The role of health plans in a local homeless services continuum of care:
Collaborating to improve outcomes in housing and health

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CareOregon

- Founded in 1993
- Serves 190,000 Oregonians in 9 counties
  - Of those, approximately 140,000 Medicaid and Medicare members in Portland Metro area
- According to the 2014 Medicaid Behavioral Risk Factor Surveillance Study...
  - 17.1% of Health Share members reported needing or receiving housing services in the previous year
Nationally

EXHIBIT 1.1: PIT Estimates of Homeless People By Sheltered Status, 2007–2015


Multnomah County

PIT Estimates of People Experiencing Homelessness in Multnomah County By Sheltered Status, 2007 - 2015

Race and ethnicity

People Experiencing Homelessness (streets and emergency shelter) in Multnomah County 2011 – 2015: Percent change (with #)

- People of Color (especially African Americans)
- Women
- People with disabilities
- Seniors

Source: Source data from Point in Time Count of Homelessness in Portland and Multnomah County, 2011 and 2015; Analyzed by Portland Housing Bureau 10/21/2015.
Shared Vision and Values

The Vision

No one should be homeless. Everyone needs a safe, stable place to call home.

Guiding Values

– Prioritize the most vulnerable
– Promote racial and ethnic justice
– Hold the programs we fund accountable and use data to make decisions
– Engage and involve the community, especially those with lived experience
– Strengthen system capacity and increase leveraging opportunities

Shared Plan

Key Focus Areas

– Housing
– Income and benefits
– Health
– Survival and emergency services
– Access to services
– Systems coordination

Priority Populations

– Families with children
– Unaccompanied youth
– Adults with disabilities
– Women
– Veterans

Racial Equity

“A racial equity lens will be used to inform and guide the allocation of resources to effectively address disparities based on race and ethnicity.”
Figure 1. A Home for Everyone Operational Flow

Note. Orange arrows indicate the active, transactional spaces in between entities.
Ending Homelessness: Inflow/Outflow Model

Inflow
- Newly homeless
- Return to homelessness

Outflow
- Permanent housing

Unmet Need
People experiencing homelessness
Before A Home for Everyone: The Status Quo

Between 2013 and 2015 about 6,000 homeless people were housed (outflow), but homelessness remained relatively unchanged. That suggests inflow more or less matched outflow.
Ending Homelessness: Expanding Prevention and Placement Capacity

- ↑ 750 people
- ↑ 1,350 people
- ↑ 1,000 people
- ↑ 2,000 people

Graph showing the expansion of prevention and placement capacity from 2015 to 2024.
The Challenge: Rents Outpacing Incomes

Federal Disability Checks Fail to Keep Up with Rent Increases

Sources: Multifamily NW survey data, U.S. Social Security Administration
2,869  Homeless individuals
+2,920  ED visits
+2,042  Hospital Admissions
=$26.5 Million Per Year
The Health Burdens Associated with Homelessness

Figure 10: Costs associated with health care services for Bud Clark Common residents with Medicaid

Bud Clark Commons Study, Health Service Utilization: Data based on surveys conducted for Home Forward in winter 2013. 76% of 130 residents participated. Cost data based on analysis of Medicaid claims data for participating residents who were on Medicaid which was 58 of the 99 individuals interviewed.

Health Care Reform & Homelessness in Multnomah County – City Club or Portland Bulletin, Vol. 97, No. 10, January 6, 2015
# Healthcare supports in affordable housing

**KEY FINDINGS:**

- Housing increases primary care visits
- Housing decreases ED utilization and total cost

<table>
<thead>
<tr>
<th></th>
<th>Before Move-in</th>
<th>After Move-in</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td># Primary Care Visits*</td>
<td>2.8</td>
<td>3.4</td>
<td>+20%</td>
</tr>
<tr>
<td># ED Visits*</td>
<td>1.1</td>
<td>0.9</td>
<td>-18%</td>
</tr>
<tr>
<td># In-Patient Non-OB Visits</td>
<td>0.08</td>
<td>0.07</td>
<td>-15%</td>
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<tr>
<td>≥ 1 Primary Care Visit*</td>
<td>0.57</td>
<td>0.67</td>
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<tr>
<td>≥ 1 ED Visit*</td>
<td>0.40</td>
<td>0.36</td>
<td>-11%</td>
</tr>
<tr>
<td>≥ 1 In-Patient Non-OB Visit</td>
<td>0.08</td>
<td>0.07</td>
<td>-11%</td>
</tr>
<tr>
<td>Total Cost*</td>
<td>$386.3</td>
<td>$338.3</td>
<td>-12%</td>
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</table>

