

Using Health-Related Services to Address Housing Needs

A Guide for Oregon CCOs

Introduction and background

Health-related services (HRS) are non-covered services under Oregon’s Medicaid State Plan that are intended to improve care delivery and overall member and community health and well-being. For coordinated care organizations (CCOs) to use federal Medicaid funds to pay for these services, they must comply with state and federal criteria.

This guide focuses on how housing-related services and supports can qualify under the requirements for HRS detailed in this rule and CFR. For a full definition of HRS, CCOs should rely primarily on the OHA HRS Brief (available here: www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx) and OARs 410-141-3000 and 410-141-3150. The federal regulations should be used for supplemental CCO guidance only.

Social determinants of health and equity: definitions for CCOs

One of the goals of HRS is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health and equity (SDOH-E) as well as the health-related social needs of their members. Social determinants of health are social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.¹

In 2017, Oregon’s Medicaid Advisory Committee (MAC) identified the need for increased CCO investment in HRS as a key mechanism to address SDOH. The MAC assessed CCO and community SDOH priorities² to identify housing-related services and supports as a top community priority and an area that CCOs requested additional guidance. The MAC then collaborated with OHA to develop an HRS housing guide to help CCOs increase work in this area.

The following definitions that inform this guidance document:

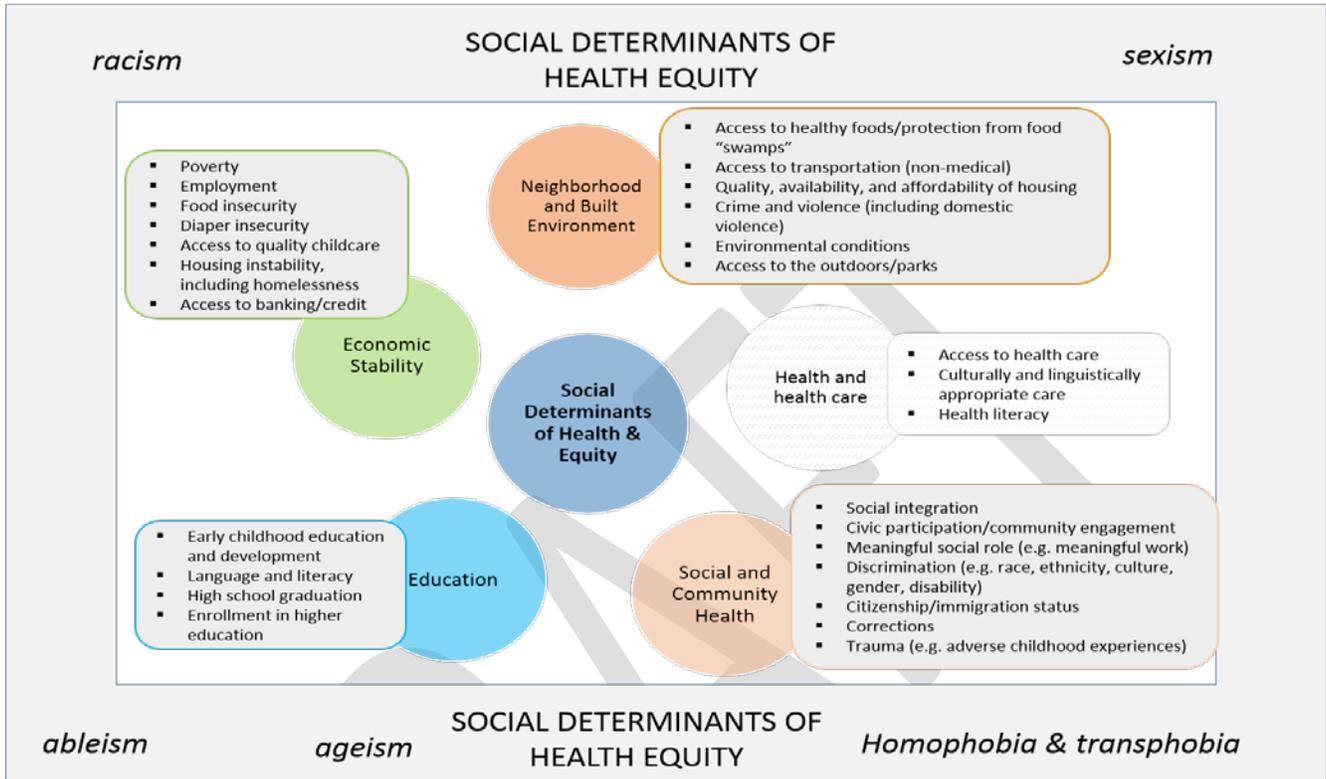
Social determinants of health: *The social, economic, political and environmental conditions in which people are born, grow, work, live and age. These conditions significantly impact length and quality of life and contribute to health inequities.*

¹ Medicaid Advisory Committee (May, 2018) https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf

² In December 2017–January 2018, the MAC administered a survey with CCOs, CCO community advisory councils, and select community partners such as regional health equity coalitions, providers, local public health and tribal public health. CCOs and community partners were unified in selecting housing as the top priority for future work in SDOH.

Social determinants of equity: Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies and political systems, both historical and current. Institutionalized racism is one example.

The graphic below contains a list of factors that fit the definitions above.



Health-related social needs: individual's social and economic barriers to health, such as housing instability or food insecurity

How to use this guide

Health-related services can be used to address an array of social needs for CCO members, ranging from food insecurity and transportation barriers to the inability to maintain safe and stable housing. Services that address these concerns, such as housing-related needs and supports, can be covered by HRS, provided these services meet criteria defined under OAR 410-141-3150 and 45 CFR 158.150 or 45 CFR 158.151.

CCOs should use this guide to inform how they use HRS to address the housing-related needs of their members and community. While there are many services CCOs can provide to create healthier housing and prevent environmental illness (such as strategies to remove toxins and molds), this guide focuses on the services and supports that help people find and maintain stable housing. This guide will help CCOs determine housing-related services and supports that qualify for HRS, the types of spending that would not qualify as HRS, and the types services and supports that have a strong evidence base to improve health outcomes.

While this guide references published studies, evidence and government/professional endorsements for investing in housing to improve health outcomes, this is not a complete nor prioritized list of housing services and supports that CCOs could cover. This guide is also not a definitive overview of all covered services and opportunities to utilize this funding stream in concert with other covered services. Additionally, due to the variation in coverage that many special populations may access, such as additional benefits available to individuals with intellectual or developmental disabilities (IDD) and those with severe and persistent mental illness (SPMI), it is important to understand when housing-related services may be covered directly within the State Plan and various waivers. It is also important to exhaust all other coverage options before utilizing HRS. Please refer to the appendices for guides on special populations to fully understand opportunities for housing-related services across all Medicaid recipients.

Background on housing-related challenges in Oregon

Given a severe lack of affordable housing across the state, many Oregonians face housing challenges. On a single night in January 2017, 13,953 people experienced homelessness, which was 6 percent higher than the 2015 count. Low-income residents, including those who qualify for the Oregon Health Plan (OHP), may experience homelessness or spend more than half of their income on rent, leaving few resources to meet their other basic needs. Communities of color, particularly African Americans and Native Americans, are much more likely than white Oregonians to experience homelessness and face other housing challenges.

How can housing-related services and supports qualify as HRS?

The following table links to sections and appendices in this guide that provide tools and resources to meet specific requirements for HRS.

