Health Care Reform & Homelessness in Multnomah County

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In 2014, homelessness remains a complex public health challenge in Multnomah County. Individuals and families experiencing homelessness are disproportionately vulnerable to dangers such as communicable diseases and the deleterious effects of the urban environment. They suffer from complications of chronic illnesses and face difficulties with basic health management. For too many individuals, the relentless struggle for safety and stability overshadows health needs – common illnesses are allowed to progress and minor injuries fester until they become emergencies. Challenges in caring for those experiencing homelessness reveal deep fault lines in our current health care system.

Providing quality health care to individuals experiencing homelessness has been a perennial challenge, even in a community with model homeless health service programs. In 2013, more than half of those counted as homeless in Multnomah County reported having one or more disabling health conditions. Many studies have found evidence of premature mortality among homeless persons; the average lifespan of a person experiencing homelessness in the United States is 30 years less than that of a person who is housed. The prevalence of complicated, co-occurring medical, psychiatric, and substance use conditions pose particular challenges to serving significant subsets of the homeless population.

The expansion of Medicaid in 2014, as part of the Affordable Care Act, presents an opportunity to shift much of this narrative. In January 2014, the Affordable Care Act expanded Medicaid eligibility to those with incomes at 138% percent of the federal poverty level, including nearly all homeless adults without dependents and those not currently eligible for Medicare. As a result, more than a quarter of all residents in Multnomah County – including nearly all individuals experiencing homelessness – are now eligible for Oregon Health Plan coverage. Under the charge of Governor John Kitzhaber, Medicaid expansion, managed by sixteen coordinated care organizations (CCOs) statewide, has united previously unaffiliated hospitals, physicians, dental and mental health agencies under one contract. CCOs emphasize preventative and holistic health services for all persons eligible for Medicaid, with the hope of creating a more unified and economical health care delivery model.

Recognizing that Medicaid expansion has the potential to create radical change for individuals experiencing homelessness in Multnomah County, the City Club of Portland charged an all-volunteer research study to answer an important question: *How can the maximum health benefit for the homeless population of Multnomah County be achieved from health care reform and expansion of the Oregon Health Plan?*

Over the course of eight months, your committee interviewed public health officials, homeless advocates, health care administrators, persons experiencing homelessness, county employees, coordinated care workers and academic researchers. Committee members attended Coordinated Care Organization stakeholder meetings, street rallies, outreach events and City Club Friday Forums on homelessness. Members spent evenings conducting interviews of people on the street; we immersed ourselves in research on homelessness, explored the changes in the Affordable Care Act, read extensively the literature on model health care programs in Portland and around the country. Lastly, your committee spent many hours discussing the intersection between homelessness and health care.

Lack of adequate health care and issues of homelessness have for too long gone hand-in-hand. Until the expansion of Medicaid, low and no-income individuals without medical insurance accessed treatment through local health service agencies who received little - if any - compensation for services, or they sought care at local emergency departments, urgent care centers and hospitals whose funding model meant sky-high patient expenses. Those with housing risked losing their homes over exorbitant medical costs; those without housing experienced continuous and dangerously compromised health outcomes.

Discrimination, marginalization, and minority overrepresentation also factor greatly into issues of health care and homelessness. Over 40% of homeless females in Multnomah County have experienced domestic violence. People of color represent 29% of the total population in the greater Portland metro area; however, they make up a disproportionate 45% of the homeless population. Further, nearly one-third of our homeless population was previously involved in the foster care system, and as many as 40% of Portland's homeless youth population self-identify as lesbian, gay, bisexual, transgender or queer.

Without adequate housing, individuals are at greater risk of poor health outcomes, including complications of chronic illness and substance use disorders and mental, and behavioral health issues such as post-traumatic-stress disorder. Underrepresented populations in Multnomah County experience the deleterious consequences of homelessness at a disproportionate rate. However, for all persons experiencing homelessness, housing is a critical social determinate of health.

While they are inexorably connected, your committee recognizes that issues of heath care and homelessness are as deep as they are broad. This report is not an exhaustive body of research on either, but was researched as a narrowly structured analysis of the impact of the newly instituted Medicaid reform on homeless persons in Multnomah County, its successes, setbacks and challenges, and the potential for positive change.