*N = 1,625  
* Findings are significant
Providing placement, care coordination and supportive housing for vulnerable homeless populations lowers total medical costs by reducing unnecessary hospital use.
CareOregon’s Commitment to Housing

**Planning**
- Participation in A Home for Everyone’s Health & Housing work groups

**Investments**
- Investing in affordable housing - $4M to help create 150+ additional units
- Community Benefit – In 2016 invested $365,000 with six agencies
- GoMobile – street outreach and engagement

**Programs**
- Services at affordable housing communities – mental and physical healthcare navigation
- Medical Respite for post-hospital support
- Housing Case Management – barrier removal, intensive housing navigation
- Care Coordination, Transitions and Health Resilience Programs – barrier removal, housing referrals

- **Homeless**
- Living in Transitional, unsafe or unhealthy housing
- Living in stable housing
CareOregon’s Participation

Participation in A Home For Everyone’s Health & Housing Workgroup and sub workgroups

Co-invest in programs and develop partnerships to extend reach and maximize impact
CareOregon’s Investments

$4 million investment in Central City Concern’s Health is Housing Initiative

$350,000 investment in housing projects through the Community Benefits program in 2016
Medical Respite Programs Decrease Hospital Readmissions

Central City Concern, Recuperative Care Program
Stays Discharged from October 1, 2014 to September 31, 2015**

<table>
<thead>
<tr>
<th>Readmission Within XX Days of RCP Discharge</th>
<th>30</th>
<th>60</th>
<th>90</th>
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<tbody>
<tr>
<td>n=50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 Admissions</td>
<td>94%</td>
<td>86%</td>
<td>80%</td>
</tr>
<tr>
<td>1 Admission</td>
<td>6%</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>2+ Admissions</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**NOTE: Many studies have demonstrated that a typical readmission rate for individuals experiencing homelessness is 50%.
Housing With Services - model

- **Housing with Services**
  - LLC model involving 9 agencies
  - CareOregon provides health care coordination and services to the residents of 10 affordable housing communities
    - 2 FTE provide care coordination
  - On-site health clinic
  - Culturally-specific services
Housing With Services – 2016 results

Portland State University Study:

- Improved access to health and social services
- Outreach may have delayed or prevented evictions.
Housing Case Management

- Housing case management
  - 2 FTE (as of October 2016)
  - Housing support for *individuals in PHP programs* facing worsening health conditions
  - Includes housing placement assistance and eviction prevention services
Results & Demographics

CareOregon Housing Case Management

What’s Under Our Roof?

Since January 2016

Housing Case Managers have made 53 housing placements for CareOregon members and stabilized another 18 in their current housing situations.

- 46% men
- 49% women

That includes...
- 64% Caucasian
- 21% Black or African American
- 7% Hispanic
- 1% American Indian or Alaska Native
- <1% Asian or Pacific Islander

- 92% individuals
- 8% with families

- 53% people ages 19-54
- 33% people ages 35-64
- 14% people ages 65+

2016, based on 1 FTE Housing Case Management
Housing Stabilization Pilot

- CO Housing Case Manager: 2 FTE
- JOIN Housing Stabilization Specialist: 2 FTE
- CareOregon Member
- Barrier removal
- Housing placement
- Health & housing stabilization

- $ from CareOregon & Joint Office of Homeless Services
- Connections to PHP
Housing Stabilization Pilot Continued

- Long-term stabilization and support
- Increase housing and health outcomes
- Increase access to housing, leverage partner support
- Collaborative model with opportunities for expansion
Discussion

• What are the challenges and opportunities arising from collaborations in your region?
• Funding accessed?
• Benefits for plans, members and CoC?
• How are health plans connected to local planning processes?
Thank You

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CareOregon
better together®

Multnomah County
JOINT OFFICE OF HOMELESS SERVICES