographically specific programs. For example, if the new VBP funding mechanism highlights demonstrable health savings in a relatively short period of time, then at least for the next several years it would be far more likely to fund programs that specifically target patients with high cost conditions that can be evidentially tied to the conditions of the home, such as asthma.

Volume will also be a factor. Whether initiated by the MCO or the clinic, the bottom line will be driven by the number of enrollees they have in either their plan or clinic system who are benefitting from their services. It was noted in one interview that patients change plans or providers with some frequency. While there are providers interested in broader, community work, these potential limitations are noted here to inform consideration of potential constraints to implementation of any new program of scale. Any future exploration could be better informed through data that identifies high utilizers by both health issue and by health plan or enrollment.

Linking CHWs to medical records will also be an important function for any funding to work. This would be a new type of work for CHWs to a large degree. As noted in the Infrastructure and Support Systems Section, there is some work being done in this area to develop new charting protocols and systems. This relationship between service and data could drive dollars, which would, in turn, inform program design decisions of where to position the work. A tight relationship to primary care, as well as documentation,

leaves a program model that is either staffed directly by a health provider, or at least one where the CHWs are working very closely with the primary care provider.

Hospital Partnerships and Community Benefit Funding

Long-term planning and partnership should include our region’s hospital system. The financial models and incentives for hospitals are different than those for community health clinics. For example, reducing emergency room visits and rehospitalizations will become a key financial driver for how hospitals develop their care models, which could result in a wider set of strategies addressing social determinants of health. These strategies would likely include more community-based work and the use of CHWs in some form. The hospital sector has been represented on the Leadership Council of the ACH (Seattle Children’s and Harborview) and are engaged in conversations that have included CHW planning as well as the importance of the housing-health connection.

The King County Hospitals for a Healthier Community (HHC) is a collaborative of the area’s 12 hospitals, including Evergreen Health, CHI Franciscan Health, Group Health Cooperative, MultiCare Health System, Navos, Overlake Medical Center, Seattle Cancer Care Alliance, Seattle Children’s Hospital, Snoqualmie Valley Hospital District, Swedish Medical Center, UW Medicine, and Virginia Mason. This group meets quarterly and may be a good forum to explore the hospitals’ roles in the housing-health intersection. The HHC collaborates to produce a regional Community Health Needs Assessment (CHNA), which is required under the ACA. See sidebar for additional detail. The process of developing this health needs assessment includes community input. Each hospital uses this information to focus strategies, including their community benefit strategies, around their own priorities. As one hospital representative noted, social determinants of health are being given an increasing amount of attention by the hospitals. This includes an increased understanding of the roles of housing, food and poverty as major factors in the health and well-being of their patients.

Locally, it seems likely that hospitals will initially develop strategies focused on obesity prevention. However, housing is a discussion item at this table and, “as housing emerges [as a health factor] hospitals will be asking what they can be doing...what happens in the house is an opportunity for partnership.”

Non-profit hospitals are required by law to provide community benefit. There is no set dollar amount, and hospitals vary in their approach. However, in general, community benefit funds fall into four areas: uncompensated care (which has been decreasing under the ACA), research, provider education and community programs and services. To date, King County hospitals have not developed a shared community benefit strategy, and it could prove challenging to do so, as hospitals have traditionally focused on their own catchment areas or target populations and established priorities that support their

2015–2016 King County Hospitals for a Healthy Community Joint CHNA's Healthy Housing Related Strategies
Access to care (including addressing workforce capacity and cultural competency, providing assistance to the uninsured and supporting non-clinical services);
Increased integration of behavioral and mental health into the primary care system;
Maternal and child health (including community-based programs offered by home visitors);
Preventable causes of death (with a stated emphasis on obesity, tobacco use, and nutrition/exercise);
Violence and injury prevention.

own strategic plans. Seattle Children's Hospital, for example, has community benefit priorities that include healthy living/food insecurity, mental and behavioral health, coordinated care for children with chronic health conditions, and suicide/violence prevention (e.g. gun safety).

