National Safe and Healthy Housing Coalition

Regulations Division, Office of General Counsel
Department of Housing and Urban Development
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The National Safe and Healthy Housing Coalition is pleased to comment on HUD's recent notice of its new plan to encourage communities to formalize relationships among health, energy, and housing programs.

HUD's Safe and Healthy Housing Investment Partnerships (SHHIP) certification system is a ground-breaking approach to solidifying relationships among key programs by providing bonus points to eligible applicants for HUD competitive grant assistance. We commend HUD for its leadership.

In response to the specific questions for which HUD sought responses:

- *Regarding the partnership agreements, what documentation should be considered sufficient to show that a partnership exists and is robust enough to merit certification?*

    - A SHHIP partnership agreement, signed by the local partners, which states the core mission and key obligations of the partners, should suffice as the core document.

    - The application should describe the extent to which recipients of services in the SHHIP the service recipients will receive services from all of the partnering institutions. The application should also include a gaps analysis, and plans for incorporating housing rehabilitation, energy efficiency, and healthy homes/lead hazard control into the SHHIP (or any barriers to the inclusion of these activities).

- *Regarding the composition of the partnership, are there any specific types of non-profit partners that should be required for certification?*

    - Entities that provide direct services, technical assistance, advocacy, funding, and training should be included. Representation by at least one community-based organization, tenants' rights organization, consumer organization, or similar entity would strengthen the accountability of SHHIPs and help ensure elimination of barriers to effective service delivery. Too often institutional service providers are reflective of underserved constituents; the SHHIP should be positioned to eradicate barriers to access by including these community-based partners.
    - HUD should not *require* the membership of a local philanthropic organization; not all localities have the same access to philanthropy either because philanthropic organizations are not present or the activities of the SHHIP are not part of the philanthropic organization's mission.
    - We understand that cities and counties have been considered the public sector partners. It is important to provide flexibility to enable state governments to be the public sector partner in relatively small states where the state agencies perform tasks that in other larger states may be handled by local government.

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- *Regarding the service disciplines included in the partnership, are there additional disciplines that should be represented, and what should HUD require as proof that each discipline is represented and appropriately credentialed? Should HUD set or adopt its own standards or should HUD accept a variety of standards adopted by State, or local units of government, private sector or non-profit organizations, or other federal agencies? Should a standard be set for each type of healthy home intervention?*
    - HUD should accept disciplines and credentials from legitimate sources yet exercise discretion by declining on a case-by-case basis credentials that do not meet minimum criteria for that subject matter.
    - The term "government accredited" seems much too limiting – perhaps it should be changed to "recognized or accredited credentialing entities." Government agencies seldom accredit all viable service organizations or individuals in a given field of expertise. Could the current terminology exclude NEHA-NRPP and NRSB in credentialing radon professionals? The EPA does not officially accredit radon credentialing organizations; it gave a one-time recognition to these organizations.
    - HUD should include resident education and engagement as examples of direct services to ensure that interventions are properly maintained over time. In addition, health care organizations providing healthy home assessments for asthma triggers should be included.
    - Rather than develop its own professional standards, HUD can rely on existing frameworks for credentials. HUD should require at least one organization in the partnership to have credentialed Healthy Homes Specialists on staff. This designation is available to staff with field experience in health, housing or energy programs and that pass the National Environmental Health Association Healthy Homes Specialist Credential exam. The National Healthy Homes Training Center and Network offer the Essentials of Healthy Homes training course through out the country, which can help prepare students for the exam. We encourage HUD to identify other credentials that are beneficial, but not require them (e.g., HERS raters, BPI Building Analyst credential). In the energy efficiency field, HUD should allow a variety of standards as set by state or local partners, or developed by accredited standards writing organizations, provided the SHHIP supply the rationale for relying on such standards in the various disciplines included in the partnership.
    - We do encourage HUD to provide examples of healthy homes intervention standards to help guide local program structures. One such example is the forthcoming *EPA Healthy Indoor Environment for Home Energy Upgrade Protocols,* published as a draft in December in the Federal Register.

Regarding the service methodology, what should HUD require as proof that the methodology will be employed?

- Existing models provide such evidence of these commitments. For example, *d*evelopers, property owners and managers seeking to prove that they carefully thought through the integration of healthy and sustainable principles to create new or preserve existing housing are certified under the Enterprise Green Communities certification pathway. BPI certifications and LEED offer similar attributes.