Health care and homelessness require effective cross-sector collaboration as well as sufficient resources and greater political will to address the full scale of the problem. As Nan Roman, CEO and President of the National Alliance to End Homelessness remarked at the City Club of Portland's April 14, 2014 Friday Forum: "We do know what to do [to end homelessness]. . . You have the capacity to do that here in Portland. You have the knowledge. You have resources. The question really is whether you have the public and political will to do enough of it and do it long enough."

Conclusions

After much consideration, your committee concluded:

Health Care for the Homeless

1. Medicaid expansion through the Oregon Health Plan has made available services that were not available previously.
2. Within the homeless community, the combination of negative institutional experiences and disproportionate trauma rates exacerbates the problem of obtaining health care.
3. Access to seemingly "little things" is tremendously important in providing complete health care for people who are homeless.
4. Comprehensive wraparound services are insufficiently available for persons experiencing homelessness.
5. A lack of data exists about the capacity of health care providers to care for new Medicaid patients.
6. The power to be a consumer of health care provides both freedom and confusion.

Implementation of Health Care Reform

7. Within Portland and Multnomah County, excellent models exist.
8. Health care literacy is a barrier to access.
9. Information sharing services among care providers, the Oregon Health Authority and CCOs could be improved.
10. Medicaid expansion, combined with low Medicaid compensation rates, has put pressure on providers' capacity, leading to access challenges for new enrollees and longer wait times for specialized care.
11. Homeless-specific data is necessary to design and deliver services to the homeless population.

Initial Outreach to the Homeless

12. Despite early challenges, efforts to enroll Oregon's newly eligible Medicaid population have been, and continue to be, a success.

Homeless Health Issues Are Housing Issues

13. Medicaid expansion provides an opportunity to reallocate funds that would otherwise have been spent on health care, to addressing root cause of such health problems, namely homelessness.

Recommendations

Based on these conclusions, your committee recommends:

Health Care for the Homeless

A. Coordinated Care Organizations (CCOs) and Multnomah County should collect data on health outcomes that result from Medicaid expansion over the next five years.

B. Home for Everyone Coordinating Board and non-profit providers should ensure provision and coverage of the seemingly "little things" that make a big difference: wound care clinics; clean water; toilets; showers; laundry facilities, etc.

Implementation of Health Care Reform

C. In two to five years, City Club and Home for Everyone Coordinating Board should analyze and report successes and failures of health care reform for the homeless population.

D. Over the next two years, CCOs and non-profit providers should ensure that every newly enrolled Medicaid beneficiary receives sufficient training on accessing services.

E. By the end of 2016, CCOs and health care providers that serve the homeless should ensure that all health care providers have been trained to address the special needs of homeless, which derive from the high incidence of physical and psychological trauma.

F. By the end of 2016, CCOs should require all hospitals' discharge plans to include housing or shelter upon discharge, with follow-up appointments for care.

G. By 2020, CCOs and the Home for Everyone Executive Committee should address the need for flexible services funding to address housing needs.

Initial Outreach to the Homeless

H. Over the next two years, CCOs, Multnomah County and non-profit providers should continue to provide multiple enrollment and re-enrollment opportunities for the homeless.

Homeless Health Issues Are Housing Issues

I. Over the next five to ten years, Home for Everyone Executive Committee, Multnomah County, City of Portland, HomeForward, and the City of Gresham should invest in supportive housing, which includes on-site, comprehensive, integrated rehabilitation and health services.

J. Over the next two years, Home for Everyone Coordinating Board, Multnomah County and others should advocate strongly for housing status as a health determinant.

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Introduction

The Impact of Medicaid Expansion on Health Care for the Homeless

Homelessness remains a bewilderingly complex public health challenge that has long thwarted simple solutions. [1] At its core, homelessness magnifies poor health, leaves those in make-shift shelters vulnerable to dangers such as communicable diseases and the environment, complicates management of chronic illnesses, and uncovers deep fault lines in our current health care system. For the homeless, the relentless struggle for stability overshadows health needs, leaving common illnesses to progress and injuries to fester. A vast array of obstacles exasperates clinicians serving the homeless and confounds delivery systems intended to help this population. As many as 13.5 million Americans are estimated to have been homeless at some point in their lives, and the nation's homeless population on any given night ranges from 250,000 to 3.5 million.[2]

Unfortunately, Multnomah County is not immune to these realities. According to a recent report looking at progress made since the introduction of Portland's "Ten Year Plan to End Homelessness" in 2004, about 1,700 people still sleep on our sidewalks on an average night.[3] Despite the concerted efforts and successes of providing health services and shelter to homeless people over the past decade, homelessness, with its many adverse effects on our community, remains an intractable problem.

