MULTNOMAH COUNTY
HEALTH DEPARTMENT

Public Health

MULTNOMAH COUNTY
ENVIRONMENTAL HEALTH

HEALTHY HOMES POLICY TOOLKIT

2010

Produced by the Multnomah County Environmental Health Division

GUIDING VALUES, PRINCIPLES & KEY TERMS 3

INTRODUCTION 9

HEALTHY HOMES POLICY FRAMEWORK 10

HOW WE GOT STARTED 11

WHY ASTHMA? 14

WHAT IS POLICY AND POLICY CHANGE? 17

APPLYING AN EQUITY LENS TO POLICY 19

WHAT IS A HEALTH EQUITY LENS AND HOW DOES IT WORK? 21

CREATING HEALTHY HOUSING POLICY:
CASE STUDIES..... 24

*CASE I: CREATING A COUNTYWIDE ORDINANC*E..... 24

CASE II: AMEND THE STATE HEALTH PLAN TO PERMIT MEDICAID..... 32

STATEWIDE ASTHMA POLICY TALKING POINTS 31

HEALTHY HOUSING POLICY CHANGE WORKSHEET 40

CONCLUSION 41

RESOURCES 44

HOW AN IDEA BECOMES A LAW..... 47

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GUIDING VALUES, PRINCIPLES & KEY TERMS

WHY ARE GUIDING VALUES IMPORTANT?

Identifying guiding values, principles, and theories is an essential step when approaching any public health issue. Throughout this toolkit, you will be introduced to conceptual frameworks and definitions that shape the approaches used by Multnomah County Environmental Health (MCEH). Understanding the principles and theories that guide us contributes to success, whether you are working in a community or trying to influence policy.

MCEH's mission is to promote health by preventing disease and injury. We take an "upstream" approach to addressing health inequities, identifying and addressing the root causes of both positive and negative health outcomes and working at an individual, family, community, and policy levels to fulfill the Multnomah County Health Department mission: healthy people in healthy communities.

GUIDING VALUES AND PRINCIPLES FOR MCEH

Multnomah County Health Department, along with many public health organizations across the country, are moving towards an intentional and important shift in language, focusing on defining, understanding, and appropriately using key terms and best practices. Below, we describe our key values and principles. As you read about our values, begin asking yourself: "What are the core values that will guide the work in our organization?"

HEALTH EQUITY AND ENVIRONMENTAL JUSTICE

Health disparities are differences between population groups in the presence of disease, health outcomes, or access to care. Disparities include both avoidable and unavoidable differences. An example of an avoidable health disparity is that African America males live x years less than the

Our hope is that our hard work can offer direction or serve as a roadmap for connecting health and housing and creating a strong Healthy Housing program in your area.

general population; an unavoidable health disparity is that older people die more often than younger people. **Health inequities** are health disparities that result from a variety of social factors such as income inequality, economic forces, educational quality, environmental conditions, individual health behavior choices, and access to health care. Health inequities are unfair and avoidable.[1]

Our health is determined by how much access we have to the benefits of society and how many burdens we bear. Equity refers to the fair distribution of social and economic benefits and burdens, and inclusive participation in decision-making. Social benefits and burdens are often determined by social policies – how, where, and with whom we invest our collective resources – and affect our health and quality of life.

Central to our health department's values is the importance of eliminating root causes of health inequities. To that end, we seek to develop and implement policies and programs which address root causes of health inequities by striving for both internal change to the organization as well as external change with community members and partners.

Environmental Justice means equal protections from environmental hazards and meaningful participation in decisions that affect the environment where people live, work, learn, practice spirituality, and play. "Environmental justice

1 World Health Organization : http://www.who.int/social_determinants/en/

communities" include low-income communities, communities of color, tribal communities, and other communities traditionally underrepresented in public processes.[2]

Low-income communities and communities of color disproportionately bear the burden of substandard housing and associated negative health effects like increased asthma and lead poisoning. Our commitment to environmental justice and our understanding of the relationship between the environment and health leads us to focus on healthy housing.

EMPOWERMENT THEORY

Throughout the second section of the toolkit, "Empowering Approaches to Healthy Affordable Housing," you'll note we frequently use the word "empowerment." We use a definition of empowerment from Nina Wallerstein, who defines it as "social-action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment." Empowerment has become more important in public health because of three related developments. First, there is increasing evidence that negative social conditions lead to poor health. Second, some researchers have suggested that powerlessness is the common factor among all the negative social conditions and therefore, empowerment is the logical solution. Finally, a number of studies have shown that if we can increase empowerment, we can improve health. Many public health workers feel it's important to work towards empowerment on three levels: individual, organizational, and community.[3] Many also agree that one person cannot empower another, but that we can help to create conditions in which empowerment is possible.

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2 Oregon Governor's Environmental Justice Task Force; http://www.oregon.gov/Gov/GNRO/environmental_justice.shtml

3 Wiggins, N. (2010). *La Palabra es Salud: A Comparative Study of the Effectiveness of Popular Education vs. Traditional Education for Enhancing Health Knowledge and Skills and Increasing Empowerment Among Parish-Based Community Health Workers (CHWs)* (Doctoral dissertation, Portland State University, 2010). Dissertation Abstracts International, in press.

GUIDING VALUES, PRINCIPLES & KEY TERMS

POPULAR EDUCATION

Popular education is a philosophy and methodology for teaching and community organizing. With roots going back more than 200 years in Latin American history and shaped by the work of educator/organizers like Paulo Freire and Myles Horton, popular education aims to create a more just and equitable society. Through the use of interactive techniques such as dinámicas (social learning games), sociodramas (social skits), brainstorming, simulations, and problem-posing, popular educators draw out and validate what participants already know and do, connect their personal experience to larger social realities, and then support participants to work collectively to change their reality.[4]

SOCIO-ECOLOGICAL MODEL

The socio-ecological model recognizes the interconnections that exist between individuals and their environment. While individuals are responsible for taking certain actions to reduce their risk and improve their health, individual behavior is determined to a large extent by social environment, e.g. community norms and values, regulations, and policies. According to MCHD's Health Promotion Framework, while it's important to work and coordinate our activities at each level of the socio-ecological model, that is not enough. We also need to work at each level of the model in a way that is empowering, or in other words, in a way that increases people's control over their lives and their health.

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4 Wiggins, N. & Rios, T. (2007). An Introduction to Popular Education. Community Capacitation Center, Multnomah County Health Dept. All rights reserved.

EXAMPLES OF THE 5 LEVELS OF THE SOCIO-ECOLOGICAL MODEL

INDIVIDUAL: Motivating change in individual behavior by increasing knowledge, or influencing attitudes or challenging beliefs.

INTERPERSONAL: Recognizing that groups provide social identity and support; interpersonal interventions target groups, such as family members or peers.

COMMUNITY: Coordinating the efforts of all members of a community (organizations, community leaders, and citizens to bring about change).

ORGANIZATIONAL: Changing the policies, practices, and physical environment of an organization (e.g., a workplace, health care setting, a school/child care, a faith organization, or another type of community organization) to support behavior change.

PUBLIC POLICY: Developing and enforcing state and local policies that can increase beneficial health behaviors. Developing media campaigns that promote public awareness of the health need and advocacy for change.[5]

What we have learned is that health equity is the why and empowerment is the how. These guiding values have been vital to our successes in creating healthy housing.

