HEALTH & HOMELESSNESS WORKGROUP
ACTION PLAN RECOMMENDATIONS
March 4, 2015

Goal: By March 2015, deliver an action plan for engaging physical and behavioral health care providers and funders in Multnomah County to:

- Assess, at an individual client level, cross over between people experiencing homelessness and high-cost utilizers of health services
- Prioritize housing options for those identified individuals with specific exploration of funding sources that leverage existing homeless service system investments with recaptured cost savings to the health system
- Further identify the health needs of people experiencing homelessness in Multnomah County and strategies to increase engagement in and delivery of appropriate health care

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ACCESS TO CARE - RECOMMENDATIONS

The Home for Everyone Coordinating Board should work with hospital systems, Coordinated Care Organizations and insurers to identify shared goals and planning opportunities to increase access to care for all low income people.

Shorter Term

1. Work with hospitals to develop transition plans to ensure that no one is discharged into homelessness. This could be accomplished by:
    - identifying housing needs when people enter the hospital;
    - creating a pool of short-term rental assistance using Community Benefits funding, Flexible Services funding through Medicaid, or something similar to STRA; (long-term). We estimate that $150,000 a year will serve 50 people needing 3 months of rental assistance each ($700/month) and housing placement services*. The HFE Board could provide resources for a portion of the rental assistance and housing placement services and request the hospital systems to pay 50% of the rental assistance and continue to provide follow up medical and support services while people are transitioning.
    - a housing specialist or "discharge" social worker (similar to former hospital model) within the hospital system that assists people with transition and care planning. In order for this to be successful hospitals could participate in the coordinated access system so that they can best use homeless services/resources. We recommending funding at least $60,000 a year for 1 FTE Housing Placement Services staff and potentially rental assistance funding. (long-term)
2. Support clinics and/or other health care service providers to develop partnerships that bring health and support services to community based settings. For example, expansion of Care Oregon's model of resiliency using peer and mental health supports to provide services where people live. A current program serves 30 – 60 people/year with 2 FTE mental health and addictions Community Health Workers for approximately $250,000/year. This will help ensure that people have access to:
    - appropriate health resources
    - are able to stay enrolled in health care
    - have the ability to successfully apply for and stay on public benefits such as, Social Security Income.
3. Develop (with one-time grant funding) an annual training program for housing services staff and case management/system navigator staff that provides pertinent updates related to available programs, retention of benefits, services, and access. It can be offered as a webinar and/or at various locations throughout the region. The training should include both health and housing providers so they are hearing the same information about how clients can access healthcare and appropriate housing. This can be shared with 211 Info, Oregon Opportunity Network and other organizations.

Longer Term

1. Work with hospital systems to develop partnerships to Increase recuperative care options for people exiting hospitals and/or mental health and addictions stays. Housing that is used should be supplemental to the system, not supplant the units that are currently being used for other low income housing.

2. Individuals with Medicare only are having difficulty accessing basic mental health services such as case management or medication management due to service limitations of Medicare funding and low provider reimbursement rates. Multnomah County's Mental Health Safety Net programs are heavily relied upon each year to assure that more than 800 individuals who are at jeopardy for hospitalization, incarceration or loss of housing receive access to basic case management and prescriber services. Funders should find ways to increase access to specialized mental health services such as Assertive Community Treatment (ACT) or Dialectical Behavior Therapy (DBT) for those that require intensive community outreach services to avoid hospitalization, incarceration and/or loss of housing.

*Estimate: 50 people needing 3 months each of RA at $700/month plus move-in expenses and 1 FTE housing placement staff at $60k/year. In the last STRA year, ending June 2014, both the average and median amounts for monthly rent assistance were approximately $600/month. The average studio rent reasonable across Mult. County is: $817.

IMPROVE INFORMATION - RECOMMENDATIONS

Little is currently known about the intersection between people experiencing homelessness and their involvement (or lack thereof) with local health care providers, primarily because housing and homeless service providers do not collect much information about client engagement in health care and few health care providers collect information about clients' housing status. We include two preliminary recommendations to remedy this:

1. Health Share and Family Care should include assessment of member housing status in their required periodic community health needs assessments. Specifically, housing status questions should align with local and federal housing status definitions related to housing and homeless service eligibility (e.g. HUD definitions of "homeless," "chronically homeless," and "at-risk" of becoming homeless). Members' housing status should be regarded as a primary social determinant of health when planning subsequent community health interventions. Begin assessment with Health Share's 2015 community health needs assessments.

