Housing Use Cases Panel

Moderated by Liz Whitworth and Justin Keller, Oregon Health Leadership Council and HIT Commons

September 13, 2023

Introductions and context

- Introductions of moderators and panelists
- Today, you'll hear three different use cases of how to connect housing and health care:
    1. How to support people with unmet medical needs who are experiencing houselessness
    2. Pilot experience at building a Medicaid housing benefit
    3. Early experience of efforts to more efficiently support people self-referring into Coordinated Entry programs

Washington County Housing and Healthcare Partnership

Allie Alexander Sheridan, Health & Housing Program Coordinator, Washington County
Rachel Smith, Population Health Project Manager, Providence Health & Services

KAISER PERMANENTE®

PROVIDENCE Health & Services

WASHINGTON COUNTY OREGON
Department of Health and Human Services

Partnership – Collaboration

Initially focused on utilizing Washington County's HMIS data and Collective Medical to have a flag of unhoused patients appear in Epic

- **Prioritized on building relationships and TRUST**
- **Breakdown hierarchies and historic unequal power dynamics between healthcare and housing sectors**
- **Refocused to collaborative process led by housing providers**
- **Centered work on addressing barriers, keeping individual at the center**

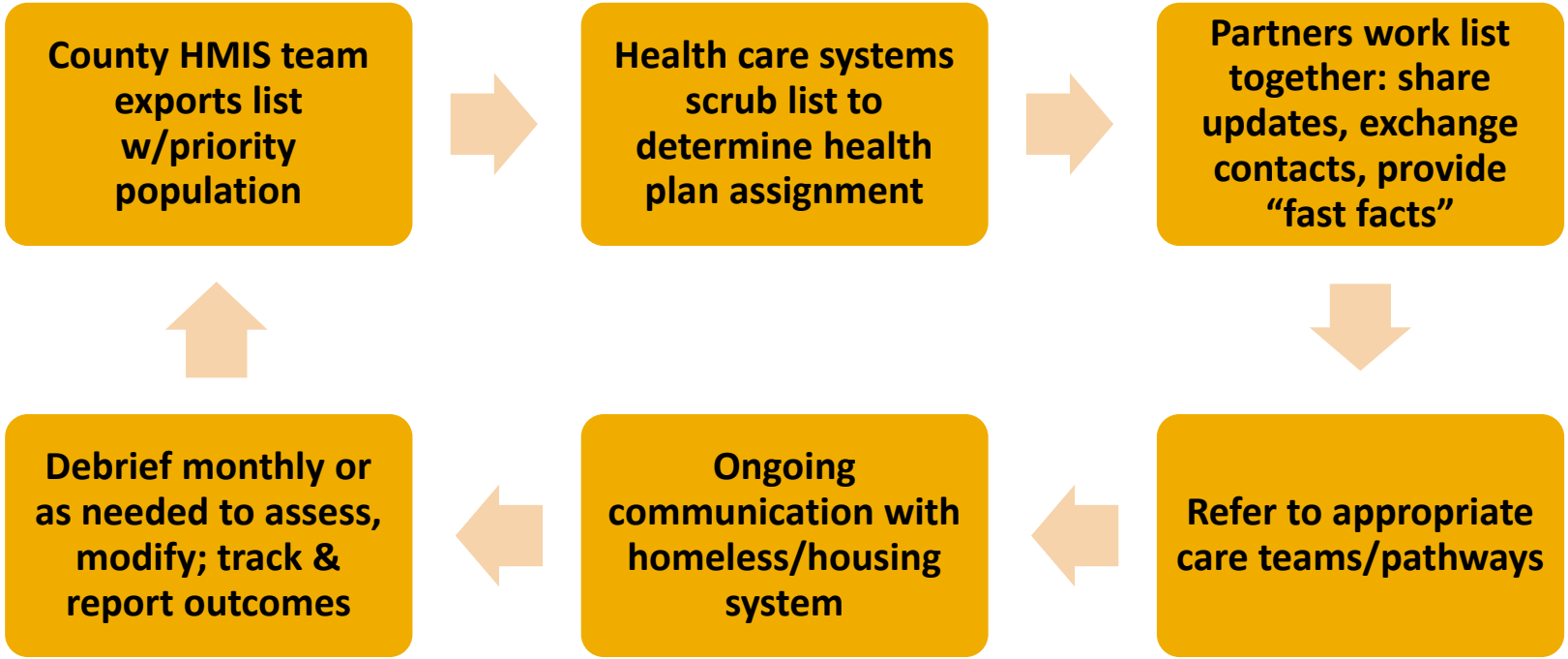
Historical Context

- County and service providers continue to see an urgent and unmet need for both unhoused and newly housed clients: **getting connected to the health care they need**
- Healthcare + Homelessness initiative, Community Solutions and the Institute for Healthcare Improvement brought together stakeholders across housing and health.
- **Shared aim:** Collaboration between County and health systems, including data sharing and coordination of resources/supports, to achieve a measurable reduction in chronic homelessness through coordinated interventions for people with unmet medical needs who are chronically homeless or at risk of becoming homeless.

Institute for Healthcare Improvement

Built For Zero.
COMMUNITY SOLUTIONS

Case conferencing workflow



Preliminary Learnings

- 143 individuals have met prioritization eligibility; 47 being case conferenced.
- 71% of individuals have Medicaid insurance, and 10% are dual-eligible.
- Scale of PCP engagement: 33% of individuals not assigned to PCP
  49% of individuals assigned but not engaged
- Individuals served often do not know where they are connected to health care or their insurance provider.
- Supporting housing partners get individuals connected to primary care is key to accessing necessary benefits (*"Participant isn't able to afford meds").*