5 http://www.livewellcolorado.org/assets/pdf/community-initiatives/communities/west-denver/dph-socio-ecological-model.pdf

INTRODUCTION

In the last 10 years, we have built a Healthy Housing program that takes a holistic approach addressing the health impacts of substandard housing by developing a program that comprehensively targets:

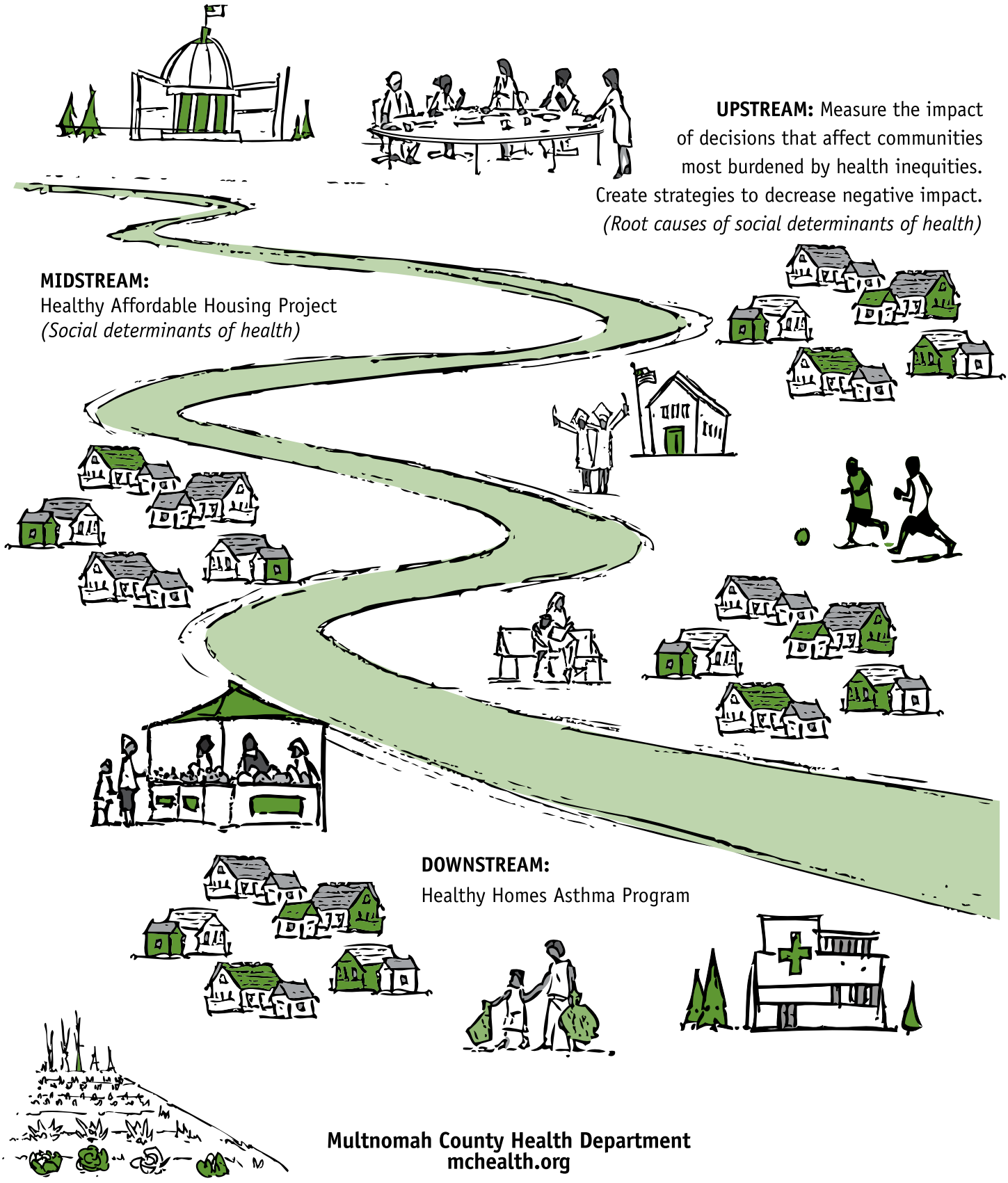
- Low-income children with asthma through our Healthy Homes Asthma Program – a home visiting model that assists children to gain more control over their asthma and identifies environmental home triggers and ways to reduce triggers.

- Landlords and Tenants through our Healthy Affordable Housing Project –a community outreach and education effort that uses the seven principles of a healthy home.

- Doctors and nurses with pediatric asthma patients through our Asthma Inspection and Referral Program (AIR). AIR is a web-based referral system, allowing doctors, nurses and other health professionals to refer their Multnomah County pediatric patients with asthma for a home inspection, conducted by an environmental health specialist.
- Policy makers through various initiatives that address root causes of environmental health hazards, such as strengthening local habitability codes to increase protection of renters' health.

These programs arose in response to a community needs assessment that identified mold, lead, trash and feelings of powerlessness as priority community issues.

HEALTHY HOMES POLICY FRAMEWORK



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Our hope is that our hard work can offer direction or serve as a roadmap for connecting health and housing and creating a strong Healthy Housing program in your area.

KEY AUDIENCES FOR THIS TOOLKIT

Health department directors, environmental health programs, health educators, housing inspectors, state environmental health, asthma or chronic disease programs, housing advocacy groups, legislators, policy decision makers

WHAT IS THE GOAL OF THIS TOOLKIT?

1. Provide definitions on key terms in policy advocacy and change.
2. Present a health equity framework for policy advocacy and change.
3. Demonstrate how to achieve successful policy change through two case studies.

HOW WE GOT STARTED

Multnomah County Environmental Health Services has traditionally served the role of enforcement and regulation – inspecting restaurants and pools and spas, enforcing Food and Drug Administration rules and other such activities. In 2002, the National Association of City and County Health Officials (NACCHO) invited member public health agencies to compete for federal funding to support community-based environmental health assessment activities using a community assessment titled PACE-EH, which stands for Protocol for Assessing Community Excellence in Environmental Health. PACE-

EH was developed by the Center for Environmental Health and NACCHO as a methodology or tool for organizations to use to offer guidance to communities and local health officials for conducting community-based environmental health assessments. The goals of this work are to:

- Identify environmental health issues.
- Prioritize the identified issues.
- Develop action plans.
- Evaluate the progress to address selected issues.

PACE EH improves the environmental health decision-making process by strengthening community involvement so that public values and priorities are considered. We were one of eight sites to receive the funding to be a demonstration site to pilot the tool.

Because sustainable public health interventions can only be developed by serving the self-identified needs of the community, we embarked on our two-year, environmental health community needs assessment. It resulted in the identification and prioritization of healthy affordable housing as a significant environmental health issue. The process was guided by a community coalition, which was comprised of community agencies working in health and housing. The Multnomah County PACE Coalition grew out of this community-driven assessment resulting in the acquisition and implementation of a Housing and Urban Development Healthy Homes demonstration grant.

TIP

CREATING A HEALTHY HOMES SUMMIT

PARTICIPANTS: Identify health and housing service providers, landlord associations, academia, community members and elected officials. Consider Housing Bureaus, Rental Housing Inspection Programs, Multifamily Housing Associations, Tenant Advocate Organizations.

