Health & Housing Partnership Toolkit

for Washington State

COMMUNITY
HEALTH NETWORK
of Washington™

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I. ACKNOWLEDGEMENTS

CHPW commitment to our employees, members, and community: We are committed to establishing and sustaining an equitable community that achieves CHPW's equity mission to guide us towards inclusivity, belonging, racial and health equity while we seek to recognize, reconcile, and rectify historical and contemporary injustices and support tribal sovereignty and culture.

We would like to offer thanks and gratitude to:

Corporation for Supportive Housing (CSH): CSH works to advance affordable housing aligned with services as an approach to help people thrive. CSH does this by advocating for effective policies and funding, equitably investing in communities, and strengthening the supportive housing field. CHNW would like to thank CSH for their leadership in supporting shared learning and opportunities to build partnerships across health and housing. When exploring CHNW's approach to supporting Health and Housing Partnerships in Washington, we valued the perspective and framework provided by CSH's own Health and Housing Partnership Toolkit. This toolkit would not be possible without the framework developed by CSH.

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Principle Allies: We are grateful for the support of consultants Principle Allies in the development of this toolkit. Their knowledge of Washington health and housing systems and experience in building out resources and tools for state agencies made them excellent partners for this project.

II. OVERVIEW OF COMMUNITY HEALTH NETWORK OF WASHINGTON

Community Health Network of Washington (CHNW) is made up of 21 Federally Qualified Health Centers (FQHCs), also known as Community Health Centers (CHC). In the early 1990s, community health care leaders began to realize that it could better meet the health care needs of the people they serve by offering managed care to its diverse communities. CHNW's Community Health Centers (CHCs) were ideally positioned to offer managed care services to these groups thanks a shared commitment to remove the financial, cultural, linguistic, geographic, and other barriers to health care.

In fall 1992, Washington's CHCs voted to form Community Health Network of Washington and a subsidiary not-for-profit managed care company, Community Health Plan of Washington (CHPW). As a network, we brought together shared values for equal access to care, years of experience in community organizing, and track records for effective care delivery and administration.

CHNW and CHPW have been making a positive impact on the lives of Washingtonians ever since. Our mission of serving the community and providing better care for patients extends to our advocacy work in the health policy. By leveraging our shared resources and expertise, we have been able to undertake strategic public policy and advocacy efforts in both Olympia, WA, and Washington, D.C., to ensure access to health care for every Washington state resident.

Since the beginning, we have been advocates for healthy equity and for holistic care rooted in our knowledge of local communities and informed by our understanding of the impact of social drivers of health (SDoH), defined as the conditions in environments where patients live, work, learn and otherwise spend their time, on health outcomes.

One of the most significant social drivers of health impacting Washington state community members is housing insecurity and homelessness. CHNW recognizes the need not just to provide direct care management support to our members to help connect them to resources to address social drivers of health needs, but also to have a strategy to address the upstream causes of inequities that affect all community members. Thus, in 2021, CHNW, in partnership with Community Health Plan of Washington, established a strategic plan roadmap to address social drivers of health. Our strategy states, "We seek to reduce upstream causes of health inequities and remove unjust barriers to health and well-being by leveraging our deep community roots and catalyzing change through local and state-wide cross-sector partnerships."

Within this strategy, based on feedback from various stakeholders, CHNW decided to focus on addressing housing insecurity through three initiatives: 1. Integration of Health and Housing Supports; 2. Housing Services and Supports Capacity Development; and 3. Affordable Housing Advocacy Framework.

CHNW believes that housing is health care and that the key to ending the housing crisis in Washington state is building strong partnerships and networks within communities.

The goals of this toolkit are to:

1. Provide resources and support to Washington CHCs, as well as to housing providers/operators seeking to build partnerships, apply for funding opportunities, and gain an understanding of Washington's health and housing systems.
2. Feature case studies of existing CHC Health and Housing partnerships to elevate examples and glean lessons learned from work already happening in the field.

We hope this toolkit is helpful and is just a jumping off point to facilitate more health and housing partnerships across the state of Washington.

III. INTRODUCTION

Washington state is experiencing an affordable housing crisis of an unprecedented magnitude, resulting in a significant increase in the number of individuals experiencing homelessness. While the cost of housing and lack of housing stock are primary causes of homelessness, people with chronic health conditions, including substance use disorders (SUD), are disproportionately impacted by housing insecurity. Health conditions can sometimes be the precipitating event to becoming homeless. Furthermore, multiple health care crises, including the COVID-19 pandemic and the opioid epidemic, have exacerbated the factors leading to homelessness. Homelessness also has a disproportionate impact on Black, Indigenous and other People of Color in Washington state because of a history of land theft, gentrification, zoning laws and discrimination and trauma from traditional systems of health care.

In developing solutions and partnerships, it is important to understand the history and current state of the housing crisis and who is most impacted and to be inclusive of those voices when developing solutions. Attention to social drivers of health underscores the impact that lack of stable housing has on overall health. Transitional and supportive housing lead to improved health outcomes for patients and long-term cost savings for health systems. This interdependence gives rise to a logical and effective strategy of partnerships between health care and housing providers.

Community Health Centers, like those in the Community Health Network of Washington, are particularly well positioned to pursue health and housing partnerships as they seek to support the most vulnerable in their communities achieve health and well-being. Furthermore, special designations from Health Resources and Services Administration (HRSA)[i] as well as innovations in Medicaid programming, provide incentives for CHCs to pursue health and housing partnerships.

Several excellent tools exist on the national level to guide organizations in their pursuit of such partnerships, notably the CSH *Health & Housing Partnerships Guide*[ii] and the CSH *Health and Housing Acronyms, Terms and Definitions* [iii] outline of key terms. CHNW has developed this toolkit to provide information specific to Washington state, its systems and programs. As a collaboration with the Washington State Department of Commerce, CHNW intends this toolkit to be used as a companion to the CSH guide. As such similar language regarding partnership types and stages of development has been used so that readers can pair the methodology outlined by CSH with the state-specific information found here.

IV. PARTNERSHIP TYPES

Health and housing partnerships are collaborations between providers of primary, mental health, substance use services and providers of housing and supportive services for individuals experiencing homelessness and/or those that are housing insecure or previously were homeless. These relationships can be referral based, structured partnerships with integrated operations, or larger community initiatives and coalitions involving multiple partners. Here are the key elements and examples of partnership types, from low to higher levels of collaboration:

Partnership Types Defined by CSH

Referrals	Care Coordination	Co-Location	Full-Service Integration
• Client referrals to preferred services • Client-initiated • Partners retain autonomy and operations are independent; resources generally are not shared • Low collaboration	• Client-centered joint care plans • May include centralized intake • Client initiated with strong transition supports • Organizations operate independently but may share resources and funding • Moderate to high collaboration, with cross-training and frequent communication	• Health center operates satellite or full center on-site at supportive housing or shelter • Wrap-around care housed in a site that tenants access for various services • Partners operate jointly, but may retain autonomy • Can be incorporated into existing site, mobile services or new joint site • High collaboration	• Single point of entry, integrated assessment • Joint case planning/ management • Wrap-around care that may be brought to where it is most accessible to the client • Partners may have independent or joint operations • Can blend with co-location • Very high collaboration, with integrated resources, service delivery and sometimes funding

While these are the primary partnership types, it is not uncommon for health centers to pursue a combination of solutions or start with referrals and gradually evolve the approach to include closer levels of collaboration. These types can also have variations within them. For example, Full-Service Integration can range from a leasing arrangement to complete ownership of a facility.

Several case studies are included in this toolkit to illustrate the ways in which CHCs have partnered to provide housing solutions for its clients. These four partnership types are represented throughout this toolkit - labels on the case studies will help identify partnership types.

V. HOW TO USE THIS GUIDE: STAGES OF COLLABORATION

Another helpful framework offered by the CSH Guide is the Four Stages of Collaboration: Make the Case, Make it Happen, Make it Work, and Make it Last.

- **Stage 1: Make the Case** starts with your awareness and capacity to lead a partnership, being very realistic about the commitment and value a partnership or collaboration would bring.
- **Stage 2: Make it Happen** guides you in exploring your community to identify and assess organizations that might fit with your needs and goals.
- **Stage 3: Make it Work** challenges you to start conversations and connect with potential partners, share information, and design and implement a plan with partners who are a fit.
- **Stage 4: Make it Last** ensures you take steps to make a collaboration that can be sustained.

This toolkit can play a role in each of these stages. The following table outlines some suggested ways to use the information contained here throughout the lifecycle of a partnership.