- Individuals are engaging in care across the community, and having only a subset of healthcare represented creates barriers.

Data as of 8/11/23

Evolution of this Work

Helping the region advance toward cross-sector, bidirectional data sharing and collaboration

- Incorporating additional health care and CCO partners
- Beginning conversations with other housing teams (Clackamas County and Joint Office of Homeless Services) to scale this model in other Counties
- Building upon our partnership to apply learnings and relationships to additional housing models like medical respite
- Informing data-sharing process for Medicaid Waiver operations
- Exploring opportunities for this project to support/align with Medicaid initaitives (redetermination, Health-Related Social Needs benefit)

Questions & Comments

Allie Alexander Sheridan, Allie_AlexanderSheridan@washingtoncountyor.gov
Rachel Smith, rachel.smith@providence.org

Pilot Implementation of a Medicaid Housing Benefit

Alyssa Craigie – Director, Health Systems Integration

September 13, 2023

Health Share of Oregon

Health Share Overview

Health Share is Oregon's largest Medicaid Coordinated Care Organization (CCO), serving over 440,000 Oregon Health Plan members in the greater Portland metro region.

Work is guided by our Community Health Improvement Plan and our Strategic Plan, which both identify access to housing as a priority and health equity as a foundational principle.

Oregon's Final Waiver Components

Overall goal is to Advance Health Equity, broken down into four sub-goals

Ensuring people can maintain their health coverage

Improving health outcomes by addressing health related social needs

Ensuring smart, flexible spending for health-related social needs and health equity

Creating a more equitable, culturally- and linguistically-responsive health care system

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Health Related Social Needs (HRSN)

- Medicaid **benefits** will be expanded to cover HRSN in housing, nutrition and climate categories
- **Housing and nutrition** services for people who going through life transitions:
  - People who are experiencing homelessness or at risk of homelessness
  - Youth with Special Health Care Needs up to age 26
  - Youth who are child welfare involved
  - Older adults who have both Medicaid and Medicare health insurance
  - Adults and youth leaving justice involvement
  - Adults leaving State Hospital
- **Climate** services: People with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor

Health Share's Housing Benefit Pilot

Housing Benefit Pilot

Goal: Pilot a “housing benefit” concept using health-related services funding, in advance of waiver approval, to address equity issues impacting access to HRS for housing.