AGENDA: Design your agenda with a framework in mind. We used the "Public Policy Solutions to Advance Healthy Housing" from the Enterprise Foundation. We focused the day on identifying resources and brainstorming solutions for gaps in five key areas:

- Forging coalitions in the community.
- Engaging market forces for change.
- Pursuing stronger regulations and better enforcement.
- Raising awareness among community organizations and developers.
- Focusing further research and advocacy on effective, achievable public policy.

How do I focus the conversation to get results? We had breakout sessions in the afternoon with volunteer facilitators focusing the dialogue with specific questions:

- What mechanisms are in place to assure decent, safe and sanitary housing for low-income renters?
- What resources are available and what additional resources are needed to mediate renter-landlord conflicts?
- Do current definitions, codes, standards and inspections effectively link housing issues with health issues supporting prevention and remediation?
- Identify market incentives for utilization of materials that are healthier for people and the environment.
- What is needed to assure culturally and linguistically competent messages describing the rights and responsibilities of renters and landlords?

The HUD grant's focus was to work with families with children under the age of six with asthma who live in affordable housing. Among the many health problems caused by substandard housing, asthma, because it is chronic and life-threatening, is one of the scariest for families. By taking on asthma we were able to help parents and children gain control over a health problem that causes stress, financial hardship and leads to children missing school days and parents missing work days. We were also able to tackle housing problems that contribute to other chronic health conditions, lack of safety and the feeling of being insecure in one's own home. This was the start of our Healthy Homes Asthma Program. Staff on this grant helped families manage environmental triggers for asthma including mold, rodents, cockroaches, dirt and animal dander, and hazardous household chemicals. Almost 80% of the children in our program were a part of the Oregon Health Plan, our statewide health insurance plan for low-income families and children. Our program evaluation and analysis was based on the health insurer's hospitalization and emergency room utilization data, which demonstrated that children in the Healthy Homes Program had better asthma control, were exposed to fewer environmental triggers and were 2 ½ times less likely to use the emergency department during the intervention as compared to a baseline period.

The multiple partnerships developed under this grant and the preliminary findings of the demonstration grant identified the need to explore the community assets that encourage and the barriers that impede the maintenance of safe, healthy, and affordable housing. To facilitate this, we convened a Health and Housing Summit of key stakeholders. On May 17, 2007,

we hosted the summit to provide information on the connections between health and housing and foster a community-level dialogue. The desired outcomes of the summit were to:

- Inform participants about the Multnomah County affordable housing community assessment model, actions and Healthy Homes findings.
- Create culturally appropriate educational materials about healthy homes.
- Identify data needs and current evidence to support informed policy recommendations.
- Convene housing and health stakeholders to collaborate on long-term sustainable solutions.

Current assets and barriers to healthy housing were identified by engaging participants in presentations on various environmental health issues and housing codes, and framing the day with a presentation on environmental justice. Participants provided advice to help advance housing policy that will improve health.

The findings and associated Healthy Homes recommendations addressed the need to: 1) increase enforceable housing codes in Multnomah County; 2) develop educational resources for landlords and tenants; 3) create a stronger connection between health and housing in public policy; 4) decrease the barrier of maintaining the availability of

SAMPLE HEALTHY HOMES RECOMMENDATIONS

- Create housing codes and enforcement mechanisms in all Multnomah County jurisdictions reflective of national standards supporting the connection between health and housing.
- Educate health care providers about the intersection of the home environment and health.

QUESTIONS TO CONSIDER:

What law, code, set of guidelines, or agreements in your area impact housing?

What public health hazards or conditions are impacted by this policy?

How does your department impact, or could your department impact, this policy?

affordable housing due to remediation costs required to keep properties healthy and safe; and 5) increase understanding of the inverse relationship between affordable, healthy housing and health disparities.

As a result of the summit, many decision and policymakers became more interested in the connection between health and housing, and how their different jurisdictions and bureaus play a role in impacting substandard housing. Several key initiatives and committees were formed after the summit ended:

- The City of Portland's Quality Rental Housing Workgroup formed to review the current complaint-driven housing inspection model and recommended: 1) changes to code language to better address the health concerns of mold, lead, pests and trash; 2) implementing an enhanced complaint-driven inspection program; 3) establishing education and community awareness programs for both tenants and landlords; and 4) creating a community mediation program to create an alternative dispute resolution program. (Appendix Y: QRHWG Executive Summary with website)

- The City of Gresham implemented both complaint-driven and compulsory inspections.

We played key roles in these workgroups, and realized that we could play a larger role in impacting laws, codes, and other local and statewide policies. After considering policies that we could change, we recognized the need to define policy for our

internal team and identify issues we could influence. We wanted to improve the health and quality of substandard housing and help sustain programs that improve the public's health as it relates to where they live. We began our journey by:

• Developing a strategy for creating a rental housing ordinance in the areas where the county has jurisdiction, specifically, the unincorporated areas of Multnomah County.

• Developing a strategy for statewide asthma legislation that would raise awareness with state policymakers about asthma, its connection to housing, and the need for further funding for home visit interventions.

WHAT IS POLICY AND POLICY CHANGE?

Before developing our strategies, we needed to start from the beginning. How were we defining policy? What does it mean to advocate for a change in policy? Are there different kinds of advocacy? What should we keep in mind before we start?

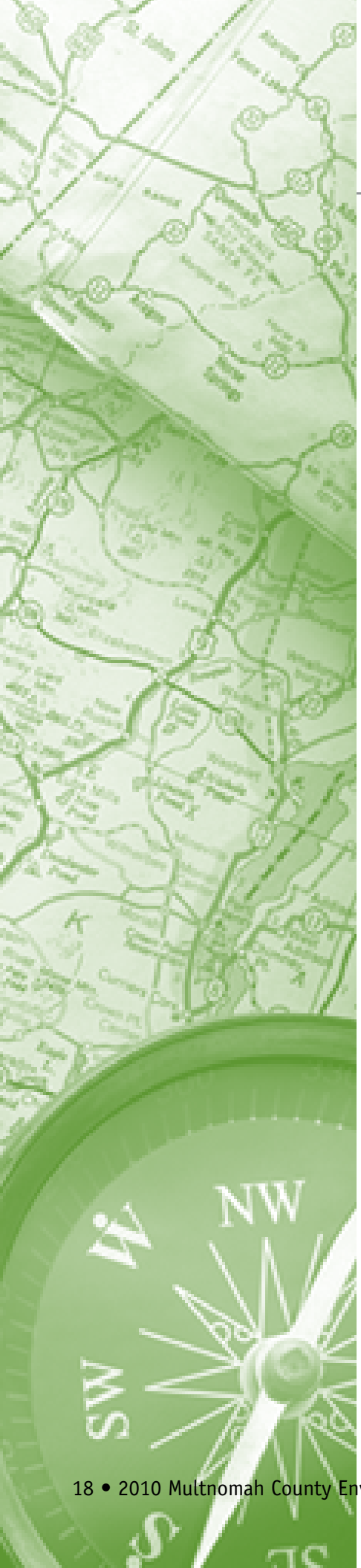
We defined policy as:

• A set of guidelines designed to govern decision-making and actions.