Providing access to quality health care has been a constant challenge, even in a community with model homeless health service programs. Care delivery has been hampered by regulations, eligibility rules, and payment methods. Scarcity of evidence-based studies, inconsistent definitions of homelessness, and difficulties with long-term follow-up are other major challenges to the evaluation of effective models of care for homeless populations. It is a bitter irony of urban life that homeless persons have existed in the long shadows cast by state-of-the-art regional medical centers that, until recently, offered sophisticated health care only to the privately insured.[4]

Further, the prevalence of complicated, co-occurring medical, psychiatric, and substance use conditions pose particular challenges to serving the homeless population. In 2013, more than half of those counted as homeless in Multnomah reported having one or more disabling health conditions. Many studies have found evidence of premature mortality among homeless persons; the average lifespan of a person experiencing homelessness in the United States is 30 years less than that of a person who is housed.[5]

The 2014 expansion of Medicaid as part of the Affordable Care Act (ACA) has the chance to shift much of this narrative.

The Research Process

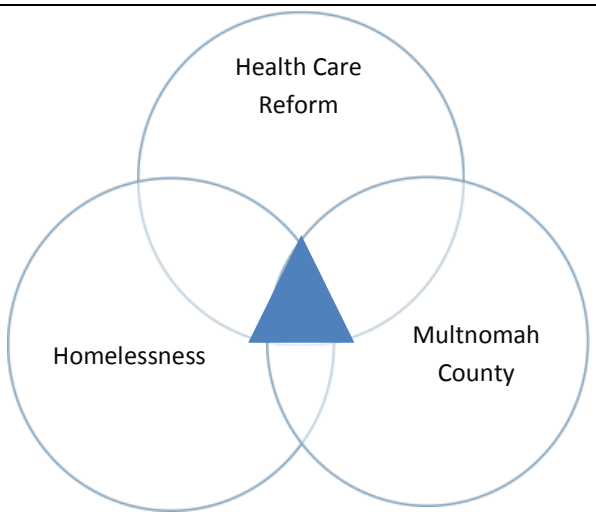
Recognizing the potential for radical changes in the lives of homeless persons in Multnomah County with the federal expansion of Medicaid in early 2014, the City Club of Portland asked your committee to explore how maximum health benefits might be achieved for the homeless population including: health care for the homeless, implementation of health care reform, initial outreach to the homeless, and homelessness, health issues and housing.

Over eight months, your committee interviewed multiple public health officials, homeless advocates, health care administrators, homeless persons, county employees, coordinated care workers and academic researchers. Committee members attended Coordinated Care Organization stakeholder meetings, street rallies, outreach events and City Club Friday Forums on homelessness. We immersed ourselves in research on homelessness, explored the changes in the Affordable Care Act, read extensively the literature about model health care programs in Portland and around the country aimed at improving health outcomes for the homeless and spent many hours discussing the intersection between homelessness and health care.

Both health care and homelessness are subjects that are as deep as they are broad. They are highly charged issues, influenced by social, economic, state and federal laws and policies. They are also influenced by each other. Until 2014, low- and no-income individuals without medical insurance accessed treatment through local social service agencies with little - if any - compensation for services, or at local emergency rooms, urgent care centers and hospitals, whose funding models meant sky-high patient expenses. Those with housing risked losing their homes over medical costs, and those without housing experienced continuous and dangerously compromised health outcomes. In other words, the challenges surrounding homelessness and health care have too often gone hand-in-hand.

Your committee recognizes that this report is not an exhaustive body of research on either topic; instead, it is a narrowly structured analysis of the impact of the newly instituted Medicaid reform on homeless persons in Multnomah County, including its successes and challenges, as well as the potential for positive change.

Figure 1: Health Care Reform & Homelessness in Multnomah County



The study charge specified the narrow scope of this study to be the intersection of Health Care Reform and Homelessness in Multnomah County.