With the increased attention to social determinants of health as well as financial pressures on hospitals, there are windows to test ideas and explore shared solutions with the regional hospitals. This work would require shared learning at the specific intersection of housing and health, including a specific understanding of the South King County hospitals' unique interests that could lead to partnership development for future programming. The HHC, which is coordinated by Public Health, meets quarterly and is a logical starting point for this discussion. While hospitals in King County are not yet at this stage, nationally some hospitals have used community benefit resources toward the housing component of health, including:

- Yale-New Haven Hospital and St. Francis Medical Center in Hartford, CT deploy program staff to visit and assess homes for lead and 29 other health hazards.
- Mercy Medical Center in Cedar Rapids, IA runs the Children's Homes Asthma Management Program and provides infectious control practitioners to assess health of homes of children newly diagnosed with asthma.
- Boston Children's Hospital's Community Asthma Initiative conducts home environmental assessment and provides education, materials, and supplies to reduce triggers, including HEPA vacuums.
- St. Joseph Health System in Orange County, CA identified housing as the top priority issue in their community in their 2008 and 2011 CHNAs and advocates for decent affordable housing.
- St. Vincent Indianapolis Hospital helped found and support the Crooked Creek Community Development Corporation, which improves existing housing stock and provides residents with essential resources and education.
- St. Mary's Health System in Lewiston, ME supplied the initial capital of \$250,000, which leveraged another \$2 million, to support construction of new affordable housing in the area around the hospital.
- Cincinnati Children's Medical Center's Community Health Initiative publicizes key health metrics and supports community organizing, including an effort to map the addresses of readmitted asthma patients to substandard housing units owned by the same landlord, on which they then collaborated with the Legal Aid Society of Greater Cincinnati to help tenants organize and compel repairs.

RRN Funding and Best Starts for Kids

While most conversations centered on the specifics of funding CHWs, we did also explore options for RRN funding. Beyond the work of CHWs, Medicaid is not a likely funding source for a referral network. Further, as noted in the RRN section, it is not recommended to fund a separate system for resource and referral links but rather to maximize the existing systems.

Leveraging Best Starts for Kids is one emerging opportunity to fund an improved coordination system, particularly the Help Me Grow Washington framework that will help with coordination of potential RRN efforts. In the long term, it could be worth exploring conversations with other potential funding partners to leverage their dollars and assets to maximize or streamline referral systems that include housing and health resources. This would potentially include King County, United Way and funding focused on serving older adults and people with disabilities.

It is not clear yet if there is potential to leverage health resources for coordination, convening and systems development that supports the expansion of a RRN that includes health resources. If Public Health and/or the ACH wanted to play this role, it would be worth exploring the resources that are potentially available for their systems support roles for this kind of collaborative planning. As the ACH already has some funding challenges, any exploration of Medicaid funding for an expanded role would probably need to be bigger in impact than the referral coordination aspect.

Our research was focused on potential sustainable funding through the health care system, with a particular emphasis on Medicaid. However, it is important to note that a cross-sector approach to strategies should also include a cross-sector approach to funding opportunities. Older adult funding was not explored in this report, but it certainly intersects directly with health and well-being of the population of older adults. Some funders of older adult programs have recently cut back funding; however, programs for this population are also, traditionally, very politically popular. Additionally, Best Starts for Kids is a massive public investment in youth and children and has a significant intersection with healthy housing goals researched here. BSK will provide new funding in a number of relevant areas, including capacity building, referral systems, quality and direct services. Partnership with this initiative could be fruitful in impacting health through housing-based interventions. To note

Best Starts for Kids Funding Distribution

2017-2021 Annual Investment Average	Programmatic Approaches (select strategies related to healthy housing)
\$9,230,000	Home-based services including home visiting; community-based approaches and innovative approaches
\$2,360,000	Community-based parenting supports, including injury prevention and environmental health such as lead, toxins and asthma
\$7,310,000	Direct services and systems building to ensure healthy development, including developmental screenings and early intervention services
\$1,440,000	Workforce development, including training and information for medical providers, child care and home-based services on multiple topics that promote healthy early childhood development
\$9,590,000	Investment in Public Health's Maternal/Child Health Services
\$1,490,000	Help Me Grow Washington framework
\$5,220,000	Meet the health and behavior needs of youth, including school-based health centers and healthy and safe environments

the new investments in relevant areas, reference the following table.