2. By June 30, 2017, assure that all major local health systems include routine assessment of housing status in clinical intake and follow-up appointments, recorded in electronic medical records. Specifically, housing status questions should align with local and federal housing status definitions related to housing and homeless service eligibility (e.g. HUD definitions of "homeless," "chronically homeless," and "at-risk" of becoming homeless). Implementation can begin with replication of Multnomah County primary care clinic procedures in other health systems, and should coincide with direct health provider training and access to homeless services coordinated access systems.

3. Provide training to the healthcare system on the definitions of "homelessness" and other housing status definitions.

PERMANENT SUPPORTIVE HOUSING - RECOMMENDATIONS

Assumptions

Multnomah County's point in time count of homelessness counted 1,150 people experiencing chronic homelessness. Most were in households without children and most were unsheltered. On an annualized basis, we estimate that 1,100 of those chronically homeless people will remain with unmet housing needs. If we assume that 75% of those individuals need permanent supportive housing we can address this need with approximately 830 additional units of permanent supportive housing.

Central City Concern was recently awarded federal Continuum of Care funding for permanent supportive housing that will support approximately 175 chronically homeless individuals. These services will include peer support, housing retention, health care navigation, and leveraged Medicaid funded primary care and mental health services. Many of the participants will already be in agency supported health care services. Increased local and federal investments in ending veteran homelessness will allow our community to place approximately 100 additional chronically homeless veterans into housing beyond our current level of effort.

This leaves a current gap of permanent supportive housing for approximately 555 individuals.

Permanent supportive housing is defined as permanent, affordable housing with comprehensive supportive services for people who are chronically homeless and with disabilities or other substantial barriers to housing stability. Permanent supportive housing is an intensive model of housing and services designed to serve chronically homeless individuals and families who cannot retain stable housing without tightly linked support services, and who cannot successfully utilize the clinical services they need to stabilize their lives without having housing. Permanent supportive housing can be scattered-site or site-based.

Proposal

In order to reduce this gap, the HFE healthcare and homelessness workgroup recommends:

- That 25% of all the very low income housing produced or created over the next five years be set aside as permanent supportive housing.
- That this commitment starts with 80 - 100 units designated as permanent supportive housing over the next two years.
- That a portion of the savings generated by this investment further create new resources for permanent supportive housing.

This will require not just deep affordability but additional on-going resources focused on supportive services. We further recommend that resources from the health care system and Medicaid, including mental health, be dedicated to supportive services. In some cases this will require redirection of public funds, in some cases funds from non-local governmental sources.

Organization of Services

Scattered Site – cost of services for 50 individuals: $470,000 annually
50 households supported by mobile wrap-around and mental health services that address a continuum of need.

Site Based – cost of services for one 30 to 50 apartments in a single site: $270,000 annually

Resources

Resources could come from a combination of local services funds, local mental health funds, and funds from the health care system for mental health and health care connection/navigation services. In addition, funding strategies could also include increased access to personal care through Aging and Disability Services and systems-level collaboration with the Community Benefits program through local hospitals. Finally, a portion of the savings identified in other systems, including the criminal justice system, should be redirected to support permanent supportive housing.

Housing agencies could remain open to housing individuals identified by the health care system as needing supportive housing as part of any larger community-wide effort.

SYSTEMS ALIGNMENT - RECOMMENDATIONS

In order to better align systems that fund and support people who need both health care and homeless/housing services to be successful, we recommend:

1. Work with not-for-profit health plans and health care systems to prioritize housing and co-located wrap around services for Community Benefits funding. Collaborate to create a more aligned and systematic approach between health care entities to maximize impact for vulnerable populations. This does not have a dollar amount other than staff time at first, although joint projects with cost associated could surface out of a conversation about shared outcomes.