Background

Homelessness in Multnomah County

Definitions of Homelessness[6]

When addressing issues surrounding health care and homelessness in Multnomah County, it is first important to define clearly the term homelessness. Contemporary accounts of homelessness are distinctly different from earlier *skid row* usages of the term. Documented by sociologists in the 1950s and 60s, then-homeless populations were defined primarily by their residence in transient housing and were usually confined to a particular area of central cities. By contrast, contemporary homeless populations are no longer defined by spatial occupation, but are delineated by an outright lack of private accommodations. They face dispersed and stark sleeping conditions, and often rely on public spaces, makeshift sleeping arrangements, and open barracks-style shelters.

Thus, for purposes of research and reporting, homeless populations are no longer broadly categorized by one type of location or accommodation. Instead, contemporary definitions of homelessness are broken into categories by type of shelter (see Table 1).

Table 1: Definitions of Homelessness[7]

Unsheltered	People who are sleeping outside, in a vehicle, or an abandoned building
Literally Homeless	Unsheltered, plus people sleeping in emergency shelter
HUD's Definition	Unsheltered and literally homeless, plus people sleeping in transitional housing for the homeless
Broadest Definition	All of the above, plus people who are doubled up or couch surfing due to the loss of housing or economic hardship

The definition used by the U.S. Department of Housing and Urban Development (HUD) is associated with the greatest amount of local and national data. Your committee has chosen to use this definition when referring to homelessness; however, we will make efforts to refer to a specific population of homeless whenever possible, as discussing homelessness in generalities too often ignores its heterogeneous nature and threatens to overlook the particular, and sometimes conflicting, needs of disparate populations. This point is particularly important when considering health care reform; how a person accesses health care greatly depends upon how she became homeless and how she experiences being homelessness, including where she finds both shelter and support.

2013 Point-In-Time Count of Homelessness [8]

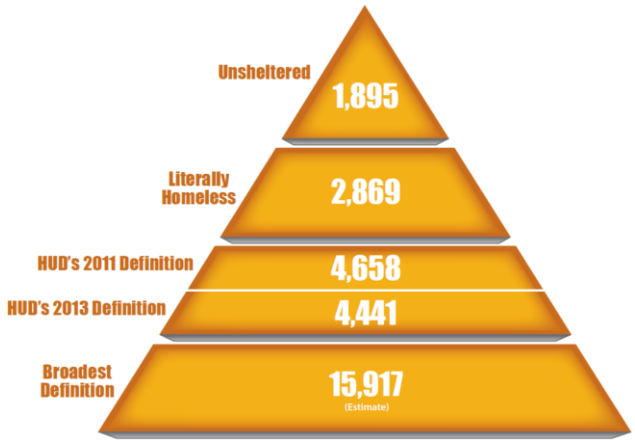
Capturing accurate data on the homeless population in Multnomah County is the first step in assessing how health care reform and Medicaid expansion has affected the homeless since 2014. To accurately assess the needs and interests of homeless populations in Multnomah County, the Portland Housing Bureau, in conjunction with the One Night Shelter Count, conducts a biannual snapshot survey of individuals and families experiencing homelessness. The most recent "Point-in-Time Count" occurred on

the night of January 30, 2013. Cities across the nation participate in this one-night count in order to create comparable data.[i]

The 2013 Point-in-Time Count reported an increase in the unsheltered population in Multnomah County between 2011 and 2013 of 177 people, or 10%. The factors contributing to the increase included unemployment, a minimum wage that does not meet basic needs, the burden of rent, reductions to federal and state human services and public benefit programs, and health related issues.[9]

"While a wide range of factors influence an individual's likelihood of becoming homeless, homelessness is first and foremost an economic issue." [10]

Figure 2: People experiencing homelessness in Multnomah County



2013 Point-in-Time Count of Homeless, Multnomah County: Data gathered from 2013 Point-In-Time Homeless Count and Analysis of over 2,800 homeless individuals in Portland.[11]

Why Are People In Multnomah County Homeless? [12]

Economic Issues

Too often, homeless individuals are viewed through a monocular lens of poor life-choices or unfortunate, and avoidable, circumstances. The data reveals another story. The economic vulnerability of low- and middle-class individuals and families in Multnomah County has been amplified by a slow economic recovery, increasing levels of economic disparity and a skyrocketing rental and real estate