Funding Landscape - Common Themes and Summary

- *Historically, CHW projects have been primarily grant funded, but that carries concerns about the time limitations and a lack of confidence in the sustainability of that funding source.*
- *There is momentum and infrastructure development currently underway, including support for the ACH and the MHNW data integration project that have a great deal of potential but have soft funding currently. There are concerns about medium- to long-term funding to keep progressing forward.*
- *The details of the future under Medicaid are not clear, and there is a great deal of excited churn in the system. Every level of the health system is rethinking the primary care model, including piloting and testing different models. Most providers see Medicaid as the potential long-term funding for CHWs, although there is a wide range from skepticism to optimism with regards to the timeline and the mechanisms that are possible.*
- *In a fast-changing and complex environment, leadership and innovation for establishing a framework to use Medicaid to fund CHWs is dispersed among a number of stakeholders from the state down to the local level. This is not a bad thing - it offers potential for collaboration and creativity, although there is an occasional “who’s on first” feeling.*
- *Locally, at the systems level, most of the energy is focused on launching a permanent governance structure for the ACH, the Medicaid Transformation Waiver and the integration of behavioral and mental health with primary care. Until this heavy lift is complete, it does not seem probable that there would be capacity for a system-level redesign or much innovative thinking for funding models for a CHW strategy with a shared housing goal, outside the work being done by MHNW.*
- *Long term, the ACH will be an increasingly influential partner on funding and in advancing innovation, including supporting CHWs.*
- *MHNW has a lead role in forwarding a funding model. To the outsider, there is some confusion between their work in affordable housing and the intent of HDC to expand to unsubsidized housing. Continued clarification and alignment will best support both cohesive funding and effective advocacy strategies.*
- *Despite strong, research-based evidence, the financial and outcome case will need to continue to be made consistently, at multiple levels for a seismic shift in the use of Medicaid dollars for CHWs. MCOs will be an important player in this decision. In addition, a few interviewees noted that while leadership on the health service delivery side of their organizations understood that CHWs save money, it still requires a great deal of convincing of their own fiscal departments to move their business model to one where CHWs are woven into their core funding design.*
- *The hospital systems are innovating and looking at community-level interventions in creative ways, and they have different resources (financial and influence) to add to the mix. There is untapped potential with the hospitals in South King County to assist in finding a solution to the challenge of substandard housing.*

Conclusions and Recommendations

Meeting the health needs of residents in substandard, unsubsidized housing is an exciting charge. The conclusions made here are drawn from the interviews conducted and a scan of the health field, as well as a literature review of healthy housing, community health worker, and resource and referral network studies. We seek to answer one question: how to achieve healthier housing in South King County, from two related but different perspectives? Are there opportunities for *new programs* to address the need, and are there opportunities for *strategies that maximize existing resources* to get to the desired outcomes?

Stakeholder Interest

Overall, there are a number of assets available in South King County to support the outcome of improved health through housing-based interventions. Health providers share concerns about the impacts of substandard housing on health and value community-level work. There is an existing CHW workforce, as well as an expanding workforce of home visitors (e.g. early childhood professionals, older adult care workers, etc.) that already provide education, linkage to services or care coordination. The entire health sector is exploring CHWs as a potential strategy to improve both health and their bottom line, and there is a general readiness for greater cross-sector approaches to integrate social determinants of health into the system. There is, in summary, a great deal of interest in the *general* idea of expanding strategies that include CHWs in addressing the social determinants of health.

However, there is also consensus that this is not the time for any new initiative or program expansion with a health and unsubsidized housing focus. Importantly, the very high level of flux in the health system at this historic point in time is an inhibiting factor to moving forward in the immediate term. How the mechanisms for Medicaid funding play out over the next several years will deeply influence the versions and the scale of any possible programmatic solutions, and too little of the chessboard is set up right now to develop a clear path forward on a specific implementation strategy. Additionally, the fundamentals of program development still need to be addressed, particularly the precision of purpose, definition of desired outcomes, geographic clarity and partnership development.

There appears to be little appetite for adding a RRN or any new entity specific to healthy housing in South King County at this time. Existing referral sources, as well as new referral initiatives, are evolving or expanding. There is potential interest in streamlining these existing RRNs for improved coordination, with a more complete continuum of care and equal access to information being the benefits. There is a great deal of work to do to develop more strategic and efficient usage of the RRNs in the region, particularly in ensuring that they incorporate effective housing resources.

Not having resources or information to help patients find safe and affordable housing is a clear gap. Regarding existing housing conditions, across the board, there was a general feeling that there was no effective way for existing CHWs or RRNs to support tenants in their interactions and potential confrontations with landlords. There are also clear limitations on the types of progress and support a RRN could be expected to achieve. While a RRN could provide tenants information about landlord-tenant law,

connect them to code enforcement programs, and give them suggestions and materials to better maintain their unit, substantial changes to the condition of a rental unit would remain (to some extent) in the exclusive control of landlords, particularly without proactive inspection programs and substantial code enforcement implementation of healthy housing building code standards.