CSH Four Stages of Collaboration

Stage	Activities	How to use this Guide
1. Make the Case	• Identify Goals • Understand Value of Potential Partners • Assess Your Capacity • Engage Leadership (See p.3-7 of *CSH Guide*)	✓ Review State System description to determine Agencies and other partners to contact for information ✓ Evaluate program information against target populations for potential fit (See p.17 of *CSH Guide*) ✓ Join mailing or funding announcement lists for agencies or programs of interest ✓ Read case studies to determine similar goals and methods to emulate
2. Make it Happen	• Identify Partners • Approach Partners • Assess Partners • Select Partners (See p.7-9 of *CSH Guide*)	✓ Contact relevant state agency and/or partner to help qualify eligibility for funding and program participation ✓ Identify program information to target for implementation ✓ Reference partnerships in case studies to brainstorm outreach efforts in your community
3. Make it Work	• Establish Champions • Create a Shared Vision • Build the Partnership Plan • Launch Partnership Activities • Create Short-Term Wins (See p.10-14 of *CSH Guide*)	✓ Solicit support from state agency and other key partners on implementation plans ✓ Apply to relevant programs for funding and operational supports, such as technical assistance ✓ Consider the component parts of the Partnership Plan and build those out (See p.22 of *CSH Guide*) ✓ Contact organizations in case studies to schedule a virtual or in-person site visit to gather information to support project plan

4. Make it Last	• Manage New Relationships • Demonstrate Flexibility • Build Momentum • Anticipate Changes • Align Funding & Data (See p.14-16 of *CSH Guide*)	✓ Contact state agencies and/or partnership programs to determine opportunities for learning about new programs and/or quality improvement ✓ Join a stakeholder group or interest group related to the program you're participating in ✓ Follow agency or program newsletters or announcement to determine new funding opportunities ✓ Leverage learnings from case studies to reinforce sustainability in your partnership ✓ Apply for operational funding ✓ Report successes and impact data to agency or program contacts

VI. SYSTEM OVERVIEW - WASHINGTON STATE

State agencies play an important role in the governance and administration of state and federal resources. The roles and responsibilities of state agencies can vary but they generally serve several key functions including policy implementation, service delivery, regulation and oversight, planning and development, data collection and analysis, and/or public outreach and education. Moreover, each state has its own agency organizational structure, making it important to understand the unique players in each state.

Following are the key agencies in Washington state that play a part in health and housing partnerships. This section also highlights considerations related to their role in **service, oversight, and data.** The next section of this toolkit will discuss specific programs within these agencies that support planning, development, funding, and implementation of housing-related programs and services.

DEPARTMENT OF COMMERCE

The Washington State Department of Commerce is a state agency responsible for promoting economic development, fostering sustainable growth, and improving the overall quality of life for the residents of Washington. The department's primary goal is to support a strong and resilient economy while ensuring that the benefits of growth are shared across communities in the state. Commerce has several key functions and responsibilities relevant to health and housing partnerships:

- **Community Development**: Commerce supports the development of vibrant and resilient communities throughout the state. It provides grants, technical assistance, and capacity-building resources to local governments and community organizations for projects related to affordable housing, infrastructure improvements, downtown revitalization, and community services.
- **Housing and Homelessness:** Commerce administers programs and funding to increase access to safe and affordable housing, prevent homelessness, and provide supportive services for vulnerable populations. The department also works with local governments and nonprofit organizations to address homelessness and housing challenges across the state.
- **Data Systems:** Commerce manages the Homeless Management Information System (HMIS) [iv] a data management system designed to capture and track information on individuals and families experiencing homelessness. It is used by homeless service providers, government agencies, and community organizations to collect and analyze data on homelessness, monitor program effectiveness, and inform resource allocation and policy decisions. HMIS typically includes data on demographics, housing history, services received, outcomes, and other relevant information to help track progress and improve interventions.

HEALTH CARE AUTHORITY

The Washington State Health Care Authority (HCA) is the state agency responsible for administering and overseeing the state's health care programs. Its primary goal is to ensure access to affordable and quality health care services for eligible residents of Washington. HCA plays a crucial role in implementing and managing various health care programs, including Medicaid, the Children's Health Insurance Program (CHIP), and other state-funded health care initiatives. HCA specifically manages the Medicaid Transformation Project (MTP), Washington's Section 1115 Medicaid demonstration waiver with the Centers for Medicare & Medicaid Services (CMS), which allows for the development of unique services to benefit enrollees in Apple Health. One of these projects is Foundational Community Supports housing program detailed in the next section.

Other key functions and responsibilities include oversight of the Health Insurance Exchange, health policy and planning, and quality improvement and analysis. Through its collaboration with managed care organizations (MCOs) and health providers, as well as data analysis, they support health and housing innovation in the following ways:

- Medicaid Administration: HCA administers Washington's Medicaid program, known as Apple Health. It determines eligibility for Medicaid, enrolls eligible individuals and families, and manages the delivery of health care services through a network of contracted health care providers. The agency works to ensure that low-income individuals and families have access to comprehensive medical, dental, and behavioral health services. Utilizing Medicaid waivers and other strategies, the state seeks to enhance innovative models that address the needs of people in ways that are cost effective.

- Health Care Innovation and Transformation: HCA promotes health care innovation and transformation efforts in Washington. It works to improve the delivery of care, enhance care coordination, and implement payment models that prioritize value and outcomes. The agency supports initiatives such as integrated care models, accountable care organizations (ACOs), and alternative payment methodologies to advance health care system reforms.

- Health Equity and Cultural Competency: HCA is committed to addressing health disparities and promoting health equity in Washington. It works to ensure that health care services are accessible and culturally appropriate for diverse populations. The agency engages in initiatives that aim to reduce disparities in health care outcomes and improve the health of underserved communities.

- Behavioral Health Services: The agency oversees the delivery of behavioral health services in Washington. It collaborates with behavioral health providers and MCOs to ensure access to mental health and substance use disorder treatment services for eligible individuals. The HCA also supports initiatives to integrate physical and behavioral health care to improve overall health outcomes.

In 2016 Washington adopted fully integrated managed care (bringing together payment and service delivery for physical and behavioral health care) and contracted with five health plans to oversee the Medicaid benefit.

MANAGED CARE ORGANIZATIONS

Under fully integrated managed care, managed care organizations (MCOs) play a significant role in the delivery and coordination of health care services for eligible individuals. These MCOs are responsible for managing and coordinating the needs of Medicaid beneficiaries and ensuring that individuals receive comprehensive, coordinated, and cost-effective care. They facilitate care coordination (including supporting members in getting connected to resources like housing, food, and transportation), maintain provider networks, determine benefit coverage and utilization management policies, promote health and wellness, drive quality improvement, engage with members, and assume financial risk for the delivery of care. Their role is crucial in ensuring that Medicaid beneficiaries receive comprehensive, coordinated, and high-quality health care services.

Five MCOs work in partnership with the Health Care Authority (HCA) to deliver coordinated and comprehensive health care to eligible individuals: Amerigroup Washington, Community Health Plan of Washington (CHPW), Coordinated Care, Molina Healthcare of Washington, and UnitedHealthcare Community Plan.

DEPARTMENT OF HEALTH

The Department of Health (DOH) plays a significant role in licensing and regulating behavioral health services. DOH is responsible for safeguarding public health and ensuring the delivery of safe and quality health care services, including behavioral health services, within the state. DOH's role in licensing behavioral health services includes the application and review process, regulatory compliance, public protection, professional discipline, and consumer education. Depending on the type of setting, DOH may need to license the "facility." In the housing sector, the only facility that DOH would license is a Residential Treatment Facility (RTF). Respites, shelter, transitional housing, and supportive housing are not under regulation by DOH.

If behavioral health or other program services (such as Foundational Community Supports) are part of the program, an organization may interact with DOH for licensing and certification. This includes facilities, programs, and professionals involved in delivering behavioral health services such as mental health treatment, substance use disorder treatment, counseling, therapy, and related services. DOH establishes and enforces standards and regulations that providers must meet to obtain and maintain their licenses.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

The Washington State Department of Social and Health Services (DSHS) administers a wide range of social and health programs to support the well-being and self-sufficiency of individuals and families. Promoting the power of choice in housing for elderly populations and people with disabilities, DSHS manages the Home and Community Based Services (HCBS) [v] Waivers. HCSBS permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide. Two key DSHS programs, the Community Behavioral Health Rental Assistance (CBHRA) [vi] and the Aging and Long-Term Support Bridge Subsidy (ALTSA) [vii], are detailed in the next section. Other DSHS services include:

- **Social Services:** DSHS provides various social services aimed at helping individuals and families in need. This includes programs such as Temporary Assistance for Needy Families (TANF), which provides financial assistance to low-income families, and the Supplemental Nutrition Assistance Program (SNAP), which offers food assistance.
- **Child Welfare:** DSHS is responsible for child welfare services, including child protective services, foster care, and adoption services. The agency works to ensure the safety and well-being of children at risk of abuse or neglect, and it supports families in need of assistance.
- **Developmental Disabilities Services:** DSHS provides services and support for individuals with developmental disabilities. This includes residential services, employment support, and assistance with accessing community resources to enhance independence and quality of life.
- **Aging and Long-Term Support:** DSHS offers programs and resources for older adults and individuals with disabilities who require long-term care and support. This includes programs like Medicaid, home and community-based services, and assistance with nursing home care.
- **Health Services:** DSHS plays a role in public health by administering programs related to health insurance coverage, medical assistance, and public health emergencies. The agency works to ensure access to health care services and promotes the health and well-being of Washington residents.