Scale and timeline:

- Planning began in January 2022.
- Believed we could reach 1,500 eligible individuals over 18 months.
- First member received services in May 2022. More than 500 have been enrolled since then.

Benefit Package

- Short-term rental assistance
- Utility assistance
- Housing navigation support
- Hotel/motel stays
- Move-in support
- Home remediation services
- Home accessibility and safety modifications

Member Eligibility

- Health Share Members at risk of, or currently experiencing, houselessness
- Identified from one of eight “transition” settings

Population
Inpatient Medical Care
Recuperative Care Program
Inpatient Psychiatric Care
Assertive Community Treatment (ACT) Programs
SUD Residential Treatment Care
Aging Out of the Foster Care System
Acute Care Rehabilitation
Transitioning from Corrections/Custody

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Referral Processes

- Partnering with referring entities who are trained on the eligibility criteria, are already working with members, and know their needs
- Referrals can be by made via:
  - Connect Oregon
  - Secure email

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Housing Service Provider Network

Community Based Organizations play a key role within the Housing Benefit Program serving as the Housing Navigators.

- Collaborate with assigned Care Coordinator to identify Member needs for housing
- Complete Housing Needs Assessments with Member
- Develop customized Housing Plan based on Member needs
- Submit invoices for expenses incurred
- Support Member throughout their housing experience

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Data Capture and Information Sharing

- Documentation: Using Epic EMR for all Member related interventions and engagements
- Information Sharing: Housing Benefit Cohort developed within Collective
- Evaluation and Tracking: Pseudo-encounter data capture, monthly dashboard, metric refinement

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Partner Collaboration

- Hosting monthly meeting to gather feedback from counties, community, and health system partners and provide status updates
- Leveraging access to long-term rent assistance when possible through county programs (for example, youth exiting foster care)
- Ongoing conversations about coordinated access and how to support members needing longer term support
- Leveraging expertise of those with lived experience through Regional Supportive Housing Impact Fund (RSHIF) Steering Committee

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Communities of Practice

- A community of practice (CoP) is a group of people who share a common concern, a set of problems, or an interest in a topic and who come together to fulfill both individual and group goals.
- Communities of practice often focus on sharing best practices and creating new knowledge to advance a domain of professional practice.
- Interaction on an ongoing basis is an important part of this.
- Many communities of practice rely on face-to-face meetings as well as web-based collaborative environments to communicate, connect and conduct community activities.

Bridging to HRSN Implementation

- Need to bridge the pilot to new Health Related Social Need (HRSN) housing benefit
  - OHA postponed implementation of housing HRSN benefit to at least July 2024
- Administration will be similar to typical medical/behavioral health benefits
  - Defined eligibility criteria with documented “clinical and social risk” requirements
  - Individual encounter-level data
  - Closed loop referral process will be required for all HRSN benefits
  - Grievance and Appeals processes
- There is still a lot of discussion about how the benefit will be administered between OHA, OHCS, and CCOs, and the roles are not clear yet.

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Questions? Please reach out!

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Connect Oregon

Lane County Coordinated Entry & 211info

2023

UNITE US

211info Connecting Informing Empowering

Proprietary and Confidential

Unite Us & Lane County Coordinated Entry

- Unite Us Assistance Request Form embedded onto the Lane County Coordinated Entry website on 2.21.23

- Allows Lane county residents to self-refer into Connect Oregon, and directly into the Lane County Coordinated Entry program.

- **Identified team at 211info are end users who process all of the incoming requests and referrals.**

    - includes referrals from community partners on Connect Oregon, and directly from individuals in the community via the Assistance Requests Form on the Lane County Coordinated Entry website.

    - 211info team has access to the HMIS database, and can follow the already-established Coordinated Entry workflows in this community, based on the need of the client and their circumstances.

Lane County Coordinated Entry

Unite Us Assistance Request Form

Lane County / Government / County Departments / Health and Human Services / Human Services Division / **Coordinated Entry**

HUMAN SERVICES DIVISION

- **Coordinated Entry**
  - What is Coordinated Entry
  - Frequently Asked Questions
  - Other Housing Resources

COORDINATED ENTRY

A- A+

Is your housing at risk?