While it is premature to launch a new program right now, it is a perfect time to engage and inform timely conversations as the health systems rethink and modify their prevention and community-level strategies. Some actions that can be taken right now include:

- Shared learning about CHW approaches, data collection and available resources.
- Increase collaboration to inform future regional planning.
- Long-term planning, including needs assessment and partnership development for new programs addressing the highest need, highest impact areas of the County, that can be implemented once Medicaid funding for CHWs is clearer.
- Understanding and leveraging the existing systems in place, including the current CHW workforce and RRNs.
 - Map the system for the level and type of CHW work currently occurring in South King County,
 - Map and assess the referral resources for both their ability to meet need and for the knowledge of workers in the field of how to appropriately use them,
 - Use this information to advocate for a more coordinated RRN that includes strong health-housing resources.

We acknowledge that there are currently significant resource limitations in implementing most of these recommendations, as there is little existing staff capacity for the planning and coordination required to move them forward. However, with the right organization taking the lead or enough advocacy to keep the issue at the forefront, these recommendations are possible either now or in the short term.

Leadership Options and Necessary Infrastructure

It does not make sense to create a new regional coordinating body specifically for healthy housing at this time, as it would only complicate the current fragmentation. Rather, existing entities are already positioned to take on the responsibilities needed to move forward on these recommendations. Assuming there is funding or increased capacity, there is leadership and coordination needed at several levels for:

- Some stakeholders are already deeply engaging in shared learning about CHW approaches, data collection and resources, as well as increased collaboration and the informing of future regional planning. A continuation of current efforts would likely involve ACH or King County as natural leads, with continued support from the HHPPG/MHNW.
- The ACH or King County would also be the most appropriate lead for conducting long-term planning for new programs that can be implemented once Medicaid funding for CHWs is clearer.

- To understand and leverage the existing systems in place, the most well-positioned groups would be the ones already leading some of those systems, including Foundation for Healthy Generations, King County and WithinReach.
- At this point, there is no recommended lead for direct implementation of a CHW program until there is more clarity on geography, target population and intended outcomes. A CHC, however, would be a logical partner. The County's hospitals should be included in any conversation as well, as they are doing strong work in this area. If the SeaTac/Tukwila area emerged as a targeted sub-regional priority, Global to Local is potentially a lead convener and has strong health partnerships in place.

Comprehensive Leadership - Planning and Collaboration

The ACH or Public Health is best positioned to develop regional strategy development, planning and coordination. No other entity has emerged with the regional focus, neutrality or ability to influence partners and funding that would be required for a regional strategy in such a complex environment. The inclusion of housing as a core sector for the ACH holds promise for the expansion of unsubsidized, regional or county-wide strategies in healthy housing. The specific role and opportunities of the ACH as a regional leader may include funding, convening, coordination or all of these. Given its stage of development, however, the ACH's ability to actualize and act on this role is limited, and the first task is to explore their possible areas of leadership with them. HDC, the housing representative on the interim ACH and the HHPPG can help inform this direction.

In addition, the HHPPG and MHNW may be appropriate both in the short and long terms to develop a shared vision, support platforms for shared learning across the field and help to coordinate the work. HDC's logical role would be at the table, leveraging its expertise and relationships as well as in keeping the focus on the long-term goal of impacting health at the intersection of unsubsidized housing.

The long-term leadership and role clarification will take time and nurturing, as well as increased staff capacity, to move this forward. The ACH, Public Health and Mercy Housing have a great deal currently on their plates. HDC and the HHPPG can help by continuing to inform and advocate for this development with a particular lens on unsubsidized housing.

As noted under the Policy and Advocacy Steps toward Sustainability section, below, knowing what to do to best target services or interventions can be driven by a strong needs assessment and access to data. Public Health has the deepest data resources in the region and is interested in partnering across sectors to better analyze the issues present. This information can inform planning and next steps.

Leveraging Existing Systems - Mapping the CHW Network

In order to better understand and leverage the existing CHW system, a systems-level perspective is needed that can detail what is happening on the ground. The Foundations for Healthy Generations has great expertise and relationships in this area. They have expressed interest in exploring how the King County CHW network could be a starting point to map the regional CHW network, either as a resource for information or possibly as a leader. The ACH and/or Public Health are other possible leads or strong partners in this process.

The interviews conducted as part of this report only illuminated enough to note that there are a great number of CHW and home visiting initiatives currently in existence in South King County. This is a powerful asset for any strategy that seeks to empower residents with better health access, education, resources or advocacy. However, with an unclear number of CHWs and others working with residents in the context of their homes, there is also the potential for great inefficiencies, missed opportunities and redundancies, as well as confusion for residents. This is part of what would make a streamlined RRN in the region valuable.

A mapping of our CHW system would need to be tied to a larger goal of understanding the CHWs as an ecosystem. Given that there are a number of job titles that are relevant to the desired impact for residents of substandard housing, this map should include other similar health professionals (e.g. patient navigators) as well as home visitors, including those working in early childhood or older adult care.