TRIBAL GOVERNANCE AND AMERICAN INDIAN/ALASKA NATIVE SERVICES

When considering health and housing initiatives in Washington, it is important to consider the unique status and resources of the state's 29 federally recognized tribes and the American Indian/Alaska Native population. Because the federal government recognizes tribal sovereignty, Indian Tribes have the authority to govern themselves and make decisions regarding their internal affairs, including health and housing services. Many tribes in the state choose to exercise the option provided by the Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 and administer programs and services previously managed by the federal government, allowing them to have greater control over their health and housing programs.

Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, provides health care services to Native American tribes and Alaska Native communities. Tribes in Washington state may enter into compacts or contracts with the IHS to operate their own health care facilities and programs. This allows tribes to tailor health care services to the specific needs of their communities. Many tribes in Washington state have established their own tribal health programs, clinics, or health authorities. These programs may receive funding from various sources, including the federal government, state government, and tribal revenues. Washington Health Plan Finder [viii] outlines the approach state tribes take with IHS, including the urban health clinics in Seattle and Spokane.

Tribes in Washington state may establish their own tribal housing authorities to address the unique housing needs of their communities. These authorities can receive funding from federal programs like the Indian Housing Block Grant, [ix] which supports the development and maintenance of affordable housing for tribal members. Tribes also have the ability to enact their own laws and regulations within their jurisdictions. This authority allows them to establish housing and health-related policies that align with their cultural values and priorities. Tribes may develop regulations related to housing construction, rental assistance, land use planning, and health and safety standards.

HOUSING FINANCE COMMISSION

Another state agency, the Washington State Housing Finance Commission (WSHFC), [x] supports affordable housing opportunities for low- and moderate-income individuals and families in the state. In addition to financing, the commission is a resource for policy, advocacy and technical assistance. Programs of particular interest to CHCs include:

- **Affordable Housing Financing:** The commission provides financial resources and affordable housing programs to developers, nonprofit organizations, and local governments. It offers low-cost financing options, including tax-exempt bonds, for the development and preservation of affordable rental housing.
- **Housing Tax Credits:** The commission allocates federal Low-Income Housing Tax Credits (LIHTC) to developers who build or rehabilitate affordable rental housing. These tax credits attract private investment in affordable housing projects and play a crucial role in expanding the supply of affordable rental units.
- **Multifamily Housing Preservation:** WSHFC actively works to preserve existing affordable rental housing units. It collaborates with property owners and stakeholders to ensure long-term affordability and prevent the loss of subsidized housing due to changing market conditions or expiring affordability restrictions.
- **Homeless Assistance:** The commission supports initiatives to address homelessness in Washington state. It collaborates with local communities, service providers, and other agencies to develop strategies, allocate resources, and implement programs aimed at reducing homelessness and providing stable housing options.

REGIONAL HOUSING AUTHORITIES

Washington state has 37 regional Housing Authorities that run a variety of housing programs, typically large volumes of housing subsidies, including HUD Housing Choice Vouchers (Section 8). They are chartered under state law as not-for-profit public corporations, working closely with local, state and federal governments. Required to follow federal regulations, Housing Authorities receive a subsidy from the U.S. Department of Housing and Urban Development (HUD), but do not receive any funds from state or local governments. *Collaboration with the local housing authority is often a key to successful health and housing partnerships.* The Association of Washington Housing Authorities [xi] maintains a directory of the state's housing authorities.

CONTINUUMS OF CARE AND COORDINATED ENTRY

Managed by the U.S. Department of Housing and Urban Development , the Continuum of Care (CoC) [xii] program consists of collaborative networks that aim to prevent and end homelessness through services that address the diverse needs of individuals and families. These services may include emergency shelter, transitional housing, permanent supportive housing, case management, mental health and substance abuse treatment, employment assistance, health care, and other supportive services. HUD provides funding to regional CoCs, establishes the guidelines and requirements, sets the criteria for the allocation of funds, and monitors the performance and outcomes of CoCs.

HUD encourages each CoC to analyze the following to inform their prioritization decisions:

- Current inventory of housing opportunities;
- Needs within its jurisdiction (geographic area);
- Expressed preferences of people being served;
- Performance of all programs to determine the appropriate mix of housing options and to ensure the most effective use of CoC Program resources; and
- How it can provide meaningful choice to people experiencing homelessness with substance use disorders who are in all stages of recovery.

CoCs are typically organized at the local or regional level and involve various organizations, agencies, and service providers working together to create a coordinated system of care. CoC Boards manage the HUD funding application, coordinate the efforts of service providers, conduct the annual Point-in-Time count, manage the Homeless Management Information System (HMIS), and oversee the implementation of the CoC's strategic plan at the local level. Washington has five major regional CoC Boards:

- King County CoC: Serving the King County and the city of Seattle [xiii]
- Spokane CoC: Serving Spokane County and the city of Spokane [xiv]
- Pierce County CoC: Serving Pierce County and the city of Tacoma [xv]
- Snohomish County CoC: Serving Snohomish County and the city of Everett [xvi]
- Clark County CoC: Serving Clark County and the city of Vancouver [xvii]

In addition, the Washington State Department of Commerce coordinates a Balance of the State CoC (BoS Coc) [xviii]which covers the remaining 34 small and medium-sized counties, helping them to leverage HUD funding.

The Coordinated Entry (CE) [xix] process is a key component of Continuums of Care (CoCs), designed to ensure that individuals and families experiencing homelessness can access appropriate and available housing and supportive services in a coordinated, equitable and transparent manner. CE typically involves the following steps:

1. **Centralized Access:** CE establishes a centralized access point where individuals experiencing homelessness can access services. This could be a physical location, a hotline, or an online portal. The purpose is to streamline the entry into the homeless assistance system and provide a single entry point for individuals seeking help.
2. **Assessment and Prioritization:** Upon contacting the centralized access point, individuals go through an assessment to gather information about their housing needs, demographics, and any additional support needs they may have, such as medical or mental health issues. Based on this assessment, individuals are prioritized based on vulnerability and need. This helps ensure that the most vulnerable and at-risk individuals receive housing and support services first.
3. **Referral and Matching:** After the assessment, individuals are referred to appropriate housing and service options based on their prioritization and availability. The CE system maintains a comprehensive database of available resources, such as emergency shelters, transitional housing, and permanent supportive housing. The referrals aim to match individuals with the most suitable and available housing options.
4. **Follow-Up and Case Management:** Once individuals are connected to housing and services, case management and support services are provided to help them maintain stability and work towards self-sufficiency. Case managers assist individuals with accessing necessary resources, addressing barriers to housing stability, and connecting them to additional support services like health care, employment assistance, and mental health or substance abuse treatment.
5. **Data Collection and Evaluation:** CE systems typically utilize the Homeless Management Information System (HMIS) to collect and track data on individuals experiencing homelessness, their housing needs, and the outcomes of the services provided. This data helps CoCs evaluate the effectiveness of their programs, identify trends and gaps in services, and make data-informed decisions for program improvement.

UNIQUE POSITION OF CHCS TO SUPPORT HEALTH & HOUSING INITIATIVES

Community Health Centers (CHCs) are key contributors to the health of their communities. They have reach, they have data, and they have connections to their patients. Many CHCs recognize the need to support the needs of the communities they serve, and this includes the need to address housing insecurity. As experts in delivering health care services with strong roots in their communities, CHCs make excellent health care partners to either provide services on site or in collaboration with housing partners. Some CHCs may also seek to develop their own housing programs after assessing the need in their community for additional programs or options. Reasons why CHCs may engage in housing initiatives include:

- Addressing Homelessness: Housing instability and homelessness significantly impact individuals' health and well-being. CHCs often encounter patients who experience homelessness or unstable housing conditions. By connecting patients to housing options, health centers can help address this critical issue and improve health outcomes by offering stable and secure housing to vulnerable populations.

- Comprehensive Care: Building or partnering with housing solutions allows CHCs to offer comprehensive care that goes beyond medical services. By addressing the social drivers of health, including housing, health centers can provide a holistic approach to patient care and support individuals' overall well-being.