• A plan or course of action(s) selected from evaluated choices.

• Any agreement, formal or informal, on how an institution, governing body, or community will address shared problems or attain shared goals.

In reviewing our Healthy Homes Summit recommendations, we developed some examples of specific policies that might impact the health of community members that live in substandard housing.



EXAMPLES OF HOUSING POLICY THAT MAY IMPACT HEALTH

A city habitability code that guides neighborhood inspectors in citing rental housing violations.
We tapped into the resources from the National Center for Healthy Housing (www.nchh.org), and evaluated our local codes against the International Property Maintenance Code to see if we needed to advocate for "healthier" language.

A state law that allows tenants on month-to-month leases to be evicted within 30 days without cause.
We researched the possible connection between evictions that are related to complaints to housing inspection programs and health issues, such as asthma.

Advocating for a change in a policy means raising critical issues, developing alliances, identifying champions, providing expertise for sound policy decisions, communicating needed policy recommendations to elected officials and key stakeholders, gathering and disseminating valuable data. So once we know the policy we want to change, what is the goal of advocacy? It is to change policies that affect a person's or a population's life, health, and livelihood. By investing in advocating for changes to a policy, we can impact strategic alliances, develop awareness by the public, stakeholders and policymakers about a vital public health issue, and shift public and political will.

Advocacy can take on various forms, from working with your local reporter, to sitting across the table from your county commissioner with a specific set of points to educate them about your issue. These different forms are:

- **DIRECT ADVOCACY** – Educating and influencing decision makers on public policy.
- **PUBLIC ENGAGEMENT** – Building awareness and support.
- **MEDIA ENGAGEMENT** – Getting your message out to decision makers and the public.

Examples of these might include: (Direct Advocacy) Holding briefings with policymakers on your key issue, such as asthma and its connection to healthy housing; (Public Engagement) Hosting community meetings to get feedback from impacted communities on the policy that you are trying to create or change; and (Media Engagement) Using your public affairs office or media liaison to send out press releases about an upcoming meeting or briefing. These different types of advocacy can be key in the development of your policy change strategy.

And lastly, we developed some guiding principles to keep in mind before we set out on our policy change journey. Keep in mind these key tips in order to be effective:

HEALTH DISPARITIES are differences between population groups in the presence of disease, health outcomes, or access to care.

HEALTH INEQUITIES are health disparities that result from a variety of social factors such as income inequality, economic forces, educational quality, environmental conditions, individual health behavior choices, and access to health care.

ENVIRONMENTAL JUSTICE is, "the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies."

"During my administration, Multnomah County will work to eliminate disparities based on race and ethnicity that exist in our community, and we will challenge other community institutions to work with us to make this happen."

- **BE INTENTIONAL** - Know what you want to accomplish and be focused.

- **BE STRATEGIC** – Think through the process, and take into account all challenges, even unlikely ones.

- **BE FLEXIBLE** – Adjust talents as needed and adapt to changes in political climate.

- **BE ORGANIZED** – Have a plan of action that informs, connects and involves people.

Core to our health department's values is eliminating root causes of health disparities. To that end, when applying an equity lens to policies, we highlight and take action in policy solution areas addressing root causes of health inequities and disparities, and use environmental justice as a value when making decisions about our policy work.

In April 2007, the Chair of our Board of County Commissioners stated, "During my administration, Multnomah County will work to eliminate disparities based on race and ethnicity that exist in our community, and we will challenge other community institutions to work with us to make this happen." In June of 2007, the Board of County Commissioners and the Multnomah County Health Department funded the Health Equity Initiative, a countywide effort focusing on health

For more on our Health Equity Initiative, visit: mchealth.org/healthequity

inequities. The Initiative supports the County's commitment to improve the health of all Multnomah County residents by considering the ways that societal conditions in which we live, learn, work and play affect health. This political will and leadership played a huge role in helping us to move our policy goal forward and contributing to direct advocacy.

By improving living conditions of vulnerable populations, we were addressing a root cause or social determinant of health. Our goal was to help children with asthma improve their health by changing rental housing codes and state law that impact healthy living conditions and access to funding supporting home-based asthma interventions.

We built our policy change efforts around asthma incidences and asthma triggers in substandard housing, highlighting asthma's impact on environmental justice communities, which are areas in our county comprised mostly of low-income community members and communities of color that are disproportionately impacted by harmful environmental hazards, such as diesel particulate, that have an impact on their health. These communities have historically not played a vital role in the policy decisions that impact their health.

A health equity lens involves several components. Here's a look at how we applied this lens to shape our policy work:

KEY QUESTIONS TO ADDRESSING HEALTH EQUITY IN HEALTHY HOUSING WORK:

What environmental health issues and hazards are prioritized by the community as problems and concerns?

Are impacted communities involved in the policy making decisions that impact them? If not, why? How could they be?

What data exists and what data needs to be collected that shows the relationship between health effects and communities of color and people in poverty?

What is the return on investment or cost benefit for preventing these health effects?

ANALYZED DATA AND INFORMATION

During our community needs assessment phase – our PACE-EH process – we collected data through a variety of tools. Community members did photo voice projects where they walked their neighborhoods and took pictures of what they thought were environmental health concerns in their area. Community organizers walked door-to-door with surveys. We also worked with our Health Assessment and Evaluation Department to collect:

- Local city rental inspection violation data
- State health division asthma data for our county
- US Census Bureau data on people of non-white origin and people below the federal poverty level
- Oregon Department of Environmental Quality data on benzene and diesel particulate concentrations
- American Housing Survey data on housing conditions in Portland, Oregon

IDENTIFIED HEALTH DISPARITIES

Our team created maps of the above data and laid them one on top of another, and discovered that the areas with the highest diesel and benzene levels, with the most rental complaints and violations and worse housing conditions were also the areas where low-income communities of color lived. Those areas also had the highest rates of asthma. We researched the costs associated with asthma that impact our financial

system. For example, the cost of school days missed by a child with asthma because of an exacerbation that caused them to go to the emergency room and the cost of an ER visit and hospitalization after being admitted. This demonstrated the savings of supporting interventions and policies that prevent asthma attacks.

• Include data gathered from community members most impacted by health disparities in the creation and editing of policy

• Define environmental justice (EJ) areas within your community. Our definition of EJ is the right to a decent, safe quality of life for people of all races, incomes and cultures in the environments where we live, work, play, learn and pray. In an effort to "define" EJ communities in the Multnomah County geographic area, we had seven key criteria:

1. Large percentage of people of non-white origin
2. Low-income residents
3. Disproportionately affected by environmental and health threats
4. People with less political power
5. Exposure to multiple environmental problems
6. The community welcomes our support
7. Availability of existing data on that area

• Convene a coalition of community members in one of the areas. Assess and prioritize environmental health concerns in the area. Align these stories and priorities with evidence-based data and literature.

• Brainstorm recommendations for policies to impact identified areas.

• Name disparate impacts explicitly when talking about problems and solutions

By combining data, community priorities, and stories about how community members' health is impacted by their key issue – substandard housing in our case – we were able to tell the story about the connection between health and housing. We designed key talking points, otherwise known as our "elevator" or "30-second" speech. Our talking points included:

• A stronger connection between health and housing needs to be created in public policy. The need and will exists to make progress on connecting health with housing.