By including healthy housing in this systems map, we will gather important data that can inform next steps. For example, who is already going into homes that can provide the functions needed to improve health at the intersection of housing (e.g. education, linkage or advocacy)? How does the geographic distribution of CHWs match with the highest need in terms of unsafe or unhealthy housing, to the degree that this data is known? What are possible ways to enhance CHW expertise or training to include home-based health interventions without overburdening staff, setting unrealistic expectations, or changing the nature of their core job?

This mapping can lead to numerous strategies on how to use the existing workforce to better impact health through housing-based interventions. As a shared learning process, HDC can play an important role in adding a perspective specific to healthy housing interventions. HDC will be able to advocate for short- and long-term enhancements or coordination needs identified at the CHW level that leverage existing resources to impact larger numbers of residents in King County. There is a natural intersection to this work, the ACH and the HHPPG, and joint planning and collaboration should be explored to determine roles on any actionable items.

Leveraging Existing Systems - Referral Systems

There is interest in streamlining South King County's RRNs, and the current conversations centered on understanding and coordinating the multiple referral systems are a positive start to understanding the needs and potential. Ensuring strong healthy housing linkages should be a part of these conversations. The energy and resources surrounding Best Starts for Kids is one starting point for improved RRN coordination that includes a health orientation. King County is a logical lead in this function. It is at a very early stage, but BSK may be in a position to act as both a visionary and connective tissue to start to tie our systems together. BSK and Public Health are exploring the potential leverage of BSK's Help Me Grow framework as a platform for improved referral coordination. It is too early to say if or how this could coordinate with 2-1-1, WithinReach or the RAPs, but these are all important existing RRNs to keep in mind. The direction this heads, beyond the specifics of the Help Me Grow requirements, is not determined but is currently taking shape.

As this planning advances, it will be helpful for HDC or other housing resource representatives to be a part of the discussion to explore if this is a larger opportunity to advance healthy housing concerns. This would be a logical forum to address some of the gaps that may be identified through the CHW map in areas of assessment, information quality and availability or coordination, for example.

As Help Me Grow and BSK are focused on children and youth, it will not likely be the only referral vehicle to support families. However, it is a promising access point that could lead to a better understanding of the potential power of the County's multiple referral systems that could hopefully lead to an exploration of the range of its ability to coordinate across sectors. WithinReach should be explored for their specific expertise and relationships in South King County.

Leading Direct Implementation of a CHW Program

Too much is unclear at this point to recommend a lead on the implementation of any new program that would directly house and hire a CHW workforce. This requires a longer-term assessment and partnership development strategy (as noted above) to build the relationships and priorities in advance of changes in the Medicaid payment system that could finance the program. The CHCs are the most likely implementers of any new program given their missions, presence into South King County and history in using CHWs as part of their care team. Neighborcare and HealthPoint seemed interested in this role, and Sea Mar or ICHS should be explored further as options.

The hospitals with a presence in South King County should be included, as their funding landscape is also changing and there is broad interest in innovation and community-level work. CHI Franciscan is taking on new roles and is interested in new ideas, and other hospitals could be engaged as well; both their Community Benefit approaches and general clinical operations have potential to be key aspects of future models. Before finding a lead to house CHWs, however, there needs to be far greater clarity on intent and purpose of any new program, including priorities in geography, health outcomes desired or target population. This can be done as a collaborative process with any CHC or hospital that is interested in the program. However, neither the clinics nor the hospitals seem in the best position to lead a full scale collaborative effort, including planning or community relationships, as noted above.

It may be more realistic to start with a clearly defined and limited geographic area and grow partnerships around that area. Geography and target population will determine natural partners. Growing or enhancing the existing Global to Local partnership, for instance, would need coordination support but is a logical starting point for their specific target areas in Tukwila or Seatac. Starting with a willing landlord partner could be a far more effective strategy to build long-term, progressive change. Global to Local noted that there are buildings occupied by new refugees in their geographic catchment area, and there could be partnerships with resettlement agencies and landlords if there were shared interests identified. King County Housing Authority is expanding its pool of landlords as well, which could be another strategic entry point. These are two ideas that emerged in the interviews, which could be fleshed out. A collaborative planning process would likely uncover other possibilities.

Best Funding Mechanisms

There is no single clear path forward, and there is a great deal of change in the funding landscape right now.