2. Work with hospital systems, CCOs and Care Oregon to determine the barriers to using Flexible Services funding for health related services and/or PSH services (this may or may not be related the Medicaid Supportive Housing Benefits waiver). This does not have a dollar amount other than staff time at first, although joint projects with cost associated could surface out of a conversation about shared outcomes.

3. Explore what is possible and what is not possible to do under Oregon's current Medicaid waivers. Consider partnering with others to provide an analysis of this. CSH has submitted a proposal to do what they call a "crosswalk" analysis of our state waivers. We recommend that HFE Coordinating Board support funding a portion of the $20,000 proposed project while working closely with state agencies who could also contribute some funds.

A Home for Everyone Health + Homelessness Workgroup Recommendations

(March 3, 2015)

Action	Proposed Outcomes	Cost Impact/ Funding Strategies	Recommended Parties	Timeline to Implement	Alignment opportunities sources	New resources	Request of other agencies	Resource reallocation	Policy
Access to Care									
1. Work with hospitals to **develop transition/discharge plans** to ensure that no one is discharged into homelessness.	• Reduce homelessness • Reduce housing instability • Improve health outcomes • Reduce hospital and Emergency Department (ED) utilization	• **Short term rental assistance for 50 people (~$150k/year)** • **1 FTE housing specialist/discharge worker (~$60k/year)** • Funding from Community Benefits, Flexible Services (Medicaid), or County STRA	• Hospitals • Insurers • County	Mid range	Yes	Yes	Yes	Yes	Yes
2. Support clinics and/or other health care service providers to develop partnerships that bring health and support services to community based settings. **(Mobile clinics.)**	• Bring appropriate health resources to where people are. • Ensure that people stay enrolled in healthcare • Increase number of people that successfully apply for and stay on public benefits (benefits recovery) • Reduce hospitalization and ED utilization	• A current program serves 30 – 60 people/year with 2 FTE mental health and addictions community health workers, **~$250,000/year**.	• Clinics • Hospitals • Insurers	Mid range	Yes	Yes	Yes	Yes	Yes
3. Develop (with one-time grant funding) an **annual training** program for housing services staff and hospital/clinic case management/system navigator staff that provides pertinent updates related to available programs, retention of benefits, services, and access.	• Improve & update knowledge of available resources across systems • Consistent information delivered across systems	• **One time funding of ~$20,000** to develop a training program	• Oregon Opportunity Network • Hospitals • Clinics that serve homeless	Immediate	Yes		Yes		

Action	Proposed Outcomes	Cost Impact/ Funding Strategies	Recommended Parties	Timeline to Implement	Alignment opportunities sources	New resources	Request of other agencies	Resource reallocation	Policy
4. Work with hospital systems to develop partnerships to **increase recuperative care** options for people exiting hospitals and/or mental health and addictions stays. Housing that is used should be supplemental to the system, not supplant the units that are currently being used for other low income housing.	• Reduce homelessness • Reduce housing instability • Improve health outcomes	Needs more research to develop cost and funding strategies.	• Hospitals • Recuperative care & service providers	Long term	Yes	Yes	Yes		?
5. **Increase access for Medicare enrollees to specialized mental health services** such as Assertive Community Treatment (ACT) or Dialectical Behavior Therapy (DBT) for those that require intensive community outreach services to avoid hospitalization, incarceration and/or loss of housing.	• Increase services for mental health case management and medication management • Increase Medicare provider reimbursement rates • Reduce homelessness, incarceration • Avoid hospitalization • Improve health outcomes	Increase funding for Multnomah County's Mental Health Safety Net programs	• County • Mental health service providers • Hospitals	Mid range	Yes	Yes	Yes	Yes	?