• Lack of affordable and healthy housing increases health disparities. Asthma prevalence is 8.4% in Oregon children less than 18 years of age, and is more than double that among the Medicaid population.

• Only the City of Portland has enforceable housing codes in Multnomah County. Gresham will begin its rental inspection program soon, and have an enforcement role. We need stronger housing codes that ensure tenant's health is protected.

• By investing in strong policies and public health programs now, we can save money. The average cost of an ER visit with asthma as the primary discharge diagnosis is estimated at $823. The average cost of hospitalization is estimated at $5,956. If we address the root causes of asthma attacks, our system will save money.

CASE I: CREATE A COUNTYWIDE RENTAL HOUSING ORDINANCE

Having done our community assessment and built the foundation of the need for healthier housing to improve the health of children with asthma, our next step was to determine a specific policy. We re-visited our Healthy Homes Summit recommendations. Both at the summit and through our community process (PACE-EH), community members stated that we needed a countywide rental housing ordinance that would protect renters, especially those with health issues, from living in uninhabitable rental units that breed mold, have lead paint, and provide homes for rat and cockroach infestations. We began the steps of policy change toward our goal:

1) CONDUCT INTERNAL CAPACITY ANALYSIS

Before proceeding on a selected policy, it's important to make sure you have the necessary skilled staff to support the advocacy process from start to finish. It can help answer these key questions:

- What is our internal capacity to advocate or create a policy?
- Do we need to build our own internal capacity? Do we have enough people, with the time and skills to implement the plan? What skills do we need that we may or may not have?
- What are our internal strengths and weaknesses as advocates? What skills do we need to obtain to turn our strengths into weaknesses?
- Is our goal winnable? What is the timeline for successfully achieving our goal?

We had a program development specialist (which could also be a program coordinator or health educator) and a program manager that created our policy team, however, we needed to strengthen our policy message

development skills. A local university offered a class by a state legislator that gave our team great skills for navigating the policy change journey.

2) ENSURE KEY STAKEHOLDERS ARE INVOLVED IN CREATING POLICY AGENDA

Equity in practice means involving the community in decision making at the initial phase of developing a policy agenda. The community must be the driving force of policy decisions because the community is impacted by policy decisions.

• Conduct meetings with key stakeholders to shape the policy. The community needs assessment we concluded in 2003 was the start of community driving our policy priorities. We redefined community so that we could include key stakeholders in our policy change process. We created a Stakeholder Advisory Committee comprised of renters, landlords, property managers, fair housing advocates, and lawyers that met three times over a six-month period to help develop the kind of rental housing ordinance we would put in place.

• Educate community and health department policy advocates about the political process you are trying to impact. Know the process for policy development in your department. There may be others in your health department that can contribute to your direct policy advocacy. It's important to meet with colleagues and inform them of your process, and keep leadership aware of your efforts as you move forward so that you have multiple allies to deliver your "30-second speech."

3) SET CLEAR POLICY ADVOCACY GOALS

Work with community to turn wants and needs into tangible, achievable goals. During the Stakeholder Advisory Meetings, we answered the following questions:

- What is the issue being addressed?
- Who is affected by the issue?
- What are the causes of the issue?
- What are possible solutions? (include all viewpoints)
- What action is needed next?

As a result of our stakeholder meetings, we agreed on common terms – the committee was willing to support a complaint-based rental inspection program, wherein tenants would be able to make a complaint to receive a housing inspection to cite possible violations. The committee was also willing to support an assessment of the exterior of potential rental housing to gain better data about the quality of housing stock in that area. Our

TALKING POINTS FOR OUR BOARD OF COUNTY COMMISSIONERS

Substandard housing conditions are a key reason why poor families suffer high rates of asthma.

Housing codes are a proven method for targeting environmental triggers of asthma and other illnesses.

WHAT ARE THE SPECIFIC ISSUES?

- Leaky pipes breed mold.
- Dead insects create dust.
- Mold and dust are key triggers of asthma.

Housing inspectors can spot these risks to human health and make sure they are addressed.

Our partners in Portland and Gresham have taken action on this issue. We're now ready to do our part.

WHAT'S OUR PLAN?

1. NOW: Get an ordinance on the books that allows us to inspect properties in response to complaints.
2. NEXT 9 MONTHS: Survey conditions of rental housing in unincorporated areas over the next year in order to develop a response based on data.

clear policy goal was defined as "pass an ordinance that allows the Health Department to respond to complaints by renters in rental housing in the unincorporated area of Multnomah County" and "to pass a resolution that allows the Health Department to conduct an assessment of the exterior of rental properties in the unincorporated area of Multnomah County."

We agreed with our stakeholder advisory group that we would reconvene the group after six months, review the assessment data, and decide whether to create a rental license fee to support a mandatory annual inspection program or maintain the complaint-based inspection program that would already be in place. It was important for us to be clear about what the group would be willing to accept or compromise.

4) GAIN FURTHER COMMUNITY INPUT THROUGH OUTREACH AND MEDIA ENGAGEMENT

Next, we held two community meetings in the impacted area to present our policy goal and to hear feedback about our suggested policy. We created a communication work plan involving our public affairs office to inform stakeholders and the media. Our activities included:

- Developing easy-to-understand key messages for community members, then converting those messages into a FAQs (frequently asked questions) sheet.
- Creating a simple website.
- Using several methods of outreach to inform the community of our meetings, such as: a) posting public meeting notices at stores, churches, and schools; b) putting information in

the local community boosters and neighborhood association newsletters; and c) direct mailing meeting notices to all the property owners and the residents of the properties.

- Releasing a time sensitive press release.

5) ANALYZE AND FRAME THE POLICY ISSUE YOU ARE ADDRESSING

As a result of our stakeholder and community meetings, we developed a sheet of concerns and issues that were raised. They included:

- Fees and fines
- Program abuse potential
- Fairness
- Confidentiality and privacy
- Government intrusion, expansion, imposition on property rights
- Notification to the public, landlords, and tenants about this process
- Tenant education

After receiving this feedback, we transformed the concerns into key guiding principles to ensure that our policy goal and implementation of the policy would align with our stakeholders concerns. The principles are:

- Minimal impact on tenant privacy and retaliation
- Prioritize housing issues related to health and safety
- Align solutions with identified issues
- Ensure fees are true costs of program and transparent
- An enforceable mechanism exists for housing complaint response
- Integrate education into the inspection process
- Evidence-based
- Assure ongoing education and opportunity for stakeholder input

Understanding the primary issues and concerns and translating them into guiding principles were vital in engaging and educating the key people who make decisions regarding housing ordinances and the people who can influence them. It helped our county commissioners have confidence that we had connected with key stakeholders, understood and heard their concerns, and created a collaborative solution. Our next step was to map out a plan to educate and persuade each decision maker. Our key audience was the Board of County Commissioners, and our plan was simple:

• Meet with the county attorney to draft a complaint-based rental housing ordinance and a resolution to assess the exterior of a random sample of rental properties in the unincorporated areas of the county. We had to review our existing county ordinances and codes, and create a new ordinance that included enforcement capabilities that was legally acceptable with our attorney.

• Create talking points or key messages around the issue. We developed an information sheet that included why we were concerned about the connection between health and substandard housing, what the specific concerns were, and what our plan was for addressing the issue. Our plan is also considered "the ask" or what we need or want from our policymaker.