Long term, Medicaid appears to be the best funding option for a sustainable, scalable CHW initiative. It is possible that this may come in the form of state mandates to MCOs to include CHWs in their contracts with providers, although this seems unlikely at least in the foreseeable future. This inclusion is more likely to be an influence strategy to ensure that CHWs are considered fundable and valued as part of the care team. The ACH will increasingly influence more Medicaid dollars, although the nature and volume are

unclear. While there may be some programs looking to the Medicaid waiver currently to support CHWs, this is not a long-term funding strategy.

It was noted in repeated interviews that without knowing the details of how payment reform will take shape, it is difficult to plan with confidence. While it may be possible that community-based organizations can access Medicaid funding for CHWs, health providers are more likely to be the employers of CHWs, and the work of the CHWs will thus need metrics for things such as increased use of primary care or other health-related outcomes, such as reduced hospital admissions. General community-level work similar to a Promotore model seems less likely to be fundable with Medicaid, at least for the next several years, with heightened scrutiny and tight timelines to produce health outcomes and return on investment.

Medicaid funding has huge potential for scale and sustainability, but it will likely have constraints that define or limit a funded program's approach or service model. There are additional, cross-sector funding possibilities to consider, however. Whether it is viewed as a possibility to blend funding, or to collaborate among partners who provide specialized services, it may be worth looking creatively outside of the health arena for sustainable funding. Weatherization programs or funding for aging in place are two areas to explore, for example. Both of these types of service have direct impacts on health within the home. While it was, to a large degree, outside the scope of this research, several interviews energetically generated creative, long-term ideas worthy of further exploration. By raising the issue and bringing the best thinkers of their respective fields together for a cross-sectoral approach, there is opportunity to generate new ideas or creative repurposing of existing funding streams to achieve the desired goals.

Best Starts for Kids presents a great opportunity to expand the impact of improved health in the context of the home. New home visiting programs will be added, infrastructure developed and capacity built to support improved outcomes for children and youth. Health and safety within the home is a key assumption of BSK. There are opportunities to work with King County/BSK staff to understand their implementation plan and identify areas where there is a clear intersection of health and housing in their planned programs. This integration could include setting expectations that home visitors are required to have knowledge of child health issues that are impacted by the home environment, as well as a connection to a network of resources to refer the family to if such health hazards are present.

If there is a very clear program design, willing partners (including landlords), and a clear project lead time-limited grants could offer the potential to build long-term partnerships and to test ideas, yet there will be greater potential impact to focus the work on long-term, sustainable goals. Pursuing short-term, time-limited grants to launch CHW programs is not recommended at this time.

Some of these recommendations require a great deal of planning and coordination to both maximize the existing CHW workforce and focus an effective program on the health and housing needs of residents in unsubsidized housing. It is premature to assess whether the Medicaid resources that the ACH will control can help to progress some of the coordination functions, but this can and should be explored should this emerge as a priority. Communities of Opportunity funding is another potential option to explore localized planning and priority setting.

Medicaid does not seem to be a funding source for a RRN per se. If there are resource needs for improving a referral network specific to health and housing, there are a number of opportunities to partner with other groups already involved in similar programs. The United Way and King County are significant funders of the current referral systems, and there is potential for streamlining to increase their efficiency. Enhancements to bolster the healthy housing connections accessed through these networks would involve

a housing stakeholder such as HDC and strategic use of funding to engage the housing community. If WithinReach, in their partnership with Global to Local, is awarded the CMS grant, their work would likely include elements of the RRN envisioned.

Policy and Advocacy Steps toward Sustainability

While there is exciting cross-sector work occurring at the intersection health and housing, the specific policy strategies to assist residents of substandard, unsubsidized housing would benefit from a greater advocacy presence.

Mercy Housing Northwest is taking a lead role in demonstrating the effectiveness of an affordable housing-CHW system. This role includes state and local policy advocacy, relationship building with MCOs and the data integration project to demonstrate health outcomes. It makes sense that this work has started with subsidized affordable housing, and the strategy to tackle issues in unsubsidized housing needs to be developed as the next phase of this work. MHNW's efforts need to be supported as a foundation for any future expansion of Medicaid funding for CHWs in unsubsidized housing, and it is recommended that HDC engage in strategic conversations in support of this work to begin to lay out a long-term plan for timely inclusion of unsubsidized housing. There are progressive steps to this strategy:

- Work closely with Mercy and their new program manager to understand the goals and limits of their work plan for the next three years, and identify gaps where HDC can add value in a shared vision.
- Assess what additional support is needed for the successful demonstration of the effectiveness of the data integration project, which is likely the heart of this work for the next few years. For example, this may include support with the WBARs elements of the data integration project or potentially continuing a relationship with CORE to lean on their experience.
- Mobilize additional support to sustain and deepen the work of the HHPPG. Utilize HHPPG's potential as a forum for shared learning or assessment, as noted in the Infrastructure and Support Systems section.
- Develop a shared advocacy and partnership plan at multiple influence levels, including state level as well as with the MCOs and the ACH.