- Enhanced Access and Engagement: Lack of stable housing can make it challenging for individuals to access health care services regularly. By integrating housing options with health centers, individuals have better access to primary care, preventive services, and follow-up care. Additionally, being located in the same facility or vicinity as housing units can facilitate patient engagement and enable more proactive health interventions.

- Improved Health Outcomes: Stable and safe housing is essential for maintaining good health. By connecting patients to housing, CHCs can help reduce the risk of health issues associated with homelessness and housing instability, such as chronic conditions, mental health challenges, and substance use disorders. This, in turn, can lead to improved health outcomes and reduced health care costs over time.

- Coordination of Supportive Services: Housing initiatives by CHCs often involve the provision of supportive services, such as case management, behavioral health counseling, and assistance with employment and education. These services can help individuals overcome barriers and improve their overall health and well-being while residing in the housing units.

- Collaboration and Partnerships: Housing solutions often requires collaboration with housing agencies, nonprofit organizations, and local government entities. Through partnerships, CHCs can leverage expertise, resources, and funding opportunities to develop affordable housing units that meet the specific needs of their patient population.

- Community Health and Neighborhood Revitalization: CHCs can play a vital role in community revitalization efforts through housing initiatives. By helping to transform underutilized properties or blighted areas into housing units, health centers contribute to the overall improvement of the community's health and well-being, creating positive ripple effects.

Each community health center's decision to engage in housing initiatives should be based on thorough planning, community needs assessment, and consideration of available resources. Additionally, partnerships and collaborations with housing experts, local organizations, and community stakeholders are crucial for successful implementation. The following section highlights programs in Washington state that support health and housing collaborations.

VII. PROGRAMS OVERVIEW - WASHINGTON STATE

State agencies and regional organizations in Washington state offer a variety of programs and services for CHCs pursuing a health and housing partnership. Here is a selection of programs which may be of most interest and are well aligned to support the goals of health and housing partnerships:

HOUSING TRUST FUND

Washington's Housing Trust Fund [xx] is the primary resource for capital funding of affordable housing in the state, both for new construction and preservation. Loans or grants are made through annual competitive application cycles to build or preserve affordable housing stock. Properties financed by the program can house people earning less than 80% of the Area Median Income, but most of these properties house households with special needs or incomes below 30% of the Area Median Income. This includes people and families experiencing homelessness, people needing supportive housing, seniors, veterans, farmworkers, and people with developmental or other disabilities. Special-needs projects coordinate with state and local service providers to ensure clients receive appropriate housing and services.

How to leverage this resource?

- Review Housing Trust Fund announcements to gather information about the types of projects being pursued in your region
- Apply to Housing Trust Fund grants for capital projects in new construction or preservation

RAPID CAPITAL HOUSING ACQUISITION FUND

A subset of the Housing Trust Fund is the Rapid Capital Housing Acquisition Fund (RCHA) which provides funding to acquire real property for rapid conversion into enhanced emergency shelters, permanent supportive housing, transitional housing, permanent housing, youth housing or shelter for people with extremely low incomes and people experiencing sheltered and unsheltered homelessness in Washington state. The program helps organizations acquire properties capable of swiftly housing people with minimal updates. The projects must have evidence of local support and must maintain the housing units and beds for the intended use for 40 years.

How to leverage this resource?

- Review grant awards to determine potential housing partners in your region
- Pursue funding if project is based on a rapid conversation of an existing property

COMMUNITY HOUSING & COTTAGE HOUSING

Community Housing and Cottage Communities is another subset of the Housing Trust Fund and reflects the popularity of community housing and "tiny house" villages in recent years. Launched in 2022 projects must be dedicated to serving individuals and/or households who are Homeless at Entry. Construction must create a minimum of four individual housing units in the same location. Structures must include insulation, electricity, overhead lights, and heating.

How to leverage this resource?

- Review grant awards to determine potential housing partners in your region
- Pursue funding if project includes multi-unit or "tiny house" components

APPLE HEALTH & HOMES

Created in 2022, Apple Health & Homes Initiative (AHAH) [xxi] is based on the idea that lack of housing is a social determinant of health, and individuals with disabling conditions such as medical, behavioral health, and physical impairments may not improve until their housing is stable. A multi-agency initiative that pairs health care services with housing resources, it provides capital and operating funding for acquiring or developing housing units, supportive services, rental subsidies and

other PSH assistance. Since FCS is a Medicaid benefit for individuals with a verifiable medical or behavioral health condition who are also at risk for housing instability, including homelessness, FCS is the cornerstone of the AHAH program.

How to leverage this resource?

- Apply for capital funding for rapid acquisition or construction of housing that is, at least in part, dedicated to subset of individuals enrolled in or eligible for FCS
- Apply for rental and other funding assistance
- Seek capacity-building or technical assistance to expand or sustain quality supportive housing

FOUNDATIONAL COMMUNITY SUPPORTS

The Foundational Community Supports (FCS) [xxii] program provides supportive housing and supportive employment services designed to enable program participants to lead independent and self-directed lives in their own homes. Supportive housing services help individuals get and keep community housing. FCS is a targeted Medicaid benefit designed to meet the needs of individuals with significant barriers to finding stable housing and employment. Participants must be Medicaid-eligible and meet certain age requirements, along with meeting specific medical risk factors including chronic homelessness, complex behavioral health and co-occurring substance use needs among others, as well as a disability or other long-term care needs. FCS services are approved for 6-month periods, but currently can be renewed indefinitely if eligibility continues. FCS does not pay for rent, rental subsidies, wages, or wage enhancements.

Amerigroup is the MCO contracted to serve as the third-party administrator of the FCS program. Amerigroup's FCS online resource [xxiii] provides detailed eligibility information and forms.

How to leverage this resource?

- Secure operational funding for case management to assist clients in finding stable housing or employment

MEDICAL RESPITE CARE

Medical Respite Care (MRC) [xxiv] facilities are growing in popularity and typically fall into the category of transitional or shelter facilities. Medical respite care is short-term residential care that allows patients who are homeless to recuperate in a safe environment while accessing medical care, behavioral health care and other support services, such as care coordination. recover on the street or in a shelter but are not ill enough to need hospital-level care. It is distinct from skilled nursing, assisted living or hospice care, and facilities do not require a special license from the Department of Health. Upon improvement in health status, individuals will often transfer to supportive housing with the assistance of respite care coordinators.

Currently there are at least eight facilities in the state with two contracted with MCOs (Edward Thomas House [xxv] and Yakima Neighborhood Health Services [xxvi]) to provide Medicaid reimbursements through a per diem rate, primarily. HCA is working on ways to formalize the benefit [xxvii] so it can contract with medical respite care programs and expand access to these services. A fee-for-service benefit [xxviii] may be available as soon as 2025. The National Institute for Medical Respite [xxix] is another resource for supporting these efforts.

How to leverage this resource?

- Outreach to MCOs to explore potential contracting for medical respite services
- Contact HCA to determine contracting for fee-for-service for medical respite if you plan to serve clients in short-term, recuperative stays
- Research best practices and standards of care with the National Institute of for Medical Respite

BEHAVIORAL HEALTH FACILITIES FUND

A program of Commerce, the Behavioral Health Facilities (BHF) Fund [xxx] distributes grants to help community providers establish new behavioral health service capacity through acquisition, renovation or new construction of real property. BHF is for capital funding only and must increase system capacity. Funding either comes in the form of competitive grants to eligible organizations or direct appropriations from the Legislature.

How to leverage this resource?

- Review grant awards to determine potential behavioral health facility partners in your region
- Pursue funding if project includes behavioral health service capacity building, such as new client space

RECOVERY RESIDENCE FUNDING

Recovery Residences are safe, healthy, community/peer based, substance-free living environments that support individuals in recovery from substance use disorder (SUD). The Washington Alliance for Quality Recovery Residences (WAQRR) [xxxi] provides technical assistance to operators and credentialing of Recovery Residences following the National Alliance of Recovery Residences (NARR) best practices. These residences allow residents to use prescribed medication for physical health, mental health, and substance use disorders. Commerce manages the Recovery Residence Operating Fund [xxxii] to encourage start up and operation of Recovery Residences. WAQRR certification is required of every Recovery Residence Operator launching a new Level II Recovery Residence seeking this grant funding.

Another source of funding is the Housing and Recovery through Peer Services (HARPS) [xxxiii] program which provides at-risk individuals supportive housing services and short-term housing bridge subsidies for items such as application fees and deposits. Some participants may also qualify for long-term housing subsidies through the Department of Commerce. At risk individuals are people who are exiting, or at risk of entering inpatient behavioral health care settings. Certified Peer Counselors deliver these services and follow evidence-based practices such as Housing First and separation of housing and services.

How to leverage this resource?