[i] The Department of Housing and Urban Development requires state Continuums of Care (integrated multi-level health care systems that treat and track individuals over an extended period of time), to count the number of people experiencing homelessness in the geographic area that they serve through a Point-in-Time count (PiT). Most PiTs are conducted the last days of January and include people served in shelter programs every year, with every other year also including people who are unsheltered. In 2013, Continuums of Care were required to count people who are unsheltered. This was the last PiT before the ACA Medicaid expansion on January 1, 2014. For more information, see: http://usich.gov/member_agency/department_of_housing_and_urban_development/point_in_time_count/

market, resulting in low vacancy rates for affordable housing units. These combined realities – high unemployment, low vacancy rates and increased cost of living – has placed a disproportionate number of individuals and families in Multnomah County at risk of homelessness, if faced with a crisis such as a medical emergency or job loss.

Until the 2014 expansion of Medicaid, most low- and no-income individuals in Multnomah County were ineligible for Medicaid or other subsidized health coverage.[ii] Federal cuts in health service organizations capable of treating the uninsured meant that individuals in already fragile economic situations were at greater risk of losing their homes over expensive medical costs.[13] Lack of access to preventative care and inadequate treatment of disabling conditions has long meant costly untreated and/or undertreated health complications.

"Lack of treatment for disabling health conditions and the financial burden of uninsured care remain major reasons people and families become homeless in Multnomah County."

Characteristics of People Experiencing Homelessness

While the homeless populations of 1950's *skid row* "consisted almost exclusively of older, single white male households, with three-quarters of the men over the age of 45," the homeless population in Multnomah County today reveals a different profile.[14] In the 2013 Point-in-Time Count, two distinct populations come to the fore. "One [population] is chronically homeless adults with disabling conditions. The other is more short-term and recently homeless and includes growing numbers of families with children, many of whom are people of color and/or victims of domestic violence."[15]

Short-term and Recently Homeless Populations

Short-term and recently homeless individuals and families report having experienced racial and sexual inequities, domestic violence, and past participation in the U.S. armed forces and foster care system.

Domestic Violence: Since 2011, the number of women categorized as literally homeless increased by 22%. Of those, nineteen percent – 41% of the total homeless female population – were affected by domestic violence. The number of homeless families with children increased by 18% in 2013, and 749 children were counted as homeless in the county, with 264 of those under the age of five. [16] Similarly, nearly one-third of the current homeless population was at some point in foster care. [17]

Culturally specific communities: While people of color represent only 29% of the total population in Multnomah County, they make up a disproportionate 45% of the homeless population (see Figure 3). In addition, a majority of communities of color (57%) spend more than 30% of their income on rent or mortgage costs, endangering their ability to cover the remainder of their expenditures, and are

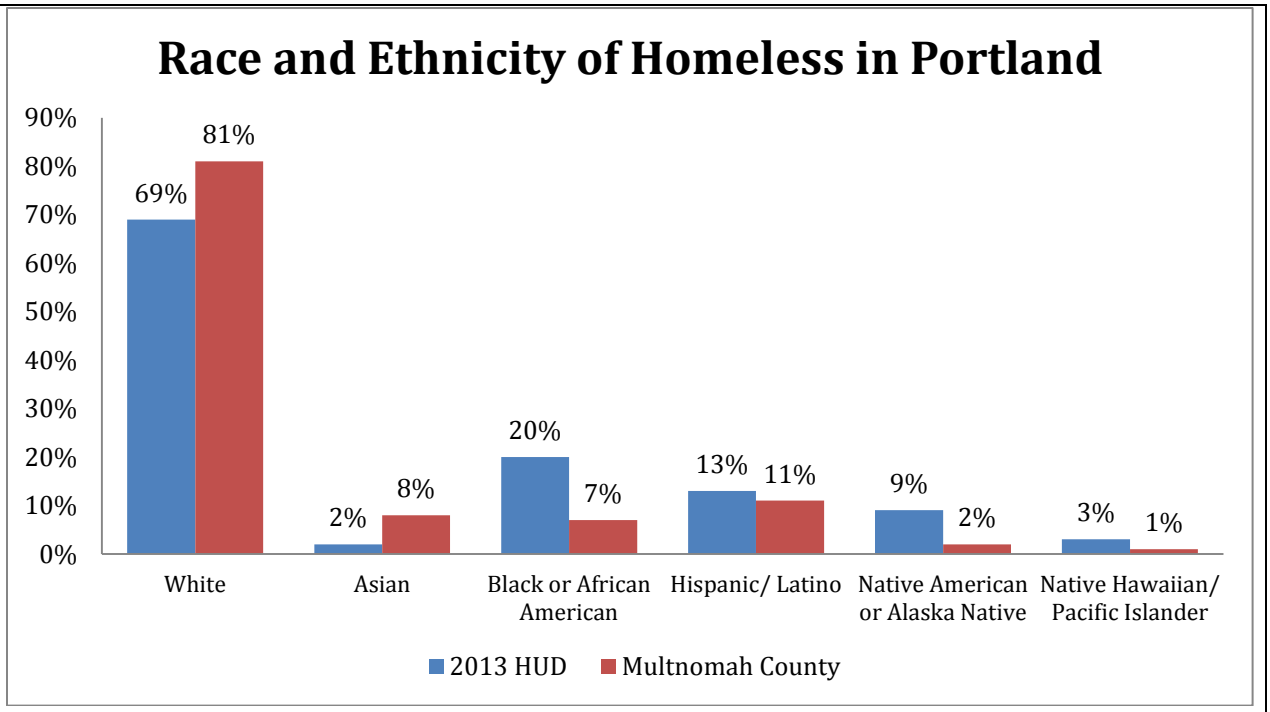
[ii] Until 2013 Medicaid was limited to individuals with dependents, individuals with a disability and a small number of people in Multnomah County who received free medical care through a lottery.