• Schedule 30-minute meetings with each commissioner and her or his chief of staff. We took our information sheet, and gave a brief 2- to 5-minute presentation to each commissioner and discussed our community assessment and Healthy Homes

STATEWIDE ASTHMA POLICY TALKING POINTS

Healthy Homes Healthy Children is a program that brings public health nurses and community health workers into communities for the purpose of reducing asthma among children and helping them overcome asthma triggers. The program:

• **SAVES LOST WAGES.** Parents' lost productivity associated with asthma care is estimated at $344.00 per day. It is estimated that on average, children with asthma lose 2.48 school, preschool, or day-care days per year. With the projected intervention, it is expected that the project will save an estimated $853.12 of parental lost productivity.

• **EXPORTS A SUCCESSFUL NURSE HOME VISITING MODEL, SHOWN TO IMPROVE HEALTH OUTCOMES, STATEWIDE TO RURAL COUNTIES.** Uses a multidisciplinary home visiting team comprised of a community health nurse and community health worker focused on identifying and overcoming asthma triggers.

• **DECREASES EMERGENCY ROOM VISITS FOR CHILDREN ENROLLED IN THE PROJECT.** Multnomah County Healthy Homes' participants were 2 ½ times less likely to use the emergency department after the intervention.

• **REDUCES CHILDREN'S EXPOSURE TO ASTHMA TRIGGERS (TOBACCO SMOKE, DUST, CHEMICAL IRRITANTS, MOLD AND INSECT/RODENT TRIGGERS)** by 60 percent by providing parents and caregivers sufficient knowledge of common substances in their home that can trigger asthma attacks.

• **IMPROVES ASTHMA CONTROL.** The in-home nursing assessment intervention improved understanding of medication use resulting in improved asthma control sustained over six months after the last visit.

• **IMPROVES HEALTH EQUITY BY FOCUSING ON ASTHMA CONTROL AS A HEALTH DISPARITY.** Asthma prevalence is 8.4% in Oregon children less than 18 years of age and is more than double among the Medicaid population.

Summit, and requested their support for the ordinance when it comes up for a vote at an upcoming briefing. This step should not be underestimated. Making sure you know which commissioners support your efforts fully, and which have reservations and why, is key to tailoring your presentation at the briefing, and to helping to address any concerns that may be present.

PHASE I:

- Educate yourself on "policy making basics"
- Research legislators and key issues
- Connect with your government relations liaison
- Identify organizations that can be allies
- Engage public health colleagues
- Listen, listen, listen

- Schedule a briefing on the official Board agenda to pass the ordinance and resolution. A formal presentation is necessary to have a vote on your ordinance. Make sure you get in your paperwork to your department staff and head, connect personally with the board secretary or scheduler, and make sure your presentation handouts and PowerPoint is provided in a timely manner.

- Work with stakeholders to provide testimony. We reached out to the National Center for Healthy Housing (NCCH) for testimony support. Our presentation was a brief PowerPoint slideshow about the connection between health and housing and our stakeholder meetings. We invited several stakeholders to testify in support of the ordinance and assessment, and requested NCHH's presentation to demonstrate that we are aligning our local work with national standards or best practices for healthy housing.

- Reconvene stakeholders and provide recommendations for next steps within nine months of the housing assessment.

The ordinance and resolution were passed on September 3, 2009. We conducted the assessment, reconvened our stakeholders, and updated the Board of County Commissioners at an information briefing on April 27, 2010. The ordinance now in place is a complaint-based rental housing ordinance.

CASE II: AMEND THE STATE HEALTH PLAN TO PERMIT MEDICAID COVERAGE FOR HOME NURSE VISITS FOR CHILDREN WITH ASTHMA

While we were working on our housing ordinance policy advocacy, the grant funding for our Healthy Homes Asthma Project began to dwindle, and we were challenged to keep the program alive through taxpayer dollars in the economic recession. In addition to our incredible outcome data, clients in our program – children with asthma under the age of six – and their families fully supported the intervention and testified to improved asthma control because of their involvement in the program. We began the process of exploring what policy we could advocate for or change to continue to improve the lives of children with asthma who live in affordable housing. We began to explore the possibility of a state policy that might help to continue to fund our project.

This would be a policy change effort that we would push forward strictly because the community need for the program was in high demand and the program was evidence-based and extremely effective. Therefore, the community engagement step was already complete – sometimes the community informs you through demand of what needs to happen to create healthy communities. In this case, it was in-depth asthma case management in the home and conducting environmental assessments of asthma triggers such as mold and cockroaches and identifying solutions for removing the triggers. The program model uses a community health nurse and community health worker who visits every family, on average, six-eight times over a six-month period. The nurse's role is to support

the family with asthma management and to develop a care plan to improve asthma management, while the community health worker's role is to conduct an environmental health home assessment and to develop a care plan to reduce or eliminate asthma triggers within the home environment. This occurs through behavior change or coordinating with community organizations to provide resources such as new mattresses.

PHASE II:

- Set a clear policy goal
- Revise key points
- Directly advocate and educate
- Engage the media
- Tell the facts and personal testimony of success
- Carefully plan and hope for good luck

We used several of the key steps from our other policy initiative, realizing that the steps were not linear, but rather that we would go back and forth between steps as we moved forward. Thus, as we walk through our process, you will note the steps being used repeatedly.

We started our journey again by analyzing and framing the policy issue. We used our data reflecting health disparities and children with asthma in Multnomah County – the literature review and mapping process from our earlier policy efforts – and the results from our Healthy Homes Asthma Program to create talking points about why we were asking the state for funds to keep the program running. Then we mapped the initial phase of our plan:

- Educate ourselves in "how a bill becomes a law." Remember government class in high school? We needed to remind ourselves about our own state processes for bill and rule making and learn key dates in our legislative session.

• Identify state legislators in the districts within the county and the legislators on the Oregon State Senate and House Health Care committees. Research and understand the key issues they have advocated for in the past.

• Identify children and families with asthma – constituents – within key legislator districts and learn their story. Bringing a face to the problem helps strengthen the need for a solution.

• Connect with our county government relations liaison and understand our county government process for prioritization of the policy that will result in advocacy by the county liason. Within our government system, we have one lobbyist. This lobbyist has limited time and many competing issues at our state Capitol. We had to ensure that our policy issue became a priority for their time, and that they were highly educated on our issue. This meant reconnecting with our commissioners and educating them about our next policy initiative and advocating for lobbyist time.

• Establish strategic alliances with lobbyists in associations and organizations. We identified several groups that were invaluable to supporting our process and helping us understand which legislators we should prioritize contacting, how to make the most efficient use of our time with these policymakers, and how to navigate the legislative session and policy system. The organizations were: Oregon Nursing Association, Oregon Primary Care Associations, Oregon Public Health Association, Oregon Medical Association, and the American Lung Association Oregon Chapter.

• Research national policy efforts to fund Healthy Homes Asthma programs.

HEALTHY HOMES HEALTHY CHILDREN STATEWIDE ASTHMA LEGISLATION

Proposed Concept Language for Bill Drafter,
November 2008

Directs the Department of Human Services (DHS)/Public Health Division, Office of Maternal and Child Health, to develop rural and urban pilot programs in asthma intervention in high risk areas to be administered through local public health authorities' nurse home-visiting programs.