- Review grant awards to determine potential behavioral health facility partners in your region
- Pursue funding if project will serve individuals in recovery from SUD

COMMERCE OPERATIONS AND MAINTENANCE FUNDS

The Department of Commerce administers two Operations and Maintenance Fund [xxxiv] programs that support building operations and regular maintenance. The original Operating & Maintenance (OM) program awards up to $50,000 per year to qualifying multifamily housing projects that are part of the Washington State Housing Trust Fund portfolio. Projects are awarded funding through short or long-term commitments (5 or up to 20 years) and are renewed yearly.

A new Permanent Supportive Housing Operating, Maintenance, and Services (PSH-OMS) program was launched in 2018 that provides “gap” operating and maintenance funding for units of permanent supportive housing where housing operations have a gap in operating revenue. PSH-OMS also includes funding for tenancy-supporting services for the tenants of such units without any other services funding.

How to leverage this resource?

- Apply for funding if you are currently a part of the state Housing Trust Fund portfolio

CONSOLIDATED HOMELESS GRANT

The Consolidated Homeless Grant (CHG) [xxxv] provides resources to fund homeless crisis response systems to support communities in ending homelessness. Grants are made to local governments and nonprofits. CHG is compiled from several fund sources, including state general fund and document recording fees. Throughout the guidelines the funding sources are referred to as CHG Standard, Permanent Supportive Housing for Chronically Homeless Families (PSH CHF), Eviction Prevention, and Housing and Essential Needs (HEN). Each of the funds has different eligibility requirements.

How to leverage this resource?

- Apply for funding if your project seeks operational support in serving homeless populations

COMMUNITY BEHAVIORAL HEALTH RENTAL ASSISTANCE

The Community Behavioral Health Rental Assistance (CBRA) [xxxvi] program provides long-term or bridge rental subsidies for high-risk individuals with behavioral health conditions and their households. When partnered with programs offering supportive housing services such as Washington's Foundational Community Supports (FCS) program, Aging and Long-Term Supports (ALTSA) programs, Housing and Recovery through Peer Services (HARPS) programs, or others, highly-vulnerable persons with complex behavioral health needs have opportunities to live independently in the communities of their choice. This program prioritizes those exiting state psychiatric hospitals and community psychiatric inpatient beds with the goal of increasing retention in the PHS program or exits to permanent housing.

How to leverage this resource?

- Apply for funding if your project serves high-risk individuals with behavioral health conditions, particularly those exiting psychiatric facilities

AGING AND LONG-TERM SUPPORTS

The Aging and Long-Term Support Bridge Subsidy (ALTSA) [xxxvii] program is managed by the Department of Social and Health Services and provides rental assistance to individuals who want to move into an apartment from a nursing facility for those eligible for and active on the Aging and Long-Term Support Administration (ALTSA) Long-Term Services and Supports (LTSS). Individuals are expected to pay 30% of income towards rent with the subsidy paying the rest directly to a landlord. This subsidy does not require an end date.

How to leverage this resource?

- Apply for funding if your project serves clients who are eligible for ALTSA supports looking to pursue independent living

VIII. ADDITIONAL FUNDING SOURCES & TECHNICAL ASSISTANCE

While state funding and resources are often a large portion of funding for a health and housing partnership, most organizations find they need to braid funding with non-state sources or pursue gap funding, particularly at start-up. As illustrated in the case studies, a variety of additional sources of funding are available in Washington state. These include City and County Government programs, grants from MCOs, and grants from foundations. These funding sources, as well as other community-based organizations, can also be a helpful source of technical assistance.

CITY & COUNTY GOVERNMENT

Every City and County manages its own funding for health and housing initiatives. However, there are some programs that are generally available statewide. These include:

- Mental Illness and Drug Dependency (MIDD) sales tax is a local sales tax that some, but not all, counties have implemented to fund behavioral health services for individuals with mental illness and substance use disorders. Authorized in 2005, it allows counties to impose an additional sales tax of up to 0.1% (one-tenth of one percent) to generate revenue specifically for behavioral health programs and services, such as supportive housing programs and services.
- Homeless Outreach Funds result from federal and state appropriations that go directly to city and county governments. Common sources might include the U.S. Department of Housing and Urban Development (HUD) grants for the Continuum of Care (CoC) program, Emergency Solutions Grants (ESG), or the Supportive Housing Program (SHP). Cities and Counties may choose to pool and spend these dollars differently depending on the needs of their communities.

FOUNDATIONS

Washington state is fortunate to be home to many generous foundations who regularly grant funds for health and housing initiatives. A good way to get to know foundations is to research the types of projects they've supported in the past, and most have detailed websites outlining their portfolios. The following is a sampling of foundations to consider engaging with as a project develops:

- The Ballmer Group [xxxviii] invests in direct services that strengthen communities for today and levers of change that transform systems for tomorrow. Both Washington state and Housing & Homelessness are specific impact areas of interest. New initiatives in behavioral health are also geared at strengthening the health care systems within behavioral health, particularly workforce issues.
- Building Changes [xxxix] manages the Washington Youth & Families Fund (WYFF), a combination of public and private dollars to make grants across the state focused on innovative housing interventions and strategies.
- Cambia Health Foundation [xl] is the corporate foundation of Cambia Health Solutions and invests in solutions that reduce disparities, eliminate systemic barriers and result in better health care experiences and outcomes.
- Empire Health Foundation [xli] invests in projects serving the Inland Northwest and advancing health equity through its equity healing framework.
- Inatai Foundation [xlii] (formerly the Group Health Foundation) focuses on social justice and racial equity. Through its Community Power Grants, it funds a wide range of organizations and projects engaged in anti-racism work in health and housing systems.
- M. J. Murdock Charitable Trust ,[xliii] based in Vancouver, Washington, is committed to improving the lives of people in the Pacific Northwest. With Human Services as a sector area, the trust invests in operational and capacity building as well as innovative programs.
- Premera Blue Cross [xliv] offers grants addressing behavioral health issues, with a particular emphasis on funding programs that help historically underserved communities, including people of color and low-income populations.
- Raikes Foundation [xlv] focuses on building power in historically marginalized communities and supporting organizations working for a fair and inclusive society. Housing stability for youth is a key area of interest.

ACCOUNTABLE COMMUNITES OF HEALTH

Accountable Communities of Health (ACHs) [xlvi] are nine independent, regional organizations located throughout the state. Playing an integral role in Washington's Medicaid Transformation Project (MTP) efforts, ACHs also collaborate with their communities on specific health care and social needs-related projects and activities. In some cases, these ACHs may have funds available to support health and housing partnership efforts and can also provide technical assistance to CHCs pursuing partnerships.

MCOS

In addition to managing benefits for state Medicaid recipients, MCOs also invest regularly in innovative programs or efforts to build system capacity to serve their subscribers. While these programs across organizations are varied, outreach to MCOs early in a project can uncover potential funding opportunities, particularly in the startup phase.

TECHNICAL ASSISTANCE

Many communities across the state have developed initiatives to address the housing crisis in their area. These are some of the best resources to plug into to best understand the needs of your specific community and to connect with local partners. These include:

- Enterprise Community Partners [xlvii] is a national organization with regional operations in the Pacific Northwest. It works to increase the supply of affordable homes, advance racial equity, and support resident communities to be resilient. It provides technical assistance grants and low-interest financing.
- Government Alliance on Race and Equity [xlviii] **,** a national government network, offers tools to address equity in housing, land, and development.
- Low Income Housing Institute (LIHI) [xlix] leads efforts to develop low-income housing, temporary shelters, tiny houses, and urban rest stops.
- National Health Care for the Homeless Council (NHCHC) [l] works to improve homeless health care through training, technical assistance, research and advocacy.
- National Institute for Medical Respite (NIMR) [li] is a special NHCHC initiative that advances best practices related to medical respite care.
- Office of Rural and Farmworker Housing [lii] offers both technical assistance and community development financing to those operating in Washington's rural areas.
- Washington Landlord Association (WLA) [liii] can provide resources and best practices in operating as a landlord in the state.
- Washington Low Income Housing Alliance (WLIHA) [liv] addresses public policy issues in the state so that access to housing in equitable and racially just. Its *Toolkit to Combat the Criminalization of Homelessness* [lv] may be helpful in community engagement efforts.

Case Studies

NEIGHBORCARE HEALTH

Building Bridges of Trust throughout Seattle

Partnership Type
Care Coordination and Co-Location

Situation
Operating in Seattle for over sixty years, Neighborcare Health is the largest provider of primary medical care for people experiencing homelessness in Seattle. Neighborcare recognizes that **this population often experiences trauma, fear, and mistrust**. As a result, it offers several alternative models of care, including neighborhood clinics, outreach, and housing-based care teams to ensure care is patient-centered and offered "on their terms and their turf."