Health-related services must...	See...
Be designed to improve health quality	How do housing challenges affect health? Evidence-based housing interventions to improve health outcomes
Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements	Housing and health outcomes: what does the research show?
Be directed toward either individuals or segments of enrollee populations or provide improvements to the population beyond those enrolled without additional costs for the non-members	Flexible services and community benefit initiatives

Health-related services must...	See...
Be grounded in evidence-based medicine, widely accepted best clinical practice, OR criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations	Who endorses housing as a health-related strategy? Government, professional and other endorsements
<p>Meet at least one of the following criteria:</p> <ul style="list-style-type: none"> • Improve health outcomes compared to a baseline and reduce health disparities among specified populations • Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge • Improve patient safety, reduce medical errors, and lower infection and mortality rates • Implement, promote and increase wellness and health activities 	<p>How does housing improve health?</p> <p>Flexible services and community benefit initiatives</p>

Flexible services and community benefit initiatives

CCOs can use HRS to offer a variety of housing-related services and supports for individual members and communities. These housing-related services and supports can help increase housing stability and housing affordability for members in ways that improve health outcomes and prevent more expensive medical costs and interventions (such as emergency department visits). **HRS must be designed to improve health care quality and cannot be designed primarily to control or contain costs.** However, health care cost reduction might be a secondary benefit of investing in many SDOH interventions.

HRS funds can be spent in two different ways.

1. **Flexible services:** These are services delivered to an individual OHP member to address social needs and improve their health and well-being. Examples of housing-related flexible services include community-based or supportive housing services, assistance searching for housing and moving costs (for example, first/last month's rent).
2. **Community benefit initiative:** These are community-level interventions that address social determinants of health that include -- but are not limited to -- OHP members and are focused on improving population health and health care quality. Examples of housing-related community benefit initiatives include funding a housing case manager at a local housing organization to provide housing supportive services to members or establishing onsite clinical services in a housing facility that services OHP and other community members.

Additional funding facts:

- ✓ CCOs can use existing resources from their global budget to pay for health-related services; there is not a specific funding source for HRS.

- ✓ Each CCO determines its own process for how housing support providers or health care providers can request HRS funding on behalf of a member.
- ✓ Decisions about whether to fund individual requests or to start programs using HRS to support housing for members remain entirely at the discretion of each CCO.
- ✓ Housing-related services covered through various Medicaid waivers and/or for specific populations can act as a template for CCOs to use HRS to expand access to housing-related services for their members.

How does housing impact health?

Research has shown that housing can impact health through four pathways: stability, affordability, quality and safety, and neighborhood environment.ⁱ This section focuses on how HRS can address the first two of these pathways: stability and affordability. Some of the health impacts of housing instability and lack of affordable housing include:

Housing condition	Health impact
Homelessness	Greater risk of poor health outcomes, including complications of chronic illness, substance use disorders, and behavioral health issues such as post-traumatic stress disorder. ⁱⁱ Children who experience homelessness, even if only prenatal (mothers homeless during pregnancy), are more likely to have fair or poor health and suffer hospitalization compared to their peers who do not experience homelessness. ⁱⁱⁱ
Chronic homelessness	More likely to be hospitalized and to die younger than the general population. ^{iv}
Housing instability	Children are more likely to engage in early drug use, experience depression, or have a teenage pregnancy. ^v
Displacement	Detrimental effects that include relocation costs, longer commutes, disruptions to health care, loss of community support networks, and homelessness. These can impact mental and psychological well-being.
Gentrification	Likely to experience financial distress as housing costs rise, and can often suffer a loss of community services and institutions.
Lack of affordability	May force individuals and families to choose between paying rent and paying for timely and appropriate medical care, which can result in unnecessary emergency room visits. ^{vi} Can compound other social determinants of health challenges, such as food insecurity. ^{vii}

Evidence-based housing interventions to improve health outcomes

Conversely, expansive evidence supports the direct relationship between housing interventions and health outcomes within low-income or otherwise vulnerable populations. Whether enabling access to

housing, creating a supportive housing environment, or simply expanding the availability of affordable housing to families in impoverished neighborhoods, research shows that housing has critical effects on the health of vulnerable individuals. An Oregon study demonstrated that supportive housing with health-related services increased primary care visits by 20 percent and emergency department visits went down 18 percent across 145 affordable housing properties.^{viii} Appendix A includes a selection of interventions and studies that indicate providing housing services and supports can result in improved health outcomes, lower utilization of high-cost health services, and reduced costs to the health care system.

Note: Appendix A is not a comprehensive list of all possible studies or evidence that any specific housing-related services “increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements” (as required by OAR 410-141-3150). CCOs are encouraged to seek additional evidence to support desired interventions.

Existing waivers and targeted services as template for HRS

CMS guidance (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>) describes a set of housing supports and services that can be covered through existing Medicaid authorities and waivers. HRS can allow CCOs to provide similar services to other members who are not already eligible for these services in Oregon, but who may have acute and immediate housing needs (such as homeless individuals and those at risk of homelessness), if the services meet HRS criteria.

Below are some services described in the CMS guidance that can offer additional guidance to CCOs. (Appendix C provides a more comprehensive look at these services and their HRS potential.)

Pre-tenancy services:

- Tenant screening and assessment of housing preferences/barriers
- Developing an individualized housing support plan

Note about HRS dollars for room and board

At this time, OHA and the Medicaid Advisory Committee see no likely scenarios where making a capital investment in a brick-and-mortar housing development, including a supportive housing development, would meet requirements under HRS, due to CMS guidance that “room and board” is not a permitted Medicaid expense.

Similarly, there are no likely scenarios where long-term rental assistance would meet requirements for HRS.

However, OHA supports a CCO’s ability to use HRS for housing assistance that is limited to short-term situations where housing is a central part of crisis intervention, stabilization and/or transition for a patient, where there is a direct health benefit, and where the assistance meets the criteria to qualify as an HRS (OAR 410-141-3150 and 45 CFR 158.150-1).

OHA also encourages CCO innovation and believes it is possible for CCOs to participate in, and potentially help fund, comprehensive projects that include brick-and-mortar housing development using multiple sources of funding, as long as Medicaid funding is only being used to pay for HRS and other services that comply with CMS guidance.

- Assisting with rent subsidy and housing application processes
- Assisting with housing search
- Identifying resources/covering start-up expenses (security deposits, other lease/rental costs)
- Assisting in arranging for and supporting the details of move-in
- Ensuring housing unit is safe and ready for move-in
- Developing an individualized housing support crisis plan
- Supporting “Rent Well” or “Ready to Rent” tenant education resources
- Bridging related covered services for limited English proficiency (LEP) and members with disabilities

Tenancy-sustaining services:

- Early identification/intervention for behaviors that may jeopardize housing
- Education on the role, rights and responsibilities of the tenant and landlord
- Coaching on developing/maintaining relationships with landlords/property managers
- Assistance resolving disputes with landlords or neighbors
- Advocacy/linkage with community resources to prevent eviction
- Assistance with the housing recertification process
- Coordination with tenant to review/update/modify housing support and crisis plan
- Continued training on being a good tenant and lease compliance
- Supports to locate new housing if at risk

While existing guidance for some types of housing-related services can provide a starting point for CCOs, additional housing-related services could be delivered to CCO members through HRS. The following list highlights additional housing-related services and their potential for coverage using HRS.