Action	Proposed Outcomes	Cost Impact/ Funding Strategies	Recommended Parties	Timeline to Implement	Alignment opportunities sources	New resources	Request of other agencies	Resource reallocation	Policy
Improve Information									
6. Health Share, Family Care and their members should **include assessment of member's housing status** in their required periodic community health needs assessments. Housing status questions should align with local and federal housing status definitions related to housing and homeless service eligibility (e.g. HUD definitions of "homeless," "chronically homeless," and "at-risk" of becoming homeless).	• Improved understanding of housing status • Using housing data to inform health interventions • Housing status as a primary social determinant of health	Needs more research to develop cost, if any, IT impacts, and funding strategies.	• CCOs • Hospitals • Clinic	Immediate	Yes		Yes		Yes
7. By June 30, 2017, assure that all major local health systems include routine **assessment of housing status in clinical intake and follow-up appointments, recorded in electronic medical records**. Specifically, housing status questions should align with local and federal housing status definitions related to housing and homeless service eligibility (e.g. HUD definitions of "homeless," "chronically homeless," and "at-risk" of becoming homeless).	• Improved understanding of housing status • Using housing data to inform health interventions • Housing status as a primary social determinant of health	• Replication of Multnomah County's primary care clinic procedures in other health systems • Training for direct health provider and access to homeless services coordinated access systems. • Needs more research to determine costs and IT impacts	• CCOs • Hospitals • Clinics	Mid range	Yes		Yes		Yes
8. Provide **training to the healthcare system on the definitions of "homelessness"** and other housing status definitions.	• Improved understanding of housing status • Using housing data to inform health interventions • Housing status as a primary social determinant of health	**One time funding of ~$20,000** to develop a training program	• PHB • Hospitals • CCOs • Insurers • Clinics	Immediate	Yes		Yes		

Action	Proposed Outcomes	Cost Impact/ Funding Strategies	Recommended Parties	Timeline to Implement	Alignment opportunities sources	New resources	Request of other agencies	Resource reallocation	Policy
Increase Permanent Supportive Housing									
9. **Set aside 25% of all affordable housing produced or created as Permanent Supportive Housing (PSH) over the next five years,** starting with 80 - 100 units in the next two years.	• More PSH units • Reduce homelessness • Reduce housing instability • Improve health outcomes • Reduce hospital and ED utilization • Reduce costs to other systems such as Medicaid and jails	• **On-going rental assistance for all PSH units** • **Site-based annual services for 30-50 apts = ~$270k/yr** • Scattered site annual services for 50 people = ~$470k/yr	• PHB • HUD • OHCS • County • Hospitals • CCOs • Insurers	Immediate & long term	Yes	Yes	Yes		Yes
10. A portion of the **savings generated by PSH investments are tracked and used to create new resources** for permanent supportive housing.	• New resource development • More PSH units	Needs more research to develop costs.	• OHA • County • Hospitals	Long term	Yes	Yes	Yes	Yes	Yes

Action	Proposed Outcomes	Cost Impact/ Funding Strategies	Recommended Parties	Timeline to Implement	Alignment opportunities sources	New resources	Request of other agencies	Resource reallocation	Policy
Systems Alignment									
11. Work with not-for-profit health plans and health care systems to **prioritize housing and co-located wrap around services for Community Benefits funding**.	• Increase funding • A more aligned and systematic approach to shared outcomes • Reduce homelessness • Improve health outcomes • Reduce ED and hospitalization use	• Immediate costs associated with staff time to work with hospitals • On-going costs needs more research	• Hospitals • Housing owners • Enterprise Community Partners • Oregon Opportunity Network	Immediate	Yes	Yes	Yes		Yes
12. Work with hospital systems, CCOs and Care Oregon **to determine the barriers to using Flexible Services funding for health related services and/or PSH services** (this may or may not be related the Medicaid Supportive Housing Benefits waiver).	• Increase funding • A more aligned and systematic approach to shared outcomes • Reduce homelessness • Improve health outcomes • Reduce ED and hospitalization use	• Immediate costs associated with staff time to work with hospitals • On-going costs needs more research	• CCOs • OHA • Hospitals • Insurers • Enterprise Community Partners	Immediate	Yes	Yes	Yes	Yes	Yes
13. Explore **what is allowed and what is not allowed under Oregon's current Medicaid waivers.**	• Better understanding of how wrap around support services, mental health and behavioral services can be paid for • Better understanding of who decides what and how Flexible Services funding is used	• CSH has submitted a proposal to do a "crosswalk" analysis of our state waivers. • **HFE board to pay a portion of the $20,000 study** • Enterprise will contribute funding too	• CSH • CCOs • OHA • OHCS • County • Insurers • Hospitals • Enterprise Community Partners	Immediate	Yes	Yes	Yes	Yes	Yes