The DHS, Office of Maternal and Child Health will initiate a request for proposal selection process for the rural public health authority. Effective asthma intervention programs are defined as a program providing six home visits to low-income families with an asthmatic child supported by the following components: 1) multidisciplinary team with a nurse case manager, 2) provision of supplies including vacuum cleaners, green cleaning materials, mattress covers, 3) multiple housing partners who work to facilitate structural repairs or relocation, and 4) an evaluation component that drives quality practice change and defined outcomes.

Sunsets January 2, 2011.

Relating to public health nurse home-visiting services; appropriating money

• Engage State Public Health Division colleagues. Many public health legislative or policy issues are advocated for through our Coalition of Local Health Officials. We, therefore, prioritized meeting with the executive director of CHLO and the state public health director to seek advice, input, and support for our issue.

Once we identified our legislators and strategic alliances, we started knocking on doors and making phone calls to gain input through direct advocacy. Sometimes our initial communications with staff to set up meetings were "cold calls" and other times we used a contact from one of our allies or a county commissioner to help open the door to get a timely meeting. We told the stories of our families and their emergency visits to the hospital and the need for someone who can help them learn to manage their asthma and advocate for changes in housing conditions to eliminate asthma triggers in the home.

As our meetings multiplied, we slowly began to unravel what our policy initiative might look like in the 2009 State Legislative Session – a general fund bill modeled after King County, Washington. Thus, we set a clear policy goal: we would seek funds from taxpayer dollars for an additional year of program implementation with the intent of doing a smaller pilot project of the program in a rural county to demonstrate the diverse need for the program.

We went back to the drawing board and decided on steps for out next phase: revise our talking points to reflect our general fund request, focus our energy on coordinating briefings to the Senate and House Health Care

CORE TARGETED CASE MANAGEMENT FUNCTIONS

- **ASSESSMENT**
- **CARE PLAN DEVELOPMENT**
- **LINKING AND COORDINATING SERVICES**
- **MONITORING AND FOLLOW-UP**
- **RE-ASSESSMENT**

Committees on "the state of asthma", and engage the media and our allies in raising awareness. We held two briefings in the summer of 2008 with these key components:

- Introduction of the connection between health and housing, by the Multnomah County Environmental Health (MCEH) program manager

- Place Matters: Illustrating this connection with health equity through a brief clip of the PBS "Unnatural Causes" series (http://www.unnaturalcauses.org), by a Multnomah County Health Equity Initiative representative

- Asthma facts and statistics, by the Oregon Public Health Division asthma manager
- Our Healthy Homes Program facts, by an MCEH Healthy Homes community health nurse
- Our Healthy Homes story, by an MCEH Healthy Homes client
- Why policy is needed, by a King County, Washington Healthy Homes representative
- Conclusion and "the ask", by the MCEH program manager

Prior to each briefing, we worked with our public affairs office to draft and distribute a press release and solicited reporters to cover our Healthy Homes story in an effort to engage media

and influence policymakers. Several families were willing to be interviewed about the program's success, The Oregonian, our statewide newspaper, and Oregon Public Broadcasting radio covered the story in between our scheduled briefings. These moments were a combination of careful planning, and luck.

During the briefing with the Oregon House Health Care committee, the majority of representatives suggested that due to the economic recession, a new funding ask would be challenging to pass. However, one representative would ask Legislative council to draft a bill to support our program, as well as a rural pilot project, and submit it during the 2009 Session. Representative Tina Kotek noted that our program needed a policy initiative that would allow the program to be fiscally sustained. She suggested that because the majority of our Healthy Homes clients were on the Oregon Health Plan, which is the state plan that provides Medicaid coverage for low-income community members, the managed care plans and Organizations should be covering this service through funding from Medicaid. She encouraged us to meet with the few local managed care providers, who are contracted through the state Division of Medical Assistance Programs (DMAP).

The circle then looped back – we watched the drafted bill "die" in legislation, set a new, clear policy goal, revised our talking points, and began a new round of direct advocacy. Our new policy goal was: to create a targeted case management Medicaid billing code for our Healthy Homes Program, serving children (18 years and younger) with asthma. We mapped out our new strategy:

• Convene the directors of managed care plans in Multnomah County with leadership from the representative who became our champion.

CORE TARGETED CASE MANAGEMENT FUNCTIONS

- **ASSESSMENT**
- **CARE PLAN DEVELOPMENT**
- **LINKING AND COORDINATING SERVICES**
- **MONITORING AND FOLLOW-UP**
- **RE-ASSESSMENT**

• Revise talking points to highlight per member, per month costs and improve return on investment data.

• Identify a champion within DMAP to help carry our work forward. All our legwork and door knocking paid off, as several legislators contacted the Oregon director of Health and Human Services and the Governor's policy analyst, and asked them to make sure our project would be fully supported within DMAP.

• Research national efforts related to billing for asthma-related, community-based work such as asthma education or nurse home-visiting models. We used various forums like the EPA Asthma Educator list serve and other mechanisms to contact and interview programs in hopes of not reinventing the wheel. We were fortunate that Health Resources in Action (http://www.hria.org/) had created a great document titled "Investing in Best Practices for Asthma: A Business Case for Education and Environmental Interventions." With cooperation from HRIA, we created our local version of the document as a valuable tool in proving the case for a Medicaid billing mechanism.

• Research statewide existing targeted case management groups (TCM), identifying lessons learned and best practices for implementing and monitoring this billing method. We connected with Babies First!, HIV, and high-risk children programs statewide to learn about various provider requirements, payment methodologies, and the different aspects of case management.

• Identify key steps to implementing a TCM, submit an amendment to our state health plan that would need to be approved by the Center for Medicaid Services (CMS) and create administrative rules that support our TCM for state documentation. The first goal – submit a state plan amendment (SPA) to CMS – would request the federal government to approve the State of Oregon to use its Medicaid money to cover our Healthy Homes Program. Case management has several core functions and our job was to understand which parts of our program fell into which core function. Once we determined this, we had to decide how we would define provider, what we wanted to require from providers as far as skills or training, and how we would bill for our services (i.e. Would we bill per every 15 minutes or per encounter or unit, and how would we define unit?). Lastly, we had to ensure that our costs would include both indirect (travel time, administrative support) and direct (salary of community health nurse and worker) expenses.

• Develop a plan and timeline and coordinate monthly meetings with DMAP staff. We had enough funds to maintain our program until December 31, 2010. We developed a plan to receive approval by July 1, 2010, giving us a buffer of time if the process was delayed.

The SPA was submitted to the Regional Center for Medicaid Services in April 2010, and we have a 90-day decision-making period, during which CMS can ask questions about our submission. The submission includes all services of the Healthy Homes Program, inclusive of the asthma management and environmental health assessment and care plan development, as well as monitoring and reassessing those plans and the linkage and coordination with community agencies and resources, physicians and health plans.

HEALTHY HOUSING POLICY CHANGE WORKSHEET

IDENTIFY YOUR POLICY:

What law, code, set of guidelines, or agreements in your area impact housing? _____

_____

IDENTIFY THE HEALTH HAZARD OR CONDITION IMPACTED:

What public health hazards or conditions are impacted by this policy?