The ACH is at an early stage in structuring and developing a scope for its next steps. Public Health — Seattle & King County has a key role in this, and is the backbone of support for this work. They are currently developing the new, permanent governance structure for the ACH, which could be done by the end of 2016. A healthy housing strategy is not the most pressing thing on the ACH's work plan immediately, but now is an opportune time to advocate and influence the parameters of the ACH's future work to ensure that the unique health challenges faced in substandard, unsubsidized housing are a part of their long-term agenda. The ACH's investment in the HHPPG's data integration project is a clear signal that housing strategies to address population-level health issues and social determinants of health are important to it, and that healthy housing is on its radar. There is open enthusiasm regarding this partnership opportunity with the ACH to help develop a comprehensive housing-health program.

It is too early in the ACH's evolution to know exactly where their leverage points will be that will drive toward improved healthy housing. However, initial relationship building and ongoing conversations on shared interests with the ACH *can* include:

- Maximizing the potential of the new governance structure to ensure strong healthy housing perspectives, including membership for housing advocates and CHWs who can inform the ACH on effective strategies, emerging needs and community engagement opportunities.
- Identifying funded Medicaid Transformation Projects that are relevant to the goal of impacting health from a housing lens and monitoring their progress. Successful pilots could provide invaluable data on the utility of housing interventions to improve health.
- Chartering a specific healthy housing needs assessment that identifies all stakeholders, the highest need populations and their locations. This would inform key program design parameters for any new, dedicated program, as well as point to the most logical and likely interested partners.
- As the ACH's long-term role in funding decisions becomes clearer, working to develop criteria or priorities that include unsubsidized housing as a major goal.

Finally, success of the Medicaid Transformation demonstration is a critical building block to future movement toward Medicaid funding being spent on more upstream, preventative programming. HDC would be well-served by continuing to support the Washington Low Income Housing Alliance's efforts to fully and successfully implement the permanent supportive housing benefit.

Outside of this, the need for local government engagement in promoting healthier housing stock will continue. Recent progress to begin and expand local rental licensing and inspection programs and to ban source of income discrimination in addition to continuing current home repair and weatherization programs are all important components to supporting access to healthy housing. The collaboration work happening through the South King Housing & Homelessness Partnership could also promote stronger information sharing with organizations serving as RRNs to ensure staff has up to date information about local landlord-tenant law and code enforcement resources.

Articulating the implications for the upcoming Veterans and Human Services Levy is outside the scope of this project but is a clear opportunity to inform the conversation and advocate for policies and funding that support cross-sector approaches to health through housing.

In summary, there is no single path forward to implementing a CHW/RRN in South King County. However, there is a great deal of important groundwork being laid right now in both the CHW sector as a field and in funding opportunities, most notably through Medicaid. This flux will continue for the next several years. As noted throughout this report, there are numerous opportunities for thoughtful planning, advocacy and cross-sector collaboration that, in the long term, can result in improved health outcomes for residents in South King County through a mix of strategic leverage of existing programs/initiatives and new program development at the intersection of health and housing. HDC as well as SKC stakeholders have the opportunity to act as lead advocates for the type of policies, programming and collaboration envisioned here.

APPENDIX A - List of Acronyms

ACA - Affordable Care Act

ACH - Accountable Community(ies) of Health

BSK - Best Starts for Kids

CBO – Community Based Organization

CCCCRR - Central Coordination of Child Care Resource and Referral

CCR&R - Child Care Resource and Referral

CHC - Community Health Clinic

CHNA - Community Health Needs Assessment

CHW - Community Health Worker

CMS – U.S. Centers for Medicare and Medicaid Services

CDC – U.S. Center for Disease Control

COO - Communities of Opportunity

CORE - Center for Outcomes Research and Education

DHHS – U.S. Department of Health and Human Services

DOH – WA Department of Health

EMR - Electronic Medical Records

HDC - Housing Development Consortium Seattle-King County

HHI - Healthy Homes Initiative

HHPPG - Healthy Housing Partnership and Planning Group

HUD – U.S. Department of Housing and Urban Development

WLIHA – Washington Low Income Housing Alliance

MCOs – Managed Care Organizations.