Solution

Housing Health Outreach Team (HHOT) and Street Outreach programs were created to **facilitate relationship-based and trauma-informed touchpoints where people live**. Led by a team of nurses who work in partnership with primary care providers and behavioral health specialists, HHOT offers medical and behavioral health services to residents in permanent supportive housing. Housing providers include the Catholic Housing Services of Western Washington, Downtown Emergency Service Center (DESC) and Plymouth Housing, representing eleven different sites. Along with **favorable resident outcomes**, housing agencies also benefit from **commendatory views of funders** who value health-housing partnership initiatives.

In addition, a **street outreach partnership** between Neighborcare nurses and Evergreen Treatment Services' REACH program connects with clients wherever they are—under overpasses, in encampments, on the streets—to provide nursing support and links to health care. This program also facilitates **low-barrier medication for opioid use disorder** to REACH [lvi] and LEAD (Law Enforcement Assisted Diversion)[lvii] participants at the REACH offices in downtown Seattle and at the Neighborcare Pike Place Market clinic.

Throughout all these initiatives, Neighborcare has relied on support and funding of the King County Health Care for the Homeless Network.[lviii] **Grant funding is essential to cover services that aren't billable.** An important element of the work is building a **"bridge of trust"** with clients so they understand the benefits of going to primary care and addressing chronic conditions for which they may hold shame. This relational work ultimately results in improved health outcomes, billable encounters, and a reduction in visits to emergency departments, often the only resource some thought they could access.

Result

As of 2020, an average of 89% of residents in buildings with HHOT services engaged with Neighborcare through an RN, medical provider, or behavioral health provider. Neighborcare staff also observe that its patients request to stay in buildings with their services even when given the opportunity to move into a newer building.

Keys to Success

- Most important components - Values, Money & Space - in that order
- Successful partners share common values and a sense of being mission-critical to each other
- Grant funding is essential to filling gaps
- Space is the least of issues; a lot of services are provided "where the client is"
- Capital funding for clinic space takes time to garner; start earlier than you think you need to
- Set up regular meetings and lines of communication from day one: "talk early, talk often"
- Level-set on what data can be shared and under what conditions, particularly for grant reporting; implement a Business Associate Agreement (BAA) for data sharing

PENINSULA COMMUNITY HEALTH SERVICES

Collaborative Funding for Medical Respite

Partnership Type

Full-Service Integration

Situation

Peninsula Community Health Services (PCHS) provides **medical, dental, behavioral health, pharmacy, and related services to over 40,000** patients each year in Kitsap, Mason, and rural Pierce Counties. Nearly one in five PCHS patients experiences homelessness. PCHS recognizes that housing insecurity can present in different ways. Last year it introduced a simplified, homegrown **social determinants of health (SDOH) survey**. The top three areas of concern indicated by patients were **housing, food insecurity and dental support.** A supportive board encouraged PCHS to address these areas with new dental clinics, emergency food boxes, and housing initiatives. With limited shelter options in the community, it considered transitional housing and medical respite options.

Solution

As the regional federally qualified health center, PCHS decided a medical respite center aligned best with its mission. **Recent advances in Medicaid coverage** also reinforced this decision. PCHS is preparing to open a 22-bed medical respite center in Bremerton in 2024. The building will also house an onsite medical and behavioral health clinic and two units of supportive housing to be used by peer resident managers. It will serve **people recently discharged from the hospital, as well as those who are ill or injured and need early medical intervention to avoid hospitalization**. Patients will receive 24/7 support for up to 30 days from providers and support staff who will work with each patient to develop an individual exit plan, enabling those experiencing homelessness to safely transition to a more stable environment.

Legislative and community engagement have been major components of the early work. **Capital funding** is coming from **state, county, and local governments**, as well as **foundations, aligned partner agencies, and individuals.** Government sources include Washington State Commerce, Kitsap Public Health District, City of Bremerton, and Kitsap County Community Development Block Grant. Community Health Plan of Washington, Coordinated Care, Molina Healthcare, United Healthcare and Virginia Mason Franciscan Health have also provided start-up funding. Kitsap Public Health District and Virginia Mason Franciscan Health have pledged operational funding support.

Regular meetings with partners, such as the police department, fire department, and Salvation Army, are building awareness of medical respite and allowing their feedback to be incorporated in building and program design. **Early conversations with all five MCOs** also clarified operational funding. **Building design purposely included a clinic** to help cover some operational costs.

Anticipated Result

Medical respite demonstrably reduces health care costs and strain on the health care system by increasing the availability of hospital beds for those who need acute care.

Keys to Success

- Changemaking attitude among leaders is crucial; willingness to not overthink and take things one step at a time
- Decide what core strengths are (medical and dental) and partner for other services (food, crisis services)
- Community engagement ensures buy-in and invites partners to be part of the solution
- Early engagement with legislators and MCOs underpinned funding efforts
- Can start small with just a few units; can always sell real estate if it doesn't work
- Strong relationships are vital and Peninsula community small enough to get things done efficiently
- Site visits were priceless to understand design and implementation details

SEA MAR HEALTH SERVICES

Cross-Sector Partnership to Expand Supportive Housing

Partnership Type
Care Coordination and Co-Location

Situation
Sea Mar Community Health Centers serves 12 counties in Washington state, including the City of Vancouver in Clark County. Sea Mar had been involved with homeless outreach and supportive housing since 2004. It views housing as a key contributing factor to a healthy, fulfilling life and has pursued housing initiatives as a part of its core mission. As an active member of the Clark County HUD Continuum of Care Steering Committee, **Sea Mar observed housing options for low-income or underserved populations shrink**. As the **housing market became more competitive,** individuals with **high health needs were disproportionately impacted**. County and elected officials saw an increasing need to locate behavioral health and housing services in closer proximity to housing. At the same time, the Washington State Health Care Authority (HCA) launched Foundational Community Supports (FCS) which provides supportive housing services to Medicaid beneficiaries with behavioral health needs and other risk factors.

Solution

With strong and motivated leadership Clark County, with the assistance of Andy Silver, **created the Housing and Health Innovation Partnership (HHIP)** to collaborate across sectors to launch FCS in Clark County. **HHIP provided start-up funds** to cover initial staffing and client costs (i.e. birth certificates). Council for Homeless identified people in need of supportive housing and referred them to Sea Mar (then Community Services Northwest). Sea Mar managed enrollment and FCS services at its Meriwether site, co-located in a VHA building, and at other locations in the community. VHA prioritized 308 units and subsidies for FCS-eligible individuals which could be used to help participants afford rent**. In addition to FCS, Sea Mar provides complementary behavioral health services** to support residents. These include Homeless Outreach, PATH programs, Peer Support, Parent Child Assistance Program (PCAP), SSI/SSDI Outreach and Recovery Access (SOAR).

Result

Since 2019, 378 individuals have been served, of which 269 were housed. The Center for Outcomes Research and Education (CORE) conducted an evaluation of the program by matching housing data and Medicaid utilization data. Nearly all FCS participants received housing through the program; 72% moved into permanent supportive housing. In the short-term (3-months after enrollment), participants had greater connection to outpatient services including primary care, specialty care, and dental care. Fewer participants had acute care visits three months after getting housed. In the long-term (12-months after enrollment), fewer participants used emergency department services after obtaining housing, but the proportion of individuals using inpatient services remained the same.

Keys to Success

- Right people in the right roles: a strong change agent and a committed administrative leader
- Relentless commitment of leadership
- Alignment of mission and philosophies of organizations with champion coordinating across the community
- Size of Clark County allowed for viable relationship-building, networking and convening
- Leveraged grant funding as a financial cushion while getting started
- Community-based outreach to clients to build trust with warm hand-offs to services
- Well-defined roles; sticking to what each organization does well; partnering for everything else

YAKIMA NEIGHBORHOOD HEALTH SERVICES

Model for Medical Respite

Partnership Type
Full-Service Integration

Situation
A Federally Qualified Health Center based in agricultural Central Washington, Yakima Neighborhood Health Services (YNHS) serves the chronically homeless through street outreach, primary care, permanent supportive housing, and medical respite. **Of the 23,000 people YNHS serves, about 3,000 are homeless, and approximately 600 are unhoused.** While just 14% of the total client population, this group consumes a much higher proportion of YNHS resources. Recognizing homelessness exacerbates chronic health conditions, is a barrier for engagement, and leads to use of emergency services, the Board of Directors encouraged YNHS to pursue outreach efforts, including the creation of a **dedicated Health Care for the Homeless Clinic** and the acquisition of **mobile clinic vans**. An engaged board member with lived experience continued quarterly focus groups with the region's homeless population, during which they indicated an urgent need for a place to be when they're sick.