Barrier removal (generally qualifies as HRS)

- Equipment, technology and modifications
- Helping someone get birth certificate/ID necessary for housing paperwork
- Moving costs (for example, first/last month’s rent)
- Basic furnishings
- Set-up fees for utilities

Medical-legal partnership (may qualify as HRS)

- Support for individuals to resolve housing-related legal issues, such as eviction

Temporary housing/shelter as a central part of a crisis intervention, stabilization and/or a transition for a patient with intention of a direct health benefit (may qualify as HRS)

- Short-term housing assistance for those transitioning from acute care setting
- Extended post-hospitalization lodging for members who are homeless or housing instable and require additional care or medical treatment after discharge
- Short-term assistance as part of a crisis intervention or stabilization

Ongoing rental assistance (does not qualify as HRS)

- Rental assistance (for example, voucher program) on an ongoing basis and/or NOT associated with a crisis intervention, stabilization and/or transition for a patient and/or NOT associated with a direct health benefit

Capital investments in brick-and-mortar housing (does not qualify as HRS)

- Directly funding development of new housing units

Conclusion

Health-related services have the potential to improve health and reduce medical costs. The MAC encourages CCOs to continue to share their success stories with the MAC and Oregon Health Policy Board, as well as through OHA-hosted learning collaboratives and other reports to OHA, to leverage this powerful tool for improving the lives of CCO members.

Appendices

Appendix A: Evidence on housing-related services and supports related to housing affordability and stability to improve health

Appendix B: Organizations that support housing as a strategy to improve health and/or health equity

Appendix C: Housing-related services coverage in current waivers and potential for HRS coverage

Appendix D: Innovative CCO examples of housing related-programs in Oregon

Appendix E: Glossary of housing terms

ⁱ “Housing And Health: An Overview of the Literature,” Health Affairs Health Policy Brief, June 7, 2018. DOI: 10.1377/hpb20180313.396577

ⁱⁱ Brickner, P., Scharer, L., Conanan, B., Savarese, M., Scanlan, B. (Eds). (1990). *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*.

ⁱⁱⁱ Sandel, M et al. (June 2015). Compounding stress: The timing and duration effects of homelessness on children’s health. Children’s Health Watch. Available at: http://media.wix.com/ugd/19cfbe_07b13c8e56a14337a316e2e991aa0bf7.pdf

^{iv} Manness, D. L. and Khan, M. (April 15, 2014). Care of the Homeless: An Overview. 89(8):634-640.

^v Jellyman, Tim and Spencer, Nicholas J. (August 2008). Residential mobility in childhood and health outcomes: A systematic review. *Journal of epidemiology and community health*. 62(7):584-592.

^{vi} Harkness J and Newman S.(2005). Housing Affordability and Children’s Well-Being: Evidence from the National Survey of America's Families. *Housing Policy Debate*, 16:223-55.

^{vii} “The State of the Nation’s Housing, 2017.” Joint Center for Housing Studies of Harvard University. Available at: http://www.jchs.harvard.edu/sites/default/files/harvard_jchs_state_of_the_nations_housing_2017.pdf

^{viii} <http://www.phi.org/news-events/1037/bending-the-healthcare-cost-curve-four-policy-recommendations-for-healthy-housing>

Appendix A: Evidence on housing-related services and supports related to housing affordability and stability to improve health

There is expansive evidence supporting the direct relationship between housing interventions and health outcomes within low-income or otherwise vulnerable populations. Whether enabling access to housing, creating a supportive housing environment, or simply expanding the availability of affordable housing to families in lower-poverty neighborhoods, research shows that housing is critical to the health of vulnerable individuals. The following interventions and studies indicate that providing housing support for low-income, high-need individuals results in net savings due to reduced health care costs. The evidence indicates that the integration of housing with some health care services can result in improved health outcomes.

Target Pop.	Evaluation Details	Intervention	Summary of Services	Results	Improvements in...			Summary of Outcomes
					Health	HC Use	HC Costs	
AFFORDABLE HOUSING								
Families living in high-poverty neighborhoods	Sanbonmatsu et al. (2011) <i>Various Locations</i> n=4,600	Moving to Opportunity	Provided either (a) unrestricted rental housing vouchers or (b) housing vouchers that could only be used in neighborhoods with poverty rates below ten percent.	4- 12 years	✓			<ul style="list-style-type: none"> • Lower prevalence of obesity and diabetes • Fewer self-reported physical limitations • Lower prevalence of psychological distress and major depression
SUPPORTIVE HOUSING (<i>affordable housing with integrated health & social services</i>)								
Medicaid enrollees: low-income families, seniors, and people with disabilities	Providence Center for Outcomes Research & Education (2016) <i>Oregon</i> n=1,625	Affordable Housing with Integrated Health Services	Low income individuals on Medicaid moved into one of the following types of affordable housing, more than half of which offered integrated medical resources of some kind: (1) <i>subsidized family housing</i> (2) <i>permanent supportive housing</i> (3) <i>housing for seniors and people with disabilities</i>	4 years		✓	✓	<ul style="list-style-type: none"> • 12% decline in total Medicaid expenditures (declines seen for all housing types) • 20% increase in outpatient primary care utilization in the year after moving in • 18% decline in ED use <p><i>The presence of health services was a driver of lower costs and ED use, despite low awareness among residents.</i></p>

Target Pop.	Evaluation Details	Intervention	Summary of Services	Results	Improvements in...			Summary of Outcomes
					Health	HC Use	HC Costs	
Homeless individuals	Flaming et al. (2009) Los Angeles, California n=10,193	Skid Row Housing Trust & Emergency Housing Vouchers	Homeless individuals entered supportive housing with (a) integrative supportive services through SRHT or (b) basic single-room occupancy through emergency housing vouchers.	22 months			✓	<ul style="list-style-type: none"> 91% savings (\$768 pp) estimated for Health Services inpatient visits 82% savings (\$348 pp) estimated for private hospital inpatient visits 87% savings (\$144) estimated for paramedics 87% savings (\$165 pp) estimated for outpatient visits 56% savings (\$81) estimated for Dept of Mental Health <p><i>Full report segments results by program/services.</i></p>
Homeless people with HIV	Szwarcz et al. (2009) San Francisco, California n=6,558	Direct Access to Housing (DAH) Program	Homeless people with HIV were housed at a DAH site, each of which have dedicated case managers and provide medical services that range from an on-site, full-time nurse and part-time, mid-level clinician to obtaining care at designated health care facilities located near the DAH residences.	5 years	✓			67% percent of the persons who were homeless survived five years compared with 81% of those who were housed
Homeless individuals with severe mental disabilities	Culhane et al. (2002) New York City, NY n=4,679	NY/NY Housing	Homeless individuals with severe mental illness were placed in subsidized permanent housing either in the form of supportive housing (with community-based service support and single-room occupancy) or community residence facilities (which have services available on site and participation mandated by the residence agreement).	2 years			✓	<ul style="list-style-type: none"> 20% decline in proportion of population accessing Medicaid hospital days (vs. 13% in control group) 36% decline in mean number of Medicaid hospital days compared to (vs. 0% in control group) 4% increase in proportion of population with Medicaid-reimbursed outpatient visits (vs. 8% decrease in control group) 90% increase in mean number of Medicaid-reimbursed outpatient visits (vs. 7% in control group) 41% decline in OMH state hospital days used (vs. 17% in control group)
Chronically homeless adults	Rosenheck & Mares (2010) Various Locations n=734	Collaborative Initiative to Help End Chronic Homelessness (CICH)	Provided permanent housing, substance abuse and mental health treatment, and supportive primary healthcare.	1 year	✓		✓	<ul style="list-style-type: none"> 50% reduction in health costs (including the costs of mental health services and substance use disorder treatment as well as medical and dental treatment) 28 -50% reduction in substance use by drug users

