Salem Housing Authority

Staff Report

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Version: 1

Date: 6/6/2016
Item #: h.

TO: Chair and Housing Authority Commissioners

THROUGH: Steve Powers, Executive Director

FROM: Andrew Wilch, Administrator

SUBJECT:

Application for funding from Willamette Valley Community Health to fund a Regional Health and Wellness Program

Ward(s): All Wards
Commissioners(s): All Commissioners
Neighborhood(s): All Neighborhoods

ISSUE:

Shall the Housing Authority Commission adopt Resolution No. 2188 to apply and receive funding from Willamette Valley Community Health (WVCH) in an amount not to exceed $1.5 million to create a two year Regional Health and Wellness Program to serve housing authority clients?

RECOMMENDATION:

Adopt Resolution No. 2188 (Attachment 1) Authorizing the Executive Director or his designee to submit an application to Willamette Valley Community Health (WVCH) requesting an amount not to exceed $1.5 million to create a Regional Health and Wellness Program.

SUMMARY AND BACKGROUND:

In February, 2016 at a monthly meeting of Housing Agencies and the Willamette Valley Community Health (WVCH) the WVCH announced grant funds were available for health care related programs.

Specifically, WVCH asked for programs that could deliver direct and more predictable health care to low income clients, and at a lower cost. The Salem Housing Authority, West Valley Housing Authority and Marion County Housing Authority discussed healthcare models with WVCH that best supports Housing Authority clients and focused on formulating a Health Navigation Services concept within our Housing communities.

The role of a Health Navigator is to educate residents about the importance of having a medical focus for life, promote positive help seeking behaviors (i.e. accessing the appropriate level of health services), provide health insurance access, provide health information and collect demographic data

for evaluation purposes.

The goals for the Health Navigator are to reduce health disparities for low income households. Health disparities are preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socio-economically disadvantaged populations. Examples of disparities may include: shorter life span, higher infant mortality, higher rates of chronic conditions such as obesity, diabetes, heart disease, cancer, stroke, etc. The rates at which these condition occur in low income households is significantly higher than those found in groups with higher education, higher income and better access to health services.

The outcome of addressing health disparities will be to increase health equity so that every person has the opportunity to "attain his or her full health potential" and are not disadvantaged from achieving this potential due to socio-economic and environmental factors.

Local, state and national initiatives are seeking to improve health outcomes of low income households, improve health equity through health education and increased access to health care services through health insurance enrollment and becoming established with a primary care physician and medical focus for life. By addressing these concerns the overall quality of life and health care for the families we serve improves significantly

FACTS AND FINDINGS:

The Housing Authority of the City of Salem, in partnership with Marion County Housing Authority and West Valley Housing Authority will partner through an Intergovernmental Agreement (IGA) to create a Regional Health and Wellness Program that utilizes Health Navigators within our housing communities to achieve the following goals:

- Reduce health disparities for low income households
- Increase health equity
- Reduce overutilization of high level medical services for chronic and non-emergent needs
- Infuse our housing communities with a culture of health & wellness.
- Gather an unprecedented quality of health related data on every housing authority resident for the purpose of developing programming specific to their articulated health concerns and needs.

These goals will be achieved by introducing Health Navigators into each housing authority community. Navigators will develop activities and services designed to address the above mentioned goals. This may be achieved through health service events held on site by community service providers, health & wellness oriented newsletters, specific to the populations needs, insurance enrollment and helping participants establish an appropriate medical focus and ongoing case management for those who need additional support.

Currently, the funding available for this project is $1.5 million. The estimated budget for this project is expected to reach close to $1 million but will not exceed the limit of $1.5 million. This supports four (4) full time staff for two (2) years each and all related operating expenses. We expect SHA will

hire two positions both on a two-year limited basis, and each of our housing authority partners will hire one position for two year period. Salaries & benefits will make up the bulk of the funding request. Additional funds will be requested to cover operational costs: (office space, equipment, marketing supplies, postage, mileage, events, newsletters, etc.) The grant does not have financial matching requirements

. All data used for reporting purposes or the exchange of information for referral purposes will be protected in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The program staff will receive a comprehensive training on adherence to HIPAA guidelines.

The Health Navigator will strive to achieve certification as a community health worker. Once certified, these workers will be able to submit billable hours to OHP for reimbursement of health services provided under the Alternate Payment Methodology (APM). This creates a revenue stream to continue Health Navigator Services beyond the life of the grant.

The expected outcomes of a Regional Health and Wellness Program are:

- Population specific data revealing the most prevalent chronic health conditions
- Population specific data on the greatest needs for specific health services and health education
- Increased rates of health insurance enrollment as evidence of enhanced health care access
- Reduce utilization rates of emergency medical services for non-emergent health needs
- Increase the rate of medical homes acquired since program began as evidence of improved health equity
- A 100% increase in the rate of "health & wellness" contacts with all housing authority residents
- A comprehensive health assessment on file for all housing households by the end of year one.

Once sufficient data is gathered, all health related services and information provided to residents will be based upon the expressed needs of each unique population within our residents (Families with Children, Seniors and Disabled residents) Access to health care and utilization of appropriate level of services creates enormous savings to the community while improving the health outcomes of those we serve.

Andrew Wilch
Administrator

Attachments:
1. Resolution No. 2188

06/06/2016