_____

_____

IDENTIFY ACTIVITIES:

How does/could your department impact this policy?

_____

_____

IDENTIFY DATA SOURCES:

What housing, demographic, etc. sources exist to help frame this policy issue?

_____

_____

IDENTIFY PARTNERS:

What community organizations, government agencies, housing providers, etc could contribute to the process?

_____

_____

IDENTIFY INTERNAL CAPACITY:

What is our internal capacity to advocate or create a policy? Do you have enough people, with the time and skills to implement the plan? What skills do you need that you may or may not have?

_____

_____

CONCLUSION

When we began our policy work, we were not savvy in navigating the political process or well-informed about where to go, who to talk to, and how to develop a specific policy to meet our needs. Our strengths were in building relationships, translating community members' concerns into solutions, highlighting the value of public health, persisting when necessary and being flexible in our approach and strategy when we needed to be. We learned the different cultures of the organizations with which we were advocating – the "language" of the Division of Medical Assistance Programs, the concerns of managed care plans, and the needed detail for the Center of Medicaid Services. We also gave ourselves permission to make mistakes, to feel awkward in these new and unknown settings, to trust and rely on those who knew more than we did, and of course, to be frustrated at times. Policy change can be challenging and controversial, and sometimes we felt lost and unsure. However, by being intentional, strategic, flexible and organized, we always found our way and moved forward to achieve our goal.

Policy change can be challenging and controversial, and sometimes we felt lost and unsure. However, by being intentional, strategic, flexible and organized, we always found our way and moved forward to achieve our goal.

Photo by Leah Nash

RESOURCES

While there are many resources on these topics, here are a few that were especially helpful to us in our process:

Empowerment and Popular Education
Popular Education News website:
http://www.popednews.org/

World Health Organization
Page on community empowerment:
http://www.who.int/healthpromotion/conferences/7gchp/track1/en/index.html

Ottawa Charter for Health Promotion:
http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Health Equity and Environmental Justice (EJ)
National Association of City County Health Officials Healthy Equity page: www.naccho.org/topics/justice

Unnatural Causes: www.unnaturalcauses.org

Environmental Protection Agency's Environmental Justice website: www.epa.gov/environmentaljustice

Organizing People, Activating Leaders (OPAL): Portland-based EJ organization: www.opalpdx.org

King County, Washington Health and Equity Initiative: www.kingcounty.gov/exec/equity

Healthy Homes and Asthma Alliance for Healthy Homes: www.afhh.org

Association for Asthma Educators: www.asthmaeducators.org

Centers for Disease Control Healthy Homes: www.cdc.gov/healthyhomes

Health Resources in Action: www.hria.org

National Center for Healthy Housing: www.nchh.org

Policy Development and Change
Oregon State Legislature: (Specifically: How a Bill Becomes a Law): www.leg.state.or.us/citizenguide

PolicyLink: www.policylink.org

HOW AN IDEA BECOMES A LAW

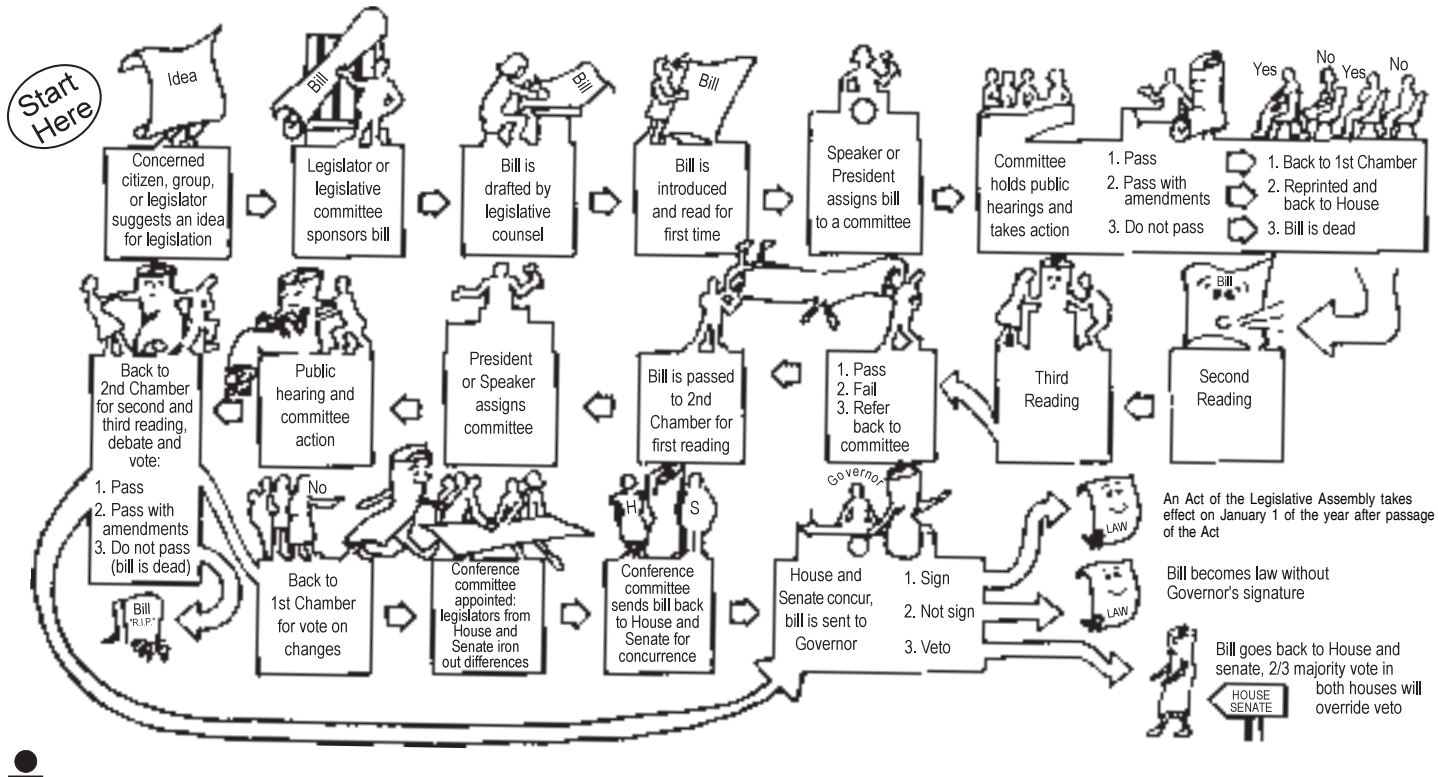
The legislative process is governed by rules, laws and procedures, making it somewhat mechanical in nature. Although the legislative process is long and complex, all laws begin as ideas.

An idea for a law can come from anyone; an individual or group of citizens, a legislator or legislative committee, the executive or judicial branch, or a lobbyist. By statute state agencies must presession file bills. Legislators or legislative committees may file an unlimited number of measures within established timelines set by rule.

If deadlines are missed, the Senate Rules Committee must approve requests for drafting and/or introduction to the Senate. Appropriation or fiscal measures sponsored by the Joint Committee on Ways and Means are exempt from filing deadlines and may be introduced at any time.

How An Idea Becomes Law

A Simple View of the Oregon Legislative Process



INFORMATION SYSTEMS
Computer and Media Technologies

www.leg.state.or.us/citizenguide