Target Pop.	Evaluation Details	Intervention	Summary of Services	Results	Improvements in...			Summary of Outcomes
					Health	HC Use	HC Costs	
Foster youth at risk of homelessness	Latham et al. (2008) <i>California</i> n=586	Foster Youth Housing Initiative	Provided with services to help them obtain and maintain housing.	15 months	✓	✓		<ul style="list-style-type: none"> Increased utilization of health services, including mental health services Decreased depression and a self-reported more positive overall outlook on life
Adults with serious mental illness	Levine & Meschede (2007) <i>Massachusetts</i> n=453	Special Homeless Initiative (HI)	Permanent supportive housing arrangements that help tenants retain their housing and achieve stable living situations. Services include protocols for discharge planning, staff training to focus on housing issues, outreach to people with serious mental illness living on the streets or in shelters, development of specialized shelters, and other aspects of homelessness prevention and intervention.	2 years			✓	93% reduction in average number of hospital days per client, resulting in \$18 million reduction in health care costs annually
Chronically homeless individuals with psychiatric disabilities and often substance abuse	Gulcur et al. (2003) <i>New York</i> n=225	Housing First & Continuum of Care	<p>Study compared two distinct approaches to supported housing for homeless individuals recruited from psychiatric hospitals and the streets:</p> <p>(1) Housing First Program: offered immediate access to independent housing without requiring psychiatric treatment or sobriety</p> <p>(2) Continuum of Care Program: made treatment and sobriety prerequisites for housing</p>	2 years		✓		<p>Housing First Program:</p> <ul style="list-style-type: none"> 0.014 decrease in proportion of time spent in hospital among those recruited from the street 0.686 decrease in proportion of time spent in hospital among those recruited from hospital <p>Continuum of Care Program:</p> <ul style="list-style-type: none"> 0.030 decrease in proportion of time spent in hospital amount those recruited from street 0.698 decrease in proportion of time spent in hospital among those recruited from hospital <p><i>Housing First was less expensive and participants had fewer days in the hospital than the continuum of care program.</i></p>

Target Pop.	Evaluation Details	Intervention	Summary of Services	Results	Improvements in...			Summary of Outcomes
					Health	HC Use	HC Costs	
Homeless individuals with disabilities	Perlman and Parvensky (2006) <i>Denver, Colorado</i> n=150	Denver Housing First Collaborative	Referred to and provided comprehensive housing and supportive services, based in a housing first strategy combined with assertive community treatment (ACT) services-- integrated health, mental health, substance treatment and support services.	2 years	✓	✓	✓	<ul style="list-style-type: none"> Emergency cost savings averaged \$31K per person ER visits and costs reduced by 34.3% Inpatient visits reduced by 40% and inpatient nights reduced by 80% Increased outpatient visits by 1% 82% decline in detox visits over two years with average cost savings of 84% (\$8,700 per person) 50% of participants documented improved health status 43% improved mental health 64% improved overall QoL
Medicaid recipients experiencing homeless	Providence Center for Outcomes Research & Education (2014) <i>Portland, Oregon</i> n=99	Bud Clark Commons	Supportive housing including case management, community building, exercises, and counseling for Medicaid recipients who were homeless, based in housing first model. Funded through a Medicaid global budget waiver.	1 year		✓	✓	<ul style="list-style-type: none"> 55 percent decrease in total monthly Medicaid costs 14 percentage point decrease in the proportion of participants using the ED 16 percentage point increase in the proportion of participants with a stable primary care provider 31 and 28 percentage point decreases in the number of participants reporting unmet physical and mental health needs
SDOH SCREENING & REFERRAL								
Patients at various risk levels	Sandberg et al. (2014) <i>Minnesota</i> n=9,054	Hennepin Health	Interdisciplinary care coordination teams located in primary care clinics assess and provide links to nonclinical services such as housing and vocational assistance.	1 year		✓		<ul style="list-style-type: none"> 9.1% decrease in ED visits 3.3% increase in outpatient visits 8%-12% increase in optimal chronic care delivery
Patients with unmet basic resource needs	Berkowitz et al. (2017) <i>Boston, Massachusetts</i> n=5,125	Health Leads	Primary care patients screened for unmet basic needs, such as food, medication, housing, and transportation. Those who reported needs linked to community resources to address them.	3 years	✓			<ul style="list-style-type: none"> Improvements in blood pressure Improvements in cholesterol level

Target Pop.	Evaluation Details	Intervention	Summary of Services	Results	Improvements in...			Summary of Outcomes
					Health	HC Use	HC Costs	
Children	Gottlieb et al. (2016) <i>San Francisco, California</i> n=1,809	Pediatric Social Needs Navigation Program	Patients screened for social needs including housing stability & habitability after which caregivers either received (a) written information on relevant community services or (b) in-person help to access services with follow-up telephone calls for further assistance if needed.	4 months	✓			Improvement in children's overall health status
Health plan members who are high utilizers of ED	Johnson et al. (2012) <i>New Mexico</i> n=448	Community Health Workers	Community Health workers (CHW) assess members' needs and provide training/education referrals and linkages to community and plan based services.	6 months		✓	✓	<ul style="list-style-type: none"> • Decrease in inpatient, prescription and narcotic counts and costs • Reduction in resource utilization
SDOH SCREENING + SUPPORTIVE HOUSING								
Frequent users of ED services	Linkins et al. (2008) <i>California</i> n=1,180	Frequent Users of Health Services Initiative	Provided case management services following discharge and connected individuals to local social service organizations. Of participants, half were homeless at the time of enrollment, among which 1/3 were connected to permanent housing through HUD vouchers and 1.2 were placed in shelters, board and care homes, or other similar placements.	2 years		✓	✓	<ul style="list-style-type: none"> • 60% decline in ED from baseline • 17% decline in hospital charges • 64% decline in admissions and 69% decline in charges • 3% increase in outpatient visits • Of the participants without insurance, 64% were connected to local county indigent program. Medi-Cal apps filed for 25%. <p><i>Full report outlines the most effective practices among the six intervention models.</i></p>

Target Pop.	Evaluation Details	Intervention	Summary of Services	Results	Improvements in...			Summary of Outcomes
					Health	HC Use	HC Costs	
High-cost homeless individuals	Flaming et al. (2013) <i>Los Angeles, California</i> n=163	10th Decile Project	The 10 percent of homeless patients with the highest public and hospital costs were identified and provided immediate services for permanent supportive housing or affordable housing that provides access to health and social services, such as mental health and addiction therapy, medical care, and case management.	2 years			✓	72% reduction in total annual health care costs, from \$58,962 to \$16,474 per person (despite 25% of those enrolled in program not yet housed but receiving services)
OTHER HOUSING SERVICES								
Young children	Frank et al. (2006) <i>Various Locations</i> n=7,074	Low-Income Energy Assistance Program (LIHEAP)	Families provided assistance with costs related to home heating, medically necessary home cooling, and emergencies due to weather-related supply shortages.	N/A	✓	✓		<ul style="list-style-type: none"> • Children in LIHEAP families had greater weight for age and lower odds of nutritional risk for growth problems • Children from households not receiving the LIHEAP had greater odds of acute hospital admission on the day of the interview
Young adults (18-24) transitioning out of foster care	First Place for Youth (2012) <i>California</i> n=103	My First Place	Rental housing, case management, education, and employment support services.	2 years	✓	✓	✓	<ul style="list-style-type: none"> • Increase in self-efficacy • Reduction in depression • Increased mental health and medical insurance coverages • \$44,000 per person per year in net savings.