Solution

Leveraging a Healthcare for the Homeless (HCN) grant and partnering with the local Continuum of Care and Housing Authority, YNHS **adapted an apartment building for medical respite**, recuperative housing for those not sick enough to be in the hospital but not well enough to go back to the streets. After five years, YNHS pursued new medical respite facilities better suited to the staffing required. In addition to converting a house they owned, **YNHS developed a purpose-built facility on vacant property** that it already owned close to its clinic. Each 5-bed facility is overseen by a registered nurse, behavioral health specialist, outreach worker, care coordinator/case manager, and housing specialist who are all supported at the nearby clinic by medical, dental, and behavioral health providers. Primary care providers or the hospital provider will refer patients to the program, and the HCH nurse at the respite program determines appropriateness of admission.

Significant collaboration with the MCOs have led to reimbursements since 2015. A major accomplishment was the development of a respite billing code, HCPCS G9006, which allows them to submit respite claims. This code represents the care coordination provided by the care team. Each plan has a different financing arrangement, including per-diem or case rate approaches. Currently the program is piloting a fee-for-service arrangement with Medicaid. YNHS also has a **leasing agreement with a nearby motel** to handle excess demand, particularly useful during the COVID-19 emergency and for additional units needing handicap access.

Result

In 2021, the medical respite care program served 199 COVID-19 patients with an average length of stay of 9 nights and 96 Non-COVID-19 patients with an average length of stay of 12 nights. With 85% of referrals coming from primary care, a significant number of unnecessary hospitalizations are avoided. With the daily hospital charge for rehab at $3,600 versus $155 ($454 with primary care) for medical respite, the public cost savings are significant. Returns to hospitalization were reduced by over 50%. The program has a goal of exiting respite patients to stable housing, however due to the lack of affordable housing, less than 30% were able to gain housing at the end of their respite stay in 2021.

Keys to Success

- Supported by an engaged Board of Directors, required as a CHC to have a majority of the board made up of CHC patients/clients.
- Partnered with local Continuum of Care for respite operations
- Leveraged federal programs (including Section 330(h)) for professional team support
- Trialed approach with pre-existing facilities before pursuing a custom build
- Collaborated with MCOs to determine mutually beneficial reimbursement models
- Joined National Health Care for the Homeless Council for training and program standards for medical respite
- Aligned with partners with similar philosophies of Housing First, Harm Reduction, and Trauma Informed Care.

VALLEY VIEW HEALTH CENTER

Leveraging Strengths in Thurston & Lewis Counties

Partnership Type

Referral & Co-Location

Situation

With 13 locations in Lewis, Pacific and Thurston counties, Valley View Health Center provides integrated medical, dental, behavioral health, and pharmacy services to everyone in the community regardless of their ability to pay. As the housing crisis has spread to its region, Valley View is addressing the needs of a growing population of homeless individuals. Adoption of laws criminalizing encampments in Lewis County have added urgency to the need to provide shelter.

Solution

Valley View's approach to housing partnership is rooted in the strategy of **allowing organizations with shared values to leverage their unique strengths.** By collaborating with other community-based organizations in two different shelter projects, Valley View contributes what it does best - access to primary care and other health services.

In Thurston County, Valley View has teamed up with Interfaith Works to provide both **referrals and on-site medical care** in the new Sergio's Place Community Care Center in Olympia. Because of previous collaboration with Interfaith Works on medical respite care, Valley View knew their missions and approach to partnership would align. Sergio's will be a **daytime resource center** to connect people with hygiene services, vital social services, and medical care in a way that **engages people where they are**. It will also serve as an **overflow shelter** during hazardous weather conditions and short-term emergencies. Two **exam rooms** have been included in the **new facility to allow on-site treatment** to be provided two days a week by Valley View staff: a provider, medical assistant and receptionist. At other times, shelter case managers will connect shelter visitors to Valley View services. Valley View is aiming to cover the cost of care with Medicaid reimbursements while paying for occupancy-based cost per square foot. Awaiting final city inspections, Sergio's will be open fully in 2023.

Looking to **duplicate this model** in Lewis County, Valley View has been involved in the early stages of the development of a shelter in Chehalis which will be funded in large part by a **2022 Commerce Cottages Grant**. Designed to be a **night-by-night shelter**, this project has been driven by the community's desire to **ensure residents without homes are not occupying public spaces as a response to the city's strategy to address homelessness**. Because this issue attracts a great deal of political attention, multiple public listening sessions are being held to consider feedback from the community. While progressing more slowly due to lack of local alignment, Valley View is working to identify partners with similar values, as required for project success, in hopes that this **shelter will be another conduit for individuals to connect to vital primary care services**. The shelter contract has been provisionally awarded to the Salvation Army, a partner that shares Valley View's mission of service to all. With **35 beds planned, the facility is still under construction.**

Anticipated Result

Valley View's goal for both projects is to drive more use of their services to ensure individuals have the health care they need to stabilize and improve their lives. Questions about social determinants of health are included in the new patient intake process with the intention of being able to track long-term impacts of making connections to services.

Keys to Success

- Stick to an organization's strengths and find partners to fill other needs
- Importance of shared philosophy with partners
- NIMBY (Not In My Backyard)[lix], political and philosophical barriers can be significant and take time to address
- Community engagement allows good faith conversations among stakeholders

XII.

Keys to success and Assessing Readiness

XIII. KEYS TO SUCCESS & ASSESSING READINESS

When comparing the case studies in this toolkit, several critical success factors rise to the top. These commonalities between successful projects can also provide a framework for assessing an organization's readiness to pursue a health and housing partnership. When evaluating options, leaders can ask - do we have these key success factors in place?

Key to Success	Why?	Assessing Readiness
Strong Leadership	The right leader can overcome the fear of the unknown and analysis paralysis as well as bridge multiple constituencies to make a decision.	Who is the leader in your organization that will drive this project from concept to completion? Do you have the support of your Board of Directors?
Mission Alignment	This is hard work. Mission alignment helps focus multiple organizations on their approach and end goal, while reducing conflict and sticking points.	Does your organization have a strong sense of mission that aligns with others in your community? Are there community barriers to overcome?
Know Core Strengths	Successful partners are built on each organization playing to their core strength and leveraging others to fill in the gaps, rather than building new services from scratch.	What is the core strength that your organization brings to the partnership that will not strain your resources? Who are the organizations in your community that align with mission and compliment your strengths?
Well-Defined Roles	Successful partnerships were built on clearly defined roles and agreements. Regular meetings and communications channels ensured progress without duplicating efforts or mismatching expectations.	Do you know what role you want to play in the partnership? What do you need others to do? Can you commit to regular coordination efforts to ensure success?
Community Engagement & Support	A supportive community can make or break the success of a project. It is important to consider political or NIMBY drivers. When aligned and organized, geographically smaller or tight knit communities more easily overcome these forces.	Is your community ready for this project? If not, does your organization have the time and resources to engage the community in good faith discussions? Is there NIMBY to overcome and do you have a community engagement strategy?

Key to Success	Why?	Assessing Readiness
Being A Good Neighbor	Community engagement doesn't end after a facility opens. Ongoing relationships with surrounding residents and businesses will support the success of your program.	Have you addressed the ongoing needs and concerns of the neighborhood? Do you have a way of keeping channels of communication open? Are you following best practices as a landlord and upholding tenant rights?
Gap Funding	No one program or revenue source covers the entirety of a housing program development, particularly start-up costs. Gap funding will provide a bridge until sustainable revenue streams begin.	Does your organization have knowledge or relationships with sources of gap funding? Have you explored planning grants?
Braided Operational Funding	Along with integrated health and housing services, revenue streams often need to be braided in order for a project to pencil out financially. Rarely does a single program completely fund housing operations.	Does your organization have experience or knowledge of multiple federal, state and local operational funding streams? This guide highlights the capital, operational, and service funds in Washington.
Population Needs Assessment	Effective housing solutions are largely based on understanding your population needs and your ability to align those with services funded by state resources.	Does your organization use tools such as SDOH surveying or a Discharge Planners' Toolkit [lx] to determine alignment between patients and programs that would serve their needs?
Person-Centered Design	By putting your clients at the center of your design, the result is more likely to successfully meet the needs of the population.	Do you have ways of incorporating client needs and preferences in your program design? Can you incorporate best practices from the Tubman Center [lxi] and other leaders in person-centered design?