- **Did you get an eviction notice?**
- **Do you need help paying rent?**
- **Are you homeless (unhoused, houseless?)**
- **Are you living in your vehicle?**
- **Are you fleeing Domestic violence?**

Ways to get help

Call 211

Enter your information online

Instructions: Please answer the questions below with your information and then click submit.

Instrucciones: Por favor conteste las preguntas debajo con su nombre ("Name"), segundo nombre, si tiene alguno, apellido ("Last Name"), fecha de nacimiento ("Date of birth"), número de teléfono ("Phone number"), su correo electronico ("Email address").

Personal Information

FIRST NAME *

LAST NAME *

Data Model Definitions

CASE	An overarching concept that represents **a client's need and their care journey** to address the need in the platform. All stages of a client's care journey are tracked under a case, including referrals (when applicable).
REFERRED CASE	A **case with at least one associated referral**, meaning the client's need was referred into the network.
REFERRAL	**Individual attempts to connect** a client or case to a specific in-network organization that might be able to serve the client's need. Cases can have multiple referrals.
MANAGED CASE	A case that has reached an **in-network organization with the capacity to serve the client** (e.g., when an associated referral has been accepted).
OFF-PLATFORM CASE	A case that ultimately ended in a traditional referral **made to an out-of-network organization**, but documented in Unite Us.

Proprietary and Confidential

Lane County Coordinated Entry - Referral Activity 2.21.23 - 8.31.23

Referral Activity

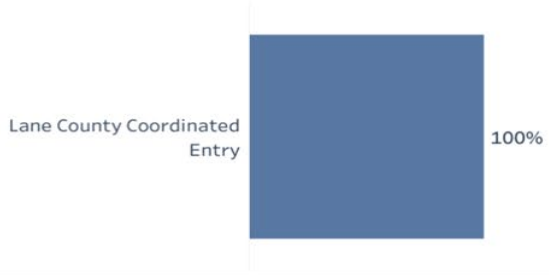
11
Organizations
Sent 1+ Referrals

1
Organizations
Received 1+ Referrals

128
Referrals

Referrals - Top 10 Sending Organizations

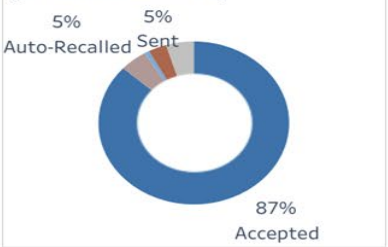
Top 10 Receiving Organizations



Rejection / Recall Reason

Referral Status

Referral Overview
(Click to filter dashboard)



	Accepted	Recalled	Rejected	Sent	Auto-Recalled
Housing & Shelter	111	1	4	6	6

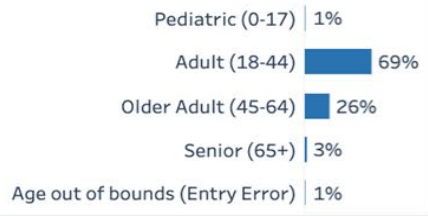
Lane County Coordinated Entry - Assistance Requests 2.21.23 - 8.31.2

Network Overview

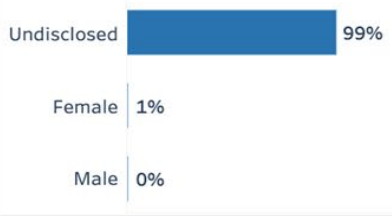
462	462	463	1.000
Clients	Cases	Managed Cases	Cases per Client (Avg)

Client Demographics (Click visualizations to filter dashboard)