Appendix B: Organizations that support housing as a strategy to improve health and/or health equity

This list is provided to illustrate the variety of governmental, medical, philanthropic and research-based organizations that are focusing on health issues and increasingly recognizing the connection between health and housing. Many of these prominent authorities are undertaking research and providing public support to inform the use of housing as a strategy to improve health and/or health equity.

U.S. GOVERNMENT AGENCIES	
<p>Advisory Committee on Training in Primary Care Medicine and Dentistry</p>	<p>Report: Addressing the Social Determinants of Health: The Role of Health Professions Education (2016). Retrieved from <https://www.hrsa.gov/advisorycommittees/bhpradvisory/actpcmd/actpcmd_13th_report_sdh_final.pdf>.</p> <p><i>“Health professions education must incorporate training in SDH to provide students with the skills needed to become quality healthcare professionals that practice in rural and underserved communities after graduation, can refer patients to social service resources to improve their health, and can advocate for changes to reduce health disparities related to SDH” (p.10).</i></p>
<p>Centers for Medicare & Medicaid Services</p>	<p>Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities (2015). Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.</p> <p><i>“This Informational Bulletin is intended to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness” (p.1).</i></p>
<p>Office of the Surgeon General</p>	<p>Report: The Surgeon General's Call to Action to Promote Healthy Homes (2009). Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK44192/pdf/Bookshelf_NBK44192.pdf>.</p> <p><i>“Health care providers and home-visiting programs can promote a more comprehensive and coordinated approach by incorporating healthy housing solutions into their protocols” (p.37).</i></p>
<p>Substance Abuse & Mental Health Services Administration</p>	<p>Topic Overview: Homelessness and Housing (2017). Retrieved from <https://www.samhsa.gov/homelessness-housing>.</p> <p><i>“SAMHSA supports programs that address homelessness and increase access to permanent housing for people with mental and/or substance use disorders.”</i></p>

MEDICAL AUTHORITIES

<p>World Medical Association</p>	<p>Topic Overview: Social Determinants: Reducing Health Inequalities (2018). Retrieved from <https://www.wma.net/what-we-do/public-health/social-determinants/>.</p> <p><i>“In 2014, the WMA hosted the H20 International Health Summit with the Australian Medical Association which highlighted the importance of SDH and urged the medical community to increase its efforts in this area. Currently the WMA is collaborating with WHO on an eBook that will help improve knowledge of SDH within the healthcare workforce.”</i></p>
<p>American Academy of Family Physicians</p>	<p>Policy Statement: Social Determinants of Health Policy (2018). Retrieved from <https://www.aafp.org/about/policies/all/social-determinants.html>.</p> <p><i>“The AAFP supports the assertion that physicians need to know how to identify and address social determinants of health in order to be successful in promoting good health outcomes for individuals and populations.”</i></p>
<p>Association of American Medical Colleges</p>	<p>Report: Achieving Health Equity: How Academic Medicine Is Addressing the Social Determinants of Health (2016). Retrieved from <https://www.aamc.org/download/460392/data/sdoharticles.pdf>.</p> <p><i>“To truly benefit all, academic medicine and its partners must increasingly focus on efforts to address health and health care inequities that continue to undermine the well-being of various groups in the United States...The need to address these social factors, these ‘social determinants of health,’ is integral to academic medical centers’ mission to improve health” (p.4).</i></p>
<p>American Hospital Association</p>	<p>Report: Social Determinants of Health Series: Housing the Role of Hospitals (2017). Retrieved from <https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/housing-role-of-hospitals.pdf>.</p> <p><i>“With more low- and middle-income individuals gaining insurance coverage under the Affordable Care Act, health care providers [hospitals and health systems] must invest in meeting the social needs that can shape the health status of these patients” (p.4).</i></p>
<p>American Medical Association</p>	<p>Resolution: 208 - Housing Provision & Social Support to Immediately Alleviate Chronic Homelessness in the United States (2017). Retrieved from <https://www.ama-assn.org/sites/default/files/media-browser/public/hod/a17-resolutions.pdf>.</p> <p><i>“Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services” (p.373).</i></p>

MEDICAL AUTHORITIES

American Academy of Pediatrics

Policy Statement: Council on Community Pediatrics (2013). **Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity.** Retrieved from <<http://pediatrics.aappublications.org/content/pediatrics/131/6/1206.full.pdf>>.

“Given the overall effects that homelessness can have on a child’s health and potential, it is important for pediatricians to recognize the factors that lead to homelessness, understand the ways that homelessness and its causes can lead to poor health outcomes, and when possible, help children and families mitigate some of the effects of homelessness” (p.1206).

Policy Statement: Council on Community Pediatrics (2016). **Poverty and Child Health in the United States.** Retrieved from <<http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf>>.

“The American Academy of Pediatrics advocates for programs and policies that have been shown to improve the quality of life and health outcomes for children and families living in poverty. With an awareness and understanding of the effects of poverty on children, pediatricians and other pediatric health practitioners in a family-centered medical home can assess the financial stability of families, link families to resources, and coordinate care with community partners” (p.1).

American College of Physicians

Position Paper: Health and Public Policy Committee (2018). **Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper.** Retrieved from <<http://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-american>>.

The American College of Physicians recommends:

- *That social determinants of health be integrated into medical education at all levels*
- *Increased professional communication and collaborative models that encourage a team-based approach to treating patients at risk to be negatively affected by social determinants of health*
- *The adequate and efficient funding of federal, state, tribal, and local agencies in their efforts to address social determinants of health, including investments in programs and social services shown to reduce health disparities or costs to the health care system and agency collaboration to reduce or eliminate redundancies and maximize potential impact*
- *Development of best practices for utilizing electronic health record (EHR) systems as a tool to improve individual and population health*
- *Adjusting quality payment models and performance measurement assessments to reflect the increased risk associated with caring for disadvantaged patient populations*