MHNPW - Mercy Housing Northwest

NCHH - National Center for Healthy Housing

PBP - Population Based Payment

PHPDA - Pacific Hospital Preservation and Development Authority

PPIC - Pediatric Partners in Care

RAP - Regional Access Point

ROI - Return on Investment

RRN - Resource and Referral Network

SIM - State Innovation Model

SSI - Supplemental Security Income

VBP - Value Based Payment

WBARS – Washington State Web-Based Annual Reporting System

APPENDIX B - List of Interviewees

Carolyn Bonner, Director, CHI Franciscan Health

Katie Bell, Chief Operating Officer, Neighborcare Health

Elizabeth Bennett, Director of Community Benefit and Guest Services, Children's Hospital

Kathy Burgoyne, Senior Director of Applied Research, Foundation for Healthy Generations

Kathleen Clark, Health Systems Improvement & Linkages Section Manager, Washington State Department of Health

Jerry DeGriek, Deputy Division Director and Regional Health Administrator, Public Health — Seattle & King County

Gretchen Hansen, Health Advocate Coordinator, Foundation for Healthy Generations

Betsy Lieberman, Betsy Lieberman Consulting, LLC

Mary Looker, CEO, Washington Association of Community & Migrant Health Centers

Carolina Lucero, Senior Vice President, Sea Mar

Marcy Miller, Program Manager (Best Starts for Kids), King County Department of Community and Human Services

Afsanch Rahimian, Prevention Health Services Director, Sea Mar

Zoe Reese, Director of Specialty Programs, Neighborcare Health

Marguerite Ro, Chief, Public Health — Seattle & King County, Assessment, Planning, Development & Evaluation

June Robinson, Washington State Representative, 38th Legislative District

Adam Taylor, Executive Director, Global to Local

Loreen Tomich, Program Manager, Transitional Care Management Program, CHI Franciscan Health

Tom Trumpeter, CEO, HealthPoint

Lisa Yohalem, Chief Strategy and Development Officer, HealthPoint

APPENDIX C - SKC Cities 2016 Housing Policy Landscape

South King County Housing Stock Preservation & Quality 2016 Policy Setting Through May 2016

*"Commitment" refers to policy items included in a city's comprehensive plan.
"Implementation" refers to items included in a city's municipal code.

	Auburn	Federal Way	Kent	Renton	Tukwila
Commitments	<ul style="list-style-type: none"> • Maintain affordability of affordable units created • Renovate City-owned buildings into affordable housing • Accessory dwelling units • Create a diverse housing stock • Maintenance/repair program • Provide a healthy environment and encourage rehabilitation • Allow manufactured and mobile homes, transitional, and multifamily housing 	<ul style="list-style-type: none"> • Incentivize various housing types\$ • Prevent displacement • Provide relocation assistance • Preserve existing affordability • Weatherization and energy efficiency program 	<ul style="list-style-type: none"> • Facilitate variety of housing stock • ADUs, reduced lot size, cottage development, and cluster development • Attached single-family within multifamily zones • Targeted reinvestment • Rental assistance to prevent displacement • Preserve existing affordable housing stock • Support rehabilitation of existing housing stock • Provide maintenance services 	<ul style="list-style-type: none"> • Generate variety of housing stock • Increase access to homeownership • Accessory dwelling units (ADUs) • Regulate manufactured homes • Prevent displacement • Home repair and energy efficiency program • Housing rehabilitation 	<ul style="list-style-type: none"> • Provide zoning for various types of housing • Develop preservation programs • Implement Residential Rental Licensing and Inspection program • Support the maintenance, weatherization, rehabilitation, and long-term preservation of existing housing resources • Work as a facilitator between property owner and affordable housing groups
Implementation	<ul style="list-style-type: none"> • Accessory dwelling units (ADUs) • Allow manufactured & mobile homes • Housing Repair Program • Cluster/Short subdivisions 	<ul style="list-style-type: none"> • Accessory dwelling units ADUs, cottage housing, cluster/short subdivisions, and manufactured housing • Housing repair loan program • Affordability covenants 	<ul style="list-style-type: none"> • Accessory dwelling units (ADUs) • Cluster or short subdivisions • Home repair program 	<ul style="list-style-type: none"> • Accessory dwelling units (ADUs) • Home repair program • Affordability covenant • Residential manufactured home park zone 	<ul style="list-style-type: none"> • Manages Residential Rental Business License and Inspection Program • Minor home repair program • Accessory dwelling units • Short subdivisions

Information gathered from:
Alexander Casey, Alena Marshak, Rose Rubel, and Xinwei Wang. "Appendix D: Snapshots." *Under One Roof Analysis of City-Level Affordable Housing Policies and Actions to Meet Housing Needs in King County*. Housing Development Consortium, June 3, 2016.