Regarding the Healthy Homes Rating Tool, is this tool sufficient or should other tools be permitted and/or required?

- We support the HHRT and believe that standardization of data collection will contribute positively to research, program evaluation, and our understanding of housing quality in the U.S. However, since many other tools are currently in use, we believe HUD should be flexible

in allowing these tools while also providing leadership in cross-walking the data elements from the most used tools with HHRT. Examples include CDC's HHLPPSS tool, as well as the Pediatric Home Assessment Tool and the Community Environmental Health Resource Center visual survey.

Regarding the reporting of data, what data should HUD collect on units?

- We encourage HUD to collect data on the # of units assessed/address by each SHHIP; # units with more than one service provided; # units with a referral generated; # units with added healthy homes services on top of the core program; and limited data on the healthy homes hazards identified (e.g., moisture, pests, radon hazards, peeling paint hazards in pre-1978, non working smoke alarm, non working co alarm, trip or fall hazards, carbon monoxide hazards, sewage, extreme cold or heat, dust, mold and humidity).
- Other measures that should be encouraged could include verification of proper installation of ventilation systems as determined by tests via blower door, duct blaster, or assessing the airflows of kitchen/bathroom exhaust fans.
- We encourage HUD to work with CDC, which is requiring similar data for its grantees under the HHLPPSS.

Should there be standards for maintaining certification, and if so what should be the requirement, e.g. continuing education requirements, actual on-the job-experience with units, and/or requirements that a specific number of units are treated on an annual basis that meet Healthy Homes Certification Standards?

- HUD could designate two levels of certification – complete fulfillment of the SHHIP criteria (two points) and partial fulfillment (one point). Given that communities may be at varying degrees of readiness, it may be reasonable to acknowledge and incentivize progress.
- The fifth criteria presented in the proposed rulemaking requests that applicants have a service methodology that includes 6 elements. Several of these elements may unnecessarily hinder the accessibility of this designation to many communities who are in fact achieving the goals of the SHHIP program.
- Single Point of Contact: This sub criterion is not sufficiently explained. If interpreted literally to mean that there is one person for all intake in any health, housing or energy efficiency program participating in the SHHIP, the criteria is too narrow. A more effective sub criteria to encourage the cross fertilization of program services, client education, and referrals would be to require programs to have a integrated intake and referral process whereby clients served by any participating partner are provided access to the related program services through the integrated intake and referral process. This is the type of system used by *One Touch* programs in two NH communities and Omaha, NE. Although each program has a different structure, clients be they enrolled in Head Start, Weatherization or Lead Programs are triaged to determine their energy and healthy homes needs and provided the services, education, or referrals for which they qualify. The *One Touch* partners also help to manage the referral process to help clients obtain any appropriate supplemental services. Similarly, the Green and Healthy Homes Initiative is a model for "braiding resources."
- Utilizing the Healthy Homes Rating Tool (HHRT): We recognize that the goal underlying this criterion is to assemble local data that can be compared and combined to create a national characterization of the housing stock. We encourage HUD to gather the feedback on the HHRT from its Lead Hazard Control Grantees and other housing and energy efficiency programs to

better understand how assessors, inspectors, and auditors in the field experience the tool before making it a universal requirement. Many of the organizations who will be a part of the SHHIP already use their own assessment forms. For example, several "*One Touch"* use the template we created to gather data about energy and health hazards and suggested referrals. The template enables local programs to tailor the tool as a supplement to an existing assessment protocol. This avoids duplication and frustration on the part of local programs that may already be asking about a similar issue. We encourage HUD to define a core set of data that should be required in all SHHIP assessment tools and provide localities the flexibility they need to structure an audit tool to acquire these data in a format and platform that works for their program. We also strongly encourage HUD to include an element to the common assessment tool that engages communities in identifying the appropriate referrals. This is an actionable item from the assessment that should be a core part of any tool. Similarly the tool should identify appropriate healthy homes repairs or education needs.

- Standardized System for Data Reporting: We support the goal of a standardized system for data reporting, **provided** that local SHHIPs can, if they choose, develop their own data gathering tools. It is reasonable to ask localities to gather data in a format that could be uploaded to HUD or other federal agencies, provided appropriate safeguards are included to protect private information.