ADDITIONAL HEALTH ORGANIZATIONS

<p>American Diabetes Association</p>	<p>Report: Standards of Medical Care in Diabetes - 2018. Retrieved from <http://care.diabetesjournals.org/content/diacare/suppl/2017/12/08/41.Supplement_1.DC1/DC_41_S1_Combined.pdf>.</p> <p><i>“Providers should assess social context, including potential food insecurity, housing stability, and financial barriers, and apply that information to treatment decisions; providers should refer patients to local community resources when available; providers should provide patients with self-management support from lay health coaches, navigators, or community health workers when available” (p.9).</i></p>
<p>American Public Health Association</p>	<p>Policy Statement: Housing and Homelessness as a Public Health Issue (2017). Retrieved from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-and-homelessness-as-a-public-health-issue>.</p> <p><i>“Homelessness continues to be a recalcitrant public health problem in the United States, as those experiencing homelessness have high rates of chronic mental and physical health conditions, co-occurring disorders, and ... overuse emergency services. To achieve an end to homelessness, APHA sets forth recommendations for federal, state, and local policymakers and agencies to work collaboratively in funding evidence-based housing acquisition practices and supportive housing stability services, as well as supporting future innovations in integrated services for individuals experiencing homelessness.”</i></p>
<p>National Quality Forum</p>	<p>Report: A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability (2017). Retrieved from <https://sirenetwork.ucsf.edu/tools-resources/resources/framework-medicaid-programs-address-social-determinants-health-food>.</p> <p><i>The [National Quality Forum] Expert Panel provided six recommendations to support the implementation of a framework for state Medicaid programs to better assess and address social needs in healthcare, using food insecurity and housing instability and illustrative examples. The recommendations are as follows (p.3):</i></p> <ol style="list-style-type: none"> <i>1. Acknowledge that Medicaid has a role in addressing social determinants of health.</i> <i>2. Create a comprehensive, accessible, routinely updated list of community resources.</i> <i>3. Harmonize tools that assess social determinants of health.</i> <i>4. Create standards for inputting and extracting social needs data from electronic health records.</i> <i>5. Increase information sharing between government agencies.</i> <i>6. Expand the use of waivers and demonstration projects to learn what works best for screening and addressing SDOH.</i>

ADDITIONAL HEALTH ORGANIZATIONS

Institute for Healthcare Improvement

White Paper: Wyatt, Laderman, Botwinick, Mate, & Whittington (2016). **Achieving Health Equity: A Guide for Health Care Organizations.** Retrieved from <www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>.

“Health care has a significant role to play in achieving health equity. While health care organizations alone do not have the power to improve all of the multiple determinants of health for all of society, they do have the power to address disparities directly at the point of care, and to impact many of the determinants that create these disparities.”

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Appendix C: Housing-related services coverage in current waivers and potential for HRS coverage

A myriad of interventions are associated with obtaining and maintaining stable housing. This table illustrates which funding sources could be used to pay for those services and how these might braid with other funding sources.

Services covered for some populations under Medicaid State Plan or existing waivers (SPMI, Seniors/APD, I/DD; * not all services covered for all populations or waivers)	HRS examples: Flexible Services, Community Benefit Initiatives, and HIT
PRE-TENANCY SERVICES	
<ul style="list-style-type: none"> • Tenant screening and assessment of housing preferences/barriers • Developing an individualized housing support plan • Assistance with rent subsidy and housing application processes • Assistance with housing search • Identify resources/cover start-up expenses (security deposits, other lease/rental costs) • Assisting in arranging for and supporting the details of move-in • Ensuring housing unit is safe and ready for move-in* • Developing an individualized housing support crisis plan 	<p>Flexible Services Cover specific services or a collection of services for patients reimbursing partner organizations or with internal staff resource (e.g., housing case manager)</p> <p>Community benefit initiative Fund an external or internal staff member to provide housing supportive services to members (e.g., housing case manager at local housing organization)</p>
TENANCY SUSTAINING SERVICES	
<ul style="list-style-type: none"> • Early identification/intervention for behaviors that may jeopardize housing • Education on the role, rights and responsibilities of the tenant and landlord • Coaching on developing/maintaining relationships with landlords/property managers • Assisting in resolving disputes with landlords and/or neighbors • Advocacy/linkage with community resources to prevent eviction. • Assisting with the housing recertification process* • Coordinating with tenant to review/update/modify housing support & crisis plan • Continuing training on being a good tenant and lease compliance* 	<p>Flexible Services Cover specific services or a collection of services for patients by reimbursing partner organizations or with internal staff resource (e.g., housing case manager)</p> <p>Community benefit initiative Fund an external or internal staff member to provide housing supportive services to members (e.g., housing case manager at local housing organization)</p>
OTHER COMMUNITY BASED SERVICES	
<ul style="list-style-type: none"> • Outreach and in-reach services • Service assessment or monitoring, • Service plan development and care coordination • Assistance with daily living skills; skill development and acquisition 	<p>Flexible Services Cover community-based or supportive housing health-related services as needed for individual, through internal staff or external reimbursement</p>

Services covered for some populations under Medicaid State Plan or existing waivers (SPMI, Seniors/APD, I/DD; * not all services covered for all populations or waivers)		HRS examples: Flexible Services, Community Benefit Initiatives, and HIT
<ul style="list-style-type: none"> • Job skills training/education including supported employment* • Transportation • Caregiver/family and peer supports • Health management* • Counseling and therapies and support groups* • Discharge planning 	Community benefit initiative Fund an external or internal staff member to provide supportive services to members in housing (e.g., traditional health workers [community health workers or peer support specialists]); on-site clinical services)	
BARRIER REMOVAL		
<ul style="list-style-type: none"> • Equipment, Technology, and Modifications • Helping someone get birth certificate/ID necessary for housing paperwork • Moving costs (e.g. first/last month’s rent) • Basic furnishings • Set-up fees for utilities 	Flexible Services	
	Community benefit initiative	
Services covered for some populations under Medicaid State Plan or existing waivers (SPMI, Seniors/APD, I/DD; * not all services covered for all populations or waivers)		HRS examples: Flexible Services, Community Benefit Initiatives, and HIT
TEMPORARY HOUSING AND SHELTER as a central part of a crisis intervention, stabilization and/or transition for a patient, where there is a direct health benefit		
<ul style="list-style-type: none"> • Short-term housing assistance for those transitioning from acute care to transitional or affordable housing units • Extended post hospitalization lodging for members that are homeless or housing instable and require additional care or medical treatment after discharge • Short-term assistance as part of a crisis intervention or stabilization 	Flexible Services	
	Community benefit initiative	
Services covered for some populations under Medicaid State Plan or existing waivers (SPMI, Seniors/APD, I/DD; * not all services covered for all populations or waivers)		HRS examples: Flexible Services, Community Benefit Initiatives, and HIT
ONGOING RENTAL ASSISTANCE		
		Flexible Services

Services covered for some populations under Medicaid State Plan or existing waivers (SPMI, Seniors/APD, I/DD; * not all services covered for all populations or waivers)	HRS examples: Flexible Services, Community Benefit Initiatives, and HIT
<ul style="list-style-type: none"> Rental assistance (e.g., voucher program) on an ongoing basis and NOT associated with a crisis intervention, stabilization and/or transition for a patient and/or NOT associated with a direct health benefit 	<p>Community benefit initiative- not covered via HRS</p>
<p>CAPITAL INVESTMENTS IN BRICK-AND-MORTAR HOUSING</p>	
<ul style="list-style-type: none"> Directly funding development of new housing units 	<p>Flexible Services– not covered via HRS</p> <p>Community benefit initiative– not covered via HRS</p>

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Appendix D: Innovative CCO examples of housing-related programs

There are a variety of ways in which CCOs have attempted to address housing insecurity and homelessness across the state. Appendix D contains a table of innovative examples that demonstrate how CCOs have pursued, in collaboration with local partners and regional stakeholders, community-based solutions. In some cases, examples which include brick-and-mortar investments are included, as examples of how other funding streams can braid with HRS funding to create more holistic solutions. As noted previously, Medicaid funding cannot be used directly for brick-and-mortar and ongoing tenancy services.