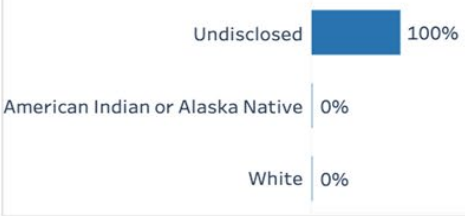
Client Age



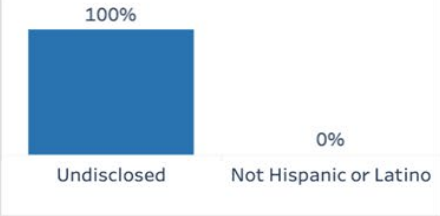
Client Gender



Client Race



Client Ethnicity



Case Summary

Origin (Click to filter dashboard)

Case Volume by Service Type

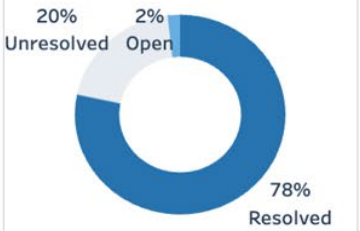
Reoccurring Needs

Lane County Coordinated Entry - Total Managed Cases 2.21.23 - 8.31.23

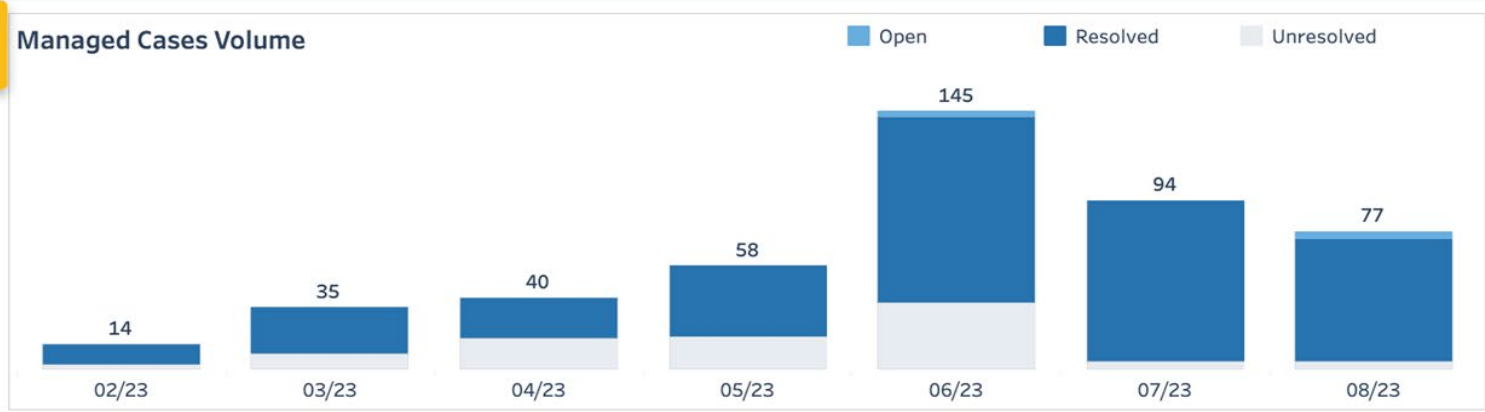
Managed Cases Summary

463 Managed Cases

Resolution Overview
(Click to filter dashboard)



Managed Cases Volume



Managed Cases by Outcome

Resolved Unresolved

Housing & Shelter	Housing Case Management	Unable to Contact Client	57
		Client Self-Resolved	54
		Unstandardized Outcome	48
		Other	29
		Refused Services	1
	Moving Assistance	Other	6
		Unstandardized Outcome	1
		Unable to Contact Client	1
		Client Self-Resolved	1
Permanent Housing		Other	77
		Unable to Contact Client	14
		Client Self-Resolved	14
		Received Services	5
Rent/Mortgage Payment Assistance		Other	71
		Client Self-Resolved	31
		Unable to Contact Client	18
		Unstandardized Outcome	14
Transitional Housing		Other	12
		Client Self-Resolved	1

Questions & Contacts

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- Monica Anthony monica.anthony@211info.org

211info 2-1-1 Connecting Informing Empowering