subsequently considered at risk of homelessness.[18] Access to housing support programs is more difficult for communities of color than for whites."[19]

In 2013, approximately 9% of Hispanic children in Oregon were uninsured, a year prior to the health care reform. Health care reform will particularly affect Hispanic individuals and families in the future, as Oregon's Hispanic population is growing five times as fast as the state's general population.[20]

Further, as many as 40% of Portland's homeless youth population self-identify as lesbian, gay, bisexual, transgender or queer.[21]

Figure 3: Race and Ethnicity of Homeless in Portland

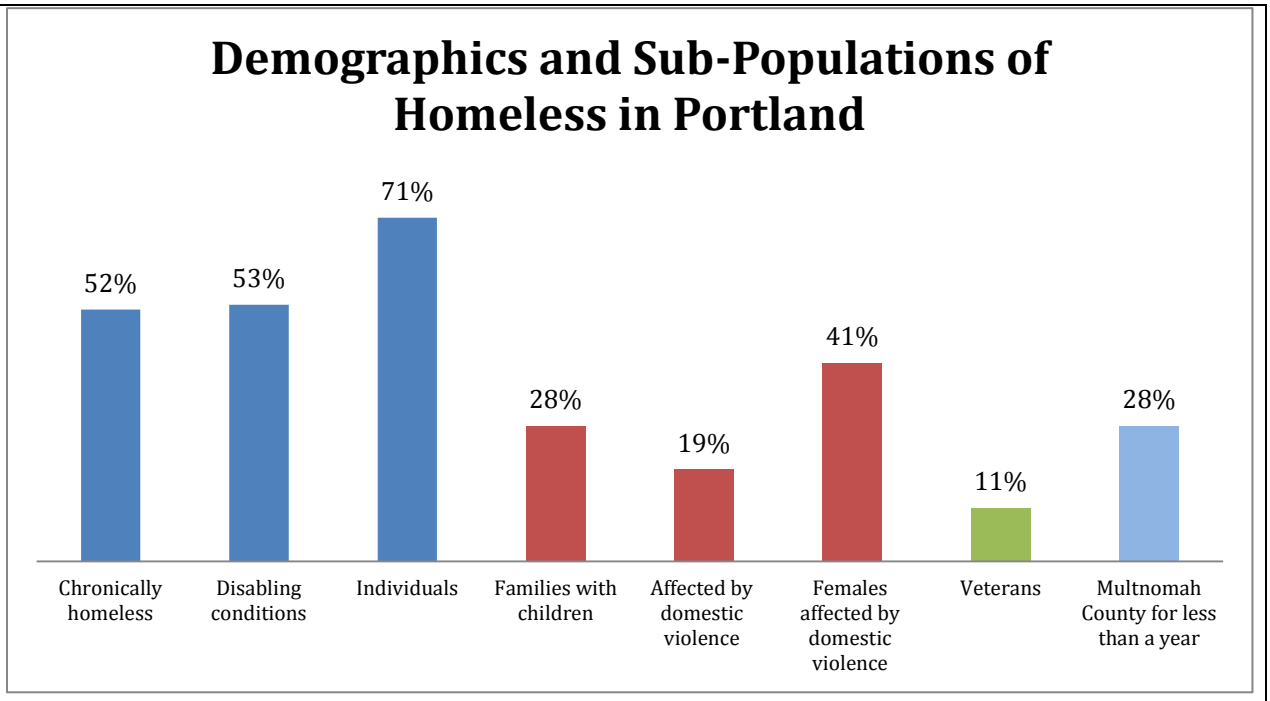


2013 Point-in-Time Count of Homeless, Multnomah County: Data gathered from 2013 Point-In-Time Homeless Count and Analysis of over 2,800 homeless individuals in Portland. [22]

Veterans: While the US Department of Veterans Affairs (VA) provides many local outreach services through its community reintegration program for veterans, 11% of the adult homeless population in Multnomah County served in the U.S. armed forces. One-third of the veterans experiencing homelessness are considered chronically homeless. [23]

Travelers: More than a quarter (28%) of the homeless population reports having been in Multnomah County for less than one year.[24] Portland has a significant population of shorter-term homeless individuals, due to its location between California and Washington.[25]

Figure 4: Demographics and Sub-Populations of Homeless in Portland



2013 Point-in-Time Count of Homeless, Multnomah Count: Data gathered from 2013 Point-In-Time Homeless Count and Analysis of over 2,800 homeless individuals in Portland. This data set based on HUD definition. Some of the populations do overlap.[26]

Cultural Characteristics

Your committee heard from witnesses the importance of understanding the culture of homelessness in order to best serve people experiencing homelessness. "Working effectively with street-affected youth [and adults] is cross-cultural work."[27] People experiencing homelessness have adapted to the culture of homelessness, which has different expectations, values, identities, hierarchies, and language.

Youth: Among youth, homelessness is broader than a simple housing issue. Being "on the streets" refers to a complex psychological state or worldview connected to a perceived lack of options that is intrinsically linked to a youth's identity and sense of self-worth.[iii] This leads to a common misconception that most youth are "choosing" homelessness.[28] A significant overlap does not exist between those that experience homelessness as a child and as an adult.[29]