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>CHANCE 2nd Chance <i>Intercommunity Health Network CCO (IHNCCO)</i></p> <p>Members experiencing challenges with mental health and addiction recovery</p> <p>This pilot provides a system of support through emergency housing assistance, transitional housing support, transportation support, reintegration into the community, and education around quality health, health care, and navigation.</p>			X		X		
<p>Health & Housing Planning Initiative <i>IHNCCO</i></p> <p>Residents of affordable housing properties</p> <p>With CCO funding, an affordable housing organization developed a health navigation program that used traditional health workers to connect residents with health care and social services where they live. The program included internal systems for earlier interventions on evictions using a trauma informed lens, 81 new health-related activities held on or near the properties, and enhanced relationships with local nutrition experts to provide educational opportunities to residents around gardening and nutrition.</p> <p><i>97 home evictions were prevented through pilot interventions</i></p>	X	X	X				

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>Youth Wrap Around & Emergency Services <i>IHNCCO</i></p> <p>Youth who are runaway, homeless, and/or at-risk</p> <p>With CCO funding, a local emergency shelter provides case-management, on-site mental health services, and referrals to health and other supportive services.</p> <p><i>100% of at-risk youth linked to a PCPCH and had an adolescent well-child exam</i></p>			X				
<p>Helping Hands Reentry Outreach Center <i>Columbia Pacific CCO</i></p> <p>Aduts & families experiencing homelessness</p> <p>With CCO funding, a shelter program which provides services in job readiness skills, education, housing attainment, and connections to health services now also offers an on-call crisis manager to respond to emergency situations with clients, who receive assistance in creating a trauma-informed comprehensive crisis plan that meets their individual needs.</p>	X		X		X		
<p>Optimal Case Management <i>Umpqua Health Alliance</i></p> <p>High-need individuals not connected to services</p> <p>High-need individuals with little access or connection to community resources (primary care, mental helath, stable housing, etc.) are referred by community organizations (hospitals, jails, etc.) to receive comprehensive case management to connect them to multiple health-promoting agencies.</p> <p><i>Obtained housing for half of the homeless referrals off of which remained in temporary/permanent housing at end of evaluation period)</i></p>	X		X				

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>Aspen Ridge Supportive Housing Program <i>Yamhill Coordinated Care Organization</i></p> <p>Individuals with co-occurring serious mental health and chronic medical challenges</p> <p>Aspen Ridge is a 16-unit mental health permanent supportive housing complex, complete with an on-site peer housing specialist who provides ongoing support and skills training.</p>		X					
<p>Frequent Users System Engagement Project (FUSE) <i>Trillium Community Health Plan</i></p> <p>High-utilizers of ED experiencing homelessness</p> <p>Homeless members with high utilization of health, social and government services are engaged in street outreach for housing services.</p> <ul style="list-style-type: none"> ED utilization decreased by 26% Inpatient stays by decreased by 55% Behavioral healthcare utilization decreased 14% 	X	X	X				
<p>ShelterCare Respite Program <i>Trillium Community Health Plan</i></p> <p>Recently-discharged individuals experiencing homelessness</p> <p>CCO refers members who are experiencing homelessness and have recently been discharged from the hospital after an acute medical episode to a medical recuperation facility that provides safe, temporary housing for one month, health care, and connections to community resources.</p> <p><i>Inpatient rates were 85% lower and 40% lower during and post-ShelterCare stays, respectively</i></p>			X		X		

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>HACSA Sponsors Program <i>Trillium Community Health Plan</i></p> <p>Individuals who are previously-incarcerated</p> <p>This program provides transitional housing, employment opportunities, and other reentry services to people released from Oregon state correctional facilities and the county Jail.</p> <ul style="list-style-type: none"> • Lower utilization of ED among sponsors members • Pharmacy and behavioral health utilization higher 	X		X		X		
<p>ADAPT Residential Treatment Programs <i>Western Oregon Advanced Health & Umpqua Health Alliance (UHA)</i></p> <p>Youth and adults struggling with addiction</p> <p>This organization offers addiction treatment programs to CCO members, including medical and social detox and a full range of mental health services, through outpatient or (in some locations) residential intensive day treatment with housing.</p>			X		X		
<p>Rogue Retreat <i>Jackson Care Connect</i></p> <p>Women in recovery & individuals experiencing homelessness</p> <p>CCO partners with RR to provide housing and case management for women in recovery, supporting members in moving along a continuum of housing and self-sufficient stability. CCO also funds a shower, laundry facility and drinking water for homeless county residents through Rogue Retreat.</p>		X	X			X	

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>Housing for All (H4A) PacificSource - Central Oregon CCO</p> <p>Individuals experiencing housing-insecurity</p> <p>H4A is a regional housing consortium made up of community partners, government bodies, and private businesses, formed to address the multiple dimensions of the housing affordability and availability crisis in Central Oregon.</p>	X	X	X				
<p>Pfeifer and Associates SUD Housing PacificSource - Central Oregon CCO</p> <p>Individuals experiencing homelessness and substance use disorders</p> <p>This organization provides permanent supportive housing to homeless individuals suffering from SUD.</p>		X			X		
<p>Pacific Crest Affordable Housing Asimeth 315 PacificSource - Central Oregon CCO</p> <p>Low-income individuals and families</p> <p>This organization provides affordable housing to low-income households, including resident services that focus on health (fitness room, a walking/jogging path, raised-bed community gardens, and bicycles available to residents) and access to health care (immunization clinics, health care navigation, physical and mental health screenings, referrals and more).</p>		X	X				
<p>Bethlehem Inn PacificSource - Central Oregon CCO</p> <p>Individuals and families experiencing homelessness</p> <p>This organization provides temporary housing, meals, and an array of health, housing, and social services intended to improve lives and prevent further homelessness.</p>		X	X				

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>NeighborImpact <i>PacificSource - Central Oregon CCO</i></p> <p>Economically disadvantaged individuals and families</p> <p>This organization assists low-to-moderate-income families and individuals with housing stabilization, early education, childcare, access to food, and financial skills training to help them remain in housing and avoid homelessness.</p>	X	X	X				
<p>Housing Advisory Committee <i>PrimaryHealth</i></p> <p>Regions lacking housing resources and capacity</p> <p>Faced with limited housing resources, this CCO proposed and helped to create city-appointed Housing Advisory Committee--a task force made up of concerned community partners and housing entities--which explores opportunities to facilitate provision of housing for all income levels, promotes public participation in identifying housing issues, and makes recommendations to the city council.</p> <p><i>Committee recently helped to pass a local policy that increased the amount of available housing</i></p>			X				
<p>Understanding Homelessness <i>AllCare Health CCO</i></p> <p>Individuals experiencing homelessness</p> <p>CCO partnered with an investigative journalist to generate an article and series of blogs raising awareness of the nature of homelessness in the region, breaking down stereotypes about why people become homeless, and increasing community will/efforts to address the issue: https://www.allcarehealth.com/articles-events/blog/a-place-to-call-home-stories-of-homelessness-and-hope-in-southern-oregon.</p>			X				