Key to Success	Why?	Assessing Readiness
Center Work in Equity	In addition to person-centered design, equity should be a central component in all the work done during the partnership process and is necessary in order to achieve health equity and access.	Does your data collection include SDOH and REAL/SOGI (race, ethnicity, language, sexual orientation, gender identity) data? Does your staff have equity focused trainings? Do you have systems in place to engage and include patients/community in partnership planning? How can you incorporate practices recommended in Addressing Health Equity through Health and Housing Partnerships? [lxii]
Client Outreach	Successful programs rely on meeting clients where they are, rather than hoping they'll come to a central clinic. It takes time to build trust before clients are willing to visit a new provider location.	Do you have a plan for client outreach, such as a street team or mobile clinic? Are there grants that fund care coordination or homeless outreach?
Workforce Capacity	Staff shortages, particularly in primary care and behavioral health, are common. It is important to be realistic about the skills and manpower to serve the needs of the partnership and consider whether a phased approach is more appropriate given staffing constraints.	Do you have the staff in place - both administrative and clinical - to expand services into a partnership? What conversations are already taking place among partners that you can leverage?
Start Small	While the need is great, small movements in the right direction build up over time. Successful organizations mapped out milestones and worked one step at a time.	Can you pilot a referral-based partnership to test alignment with an organization? Can you buy a small housing unit rather than building a large complex from scratch?
Site Visits	Visiting organizations already doing this work was cited as a helpful component to support deciding where to start and understanding the required steps.	Are there organizations locally or at the state doing this work? Can they share resources? Contact CHNW staff to connect with organizations to schedule site visits.

XIV. LOOKING AHEAD

As your organization considers pursuing a Health and Housing partnership, this toolkit can serve as a guide to familiarize you with agencies and programs unique to Washington state. Close review of the case studies offered here will illustrate the elements that need to be in place in order to be successful. Consider the questions offered by analyzing the keys to success of other CHCs. When your organization is familiar with the landscape in Washington state and your community, jump over to the CSH *Health & Housing Partnerships Guide* [lxiii] to follow the specific steps to get your program off the ground.

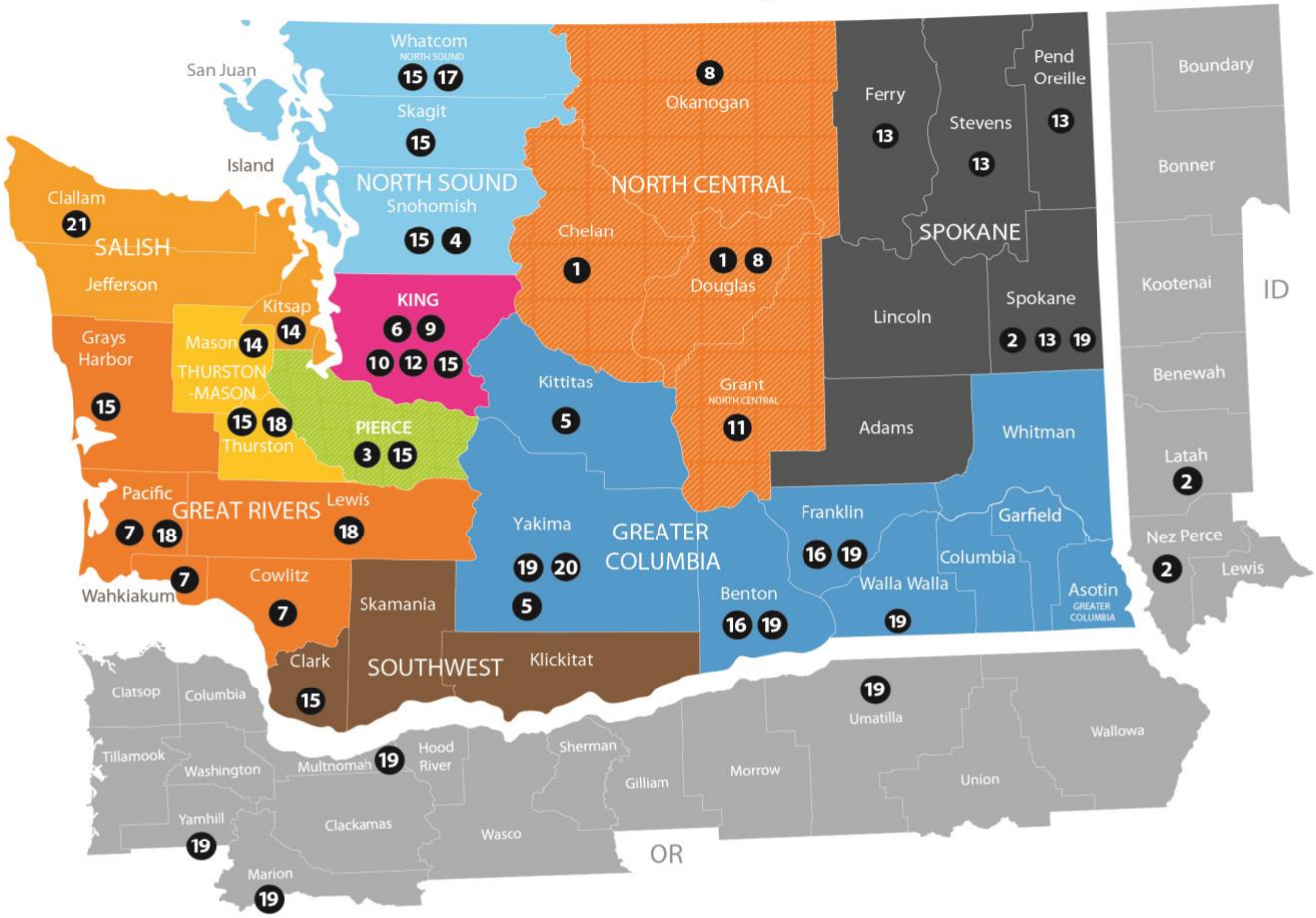
We believe that the work to end Washington state's housing crisis must be done through cross-sector partnerships and collaboration, including with local community health centers. If you're interested in further connecting to Washington state Community Health Centers to serve as partners in health and housing work, or to further discuss their keys to success, feel free to reach out the Community Health Network of Washington representatives who can assist in facilitating connections:

Kat Latet, she/her, Director of Health Systems Innovation, Kat.Latet@chpw.org

Rachel Briegel, she/her, Program Manager Rachel.Briegel@chpw.org

XV. LIST AND MAP OF CHNW COMMUNITY HEALTH CENTERS

CHC Coverage Map



	Community Health Network	County
1	Columbia Valley Community Health	Chelan, Douglas
2	CHAS Health	Spokane IDAHO: Latah, Nez Perce
3	Community Health Care	Pierce
4	Community Health Center of Snohomish County	Snohomish
5	Community Health of Central Washington	Kittitas, Yakima
6	Country Doctor Community Health Center	King
7	Cowlitz Family Health Center	Cowlitz, Pacific, Wahkiakum
8	Family Health Centers	Douglas, Okanogan
9	HealthPoint	King
10	International Community Health Services	King
11	Moses Lake Community Health Center	Grant

	Community Health Network	County
12	Neighborcare Health	King
13	N.E. Washington Health Programs	Ferry, Pend Oreille, Spokane, Stevens
14	Peninsula Community Health Services	Kitsap, Mason
15	Sea Mar Community Health Center	Clallam, Clark, Cowlitz, Franklin, Grays Harbor, Island, King, Pierce, Skagit, Snohomish, Thurston, Whatcom
16	Tri-Cities Community Health	Benton, Franklin
17	Unity Care NW	Whatcom
18	Valley View Health Center	Lewis, Pacific, Thurston
19	Yakima Valley Farm Workers Clinic	Benton, Franklin, Spokane, Walla Walla, Yakima, OREGON: Marion, Multnomah, Umatilla, Yamhill
20	Yakima Neighborhood Health Services	Yakima
21	North Olympic Healthcare Network	Clallam

XVI. CHNW CHC HOUSING PROGRAM CROSSWALK

A high-level analysis of current housing partnerships and programs offered via CHNW CHCs is outlined below.

CHC	General Housing Programs and Partnerships	Foundational Community Supports (FCS)	Medical Respite (Operating/Partnering/In Development)	Health Care for the Homeless Grantee
Community Health Association of Spokane (CHAS)	x		x	x
Community Health Care			x	
Community Health Center (CHC) of Snohomish County	**X**			x
Country Doctor Community Health Center (CDCHC)	x			
Cowlitz Family Health Center	x			x
Family Health Centers		x		
HealthPoint	x			
International Community Health Services (ICHS)	x			
NeighborCare Health	x			
Peninsula Community Health Services (PCHS)	X	x	x	
Sea Mar Community Health Center	x	x		x
Unity Care NW	x			
Valley View Health Center	x		x	
Yakima Neighborhood Health Services	x	x	x	x
Yakima Valley Farm Workers	x			

All CHNW CHCs are key community health providers that engage with the local housing community and provide support services to individuals experiencing homelessness or are housing insecure. In addition to those listed above, we want to acknowledge the work of these additional network organizations:

- Columbia Valley Community Health Services (CVCH)
- Community Health of Central Washington (CHCW)
- Moses Lake Community Health Center (MLCHC)
- New Health
- North Olympic Health Network
- Tri Cities Community Health

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