[iii] "The Drift"- The longer a young person survives outdoors away from caring adults, the more likely they are to become deeply alienated from broader society and resources that may exist to aid them in setting and achieving life goals. This can result in chronic instability and the perception that youth are "choosing" homelessness. [iii]

Street Families: Street "families" are non-biological support networks to facilitate survival in a rough outdoor subculture. Members at times refer to one another in nuclear terms (e.g. brother, sister, mom and dad) which indicates the emotional need being served by these roles. For the youth experiencing homelessness, the street families meet critical emotional needs that were not adequately met elsewhere.[30]

Homeless youth are often as unwilling to separate from their street family as we might be to separate from our own biological kin which is a frequent barrier to obtaining services, including shelter. [31]

Street Names: Many street-dependent youth have a street name or alias to help them shed their "victim identity" and survive on the streets, by developing a separate persona. Sometimes the name is given by an older or more experienced homeless person and other times it is self-chosen. This name is crucial to a youth's identity. [32]

Street pets: Homeless youth often have pets for companionship, protection, or therapeutic service. For many homeless youths, loyalty to a pet is an important value, and they can be unwilling to abandon a pet to access services, including shelter. [33]

Mistrust of the system: Many within the homeless population believe that they will be mistreated if they attempt to obtain services, including health care. Individuals with outstanding warrants or who are pregnant fear that their visit to a hospital will trigger a report to law enforcement or child services. In addition, a lack of recovery locations after discharge from a surgery or medical procedure can lead to the fear that a visit to obtain care will result in even further illness and vulnerability. [34] Native Americans suffering from temporary or long term homelessness may be unwilling to seek health care, utilize Medicaid, or enter a shelter due in part to distrust of the federal government. [iv]

Culturally specific services: People of color often prefer that professionals within their community deliver