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>Central City Concern's Housing is Health Campaign <i>Health Share of Oregon</i></p> <p>Individuals and families experiencing or at-risk of homelessness</p> <p>CCO is helping to fund CCC's push to build 379 new homes spread across three separate locations, one of which is anchored by a critically needed health care clinic. All locations will offer residents a variety of support services, including substance use disorder recovery support, mentoring, life skills training and help re-entering the workforce.</p>		X	X		X		X
<p>Bud Clark Commons <i>Health Share of Oregon</i></p> <p>Medicaid recipients experiencing homelessness</p> <p>In 2014, CCO funded establishment of a medical clinic at Bud Clark Commons--an organization that provides supportive housing including case management, community building, exercises, and counseling for Medicaid recipients who were homeless.</p> <div style="border: 1px solid #ccc; border-radius: 15px; background-color: #e6f2ff; padding: 10px; margin-top: 10px;"> <ul style="list-style-type: none"> • 14% decrease in the proportion of participants using the ED • 16% increase in the proportion of participants with a stable primary care provider • 28-31% decreases in # of participants reporting unmet physical and mental health needs </div>			X				X
<p>Service Integration Teams <i>Willamette Valley Health Organization</i></p> <p>High-need families</p> <p>Community partners come together to review cases of families who are experiencing difficulty in meeting needs and determine solutions such as off-setting the costs of housing insecurity through temporary rental assistance.</p>	X	X	X	X	X		

	Pre-tenancy	Tenancy-Sustaining	Other community-based	Barrier Removal	Temporary housing	Ongoing rental assistance	Capital Investments
<p>Co-Location Model <i>Willamette Valley Health Organization</i></p> <p>Individuals experiencing homelessness</p> <p>CCO provided full-time physician to help implement a co-location model for the homeless being served by 7 housing providers, with the goal of creating a single, accessible location that they can walk to for assistance in multiple areas (mail, housing, health care services, showers, etc.).</p>			X				
<p>Medical Respite <i>Willamette Valley Health Organization</i></p> <p>Recently discharged patients experiencing housing-insecurity</p> <p>CCO is coordinating peer services and convenign partners for a soon-to-open medical respite location where recently hospitalized people without immediate shelter can receive transitional housing, health care, and other helpful services.</p>			X		X		
<p>ED Case Managers <i>Willamette Valley Health Organization</i></p> <p>High-utilizers of ED</p> <p>CCO coordinates with hospitals to identify the top 1000 ED users and reach out to them to provide them with proactive intensive case management which includes referrals to housing and transportation, housing vouchers, and connections to other SDOH community services.</p>	X		X		X	X	

Appendix E: Glossary of housing related terms

ACRONYM / TERM	DEFINITION / DESCRIPTION
ACT	Assertive Community Treatment. A team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7
Chronically Homeless	HUD defines this population as an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless for a year or more OR has at least four (4) episodes of homelessness in the past three (3) years.
CoC or Continuum of Care (Housing)	A continuum of care is a local or regional system for helping people who are homeless or at imminent risk of homelessness in the community, from homeless prevention to permanent housing. There are 7 Continuum of Cares in Oregon which receive funding directly from HUD's Special Needs Assistance Program (SNAPs). Funding is competitively applied for annually on the federal cycle. You could also include a link to where one could find out more information and find out who there CoC is. https://www.hudexchange.info/programs/coc/
CoC Homeless Providers	Nonprofit agencies or state and local governments that provide housing and services for homeless persons.
Community Action Agency	Federally and state funded entity that provides anti-poverty and homeless services across all of Oregon's 36 counties. (Map and information about CAAs can be found here: http://caporegon.org/)
Coordinated Entry	A coordinated system across a CoC and its programs to initially assess the eligibility and needs of each individual or family who seeks homeless assistance, and to coordinate the entry and provision of referrals to programs. Through the coordinated entry process, people seeking assistance receive prevention, housing and/or other related services.
Displacement	Displacement occurs when individuals or families are forced to leave their homes through eviction under the guise of late payment default, or other reasons sometimes legally protected such as persistently noisy children or excessive requests for repairs.
Emergency Shelter (ES)	Any facility that the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific subpopulations of the homeless, while they prepare to move into more stable housing. The housing and services are typically provided for up to 90 days or until goals are accomplished by the client.
Fair Market Rent (FMR)	The amount of money a property would rent or lease for if it was on the market at a given time. FMR is determined through HUD survey at the 40% percentile range of rents in a Metropolitan Statistical Area (as well as some HUD defined subdivisions of OMB metropolitan areas and each nonmetropolitan county).
Gentrification	Gentrification is generally described as that which happens in neighborhoods that are seeing decreases in the number of low-income people and people of color due to an influx of high-income individuals and families who are willing and able to pay higher rents
HCH	Health Care for the Homeless

ACRONYM / TERM	DEFINITION / DESCRIPTION
HMIS	Homeless Management Information System. A computerized data collection system that tracks services received by homeless people, helps identify gaps in services within the CoC, and allows for greater collaboration among service providers by providing a “history” of a homeless person’s involvement in the system of care.
HOPWA	Housing Opportunities for Persons with AIDS. Federal program dedicated to the housing needs of people living with HIV/AIDS. Under the program HUD makes grants to local communities, State, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.
HUD	U.S. Department of Housing and Urban Development
Outreach	The initial and most critical step in connecting or reconnecting a homeless person to needed health, mental health, recovery, social welfare, and housing services. Outreach is viewed as a process rather than an outcome, with a focus on establishing rapport and a goal of engaging homeless persons into accepting services and housing.
Permanent Supportive Housing (PSH)	Permanent supportive housing (PSH) combines lease-based, affordable housing with tenancy supports and other voluntary services to more effectively serve the most vulnerable populations, including people who are homeless or at risk of becoming homeless and people who are institutionalized or at risk of institutionalization.
PHA	Public Housing Authority
Point-in-Time (PIT) Count	A one-day statistically reliable unduplicated count of sheltered and unsheltered homeless individuals and families in a specific area. CoCs are only required to conduct a one-day point-time count every two years (biennially) however, HUD strongly encourages CoCs to conduct an annual point-in-time count, if resources allow.
Rapid Re-Housing (RRH)	Places a priority on moving a family or individual experiencing homelessness into permanent housing as quickly as possible, ideally within 30 days of the client becoming homeless or entering a program. Duration of financial assistance may vary.
Respite/Recuperative care (housing assistance system)	Program that provides short-term medical care and case management to homeless persons recovering from acute illness or injury whose condition would be exacerbated by being discharged to the street or a shelter.
Safe Haven	Program that serves hard-to-reach homeless persons who have severe mental illness, are on the streets, and have been unable or unwilling to participate in supportive services. Safe Havens do not require participation in services and referrals as a condition of occupancy.
Stable Housing	Housing stability is defined as the extent to which an individual's customary access to housing of reasonable quality is secure. We define housing security among 8 main dimensions: housing type, recent housing history, current housing tenure, financial status, standing in the legal system, education and employment status, harmful substance use, and subjective assessments of housing satisfaction and stability.
Supportive Services Only (SSO)	Projects that address the services needs of homeless persons. Projects are classified as this component only if the project sponsor is not also providing housing to the same persons receiving the services. SSO projects may be in a structure(s) at a central location

ACRONYM / TERM	DEFINITION / DESCRIPTION
Tenant-Based Rental Assistance (TBRA)	Provides homeless families and individuals with very low and extremely low incomes with housing assistance. TBRA programs allow participants to choose their own housing and retain the rental assistance if they move.
Transitional Housing (TH)	Type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing. It is housing in which services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or provided by other public or private agencies.
Unsheltered Homeless	Someone who is living on the streets or in a vehicle, encampment, abandoned building, garage, or any other place not normally used or meant for human habitation.
VI-SPDAT	Vulnerability Index-Service Prioritization and Decision Assistance Tool. An evidence-based, street-use-informed assessment tool that is designed to help providers determine the most appropriate housing intervention for a particular individual or family. This assessment tool is commonly utilized as the coordinated entry assessment tool.

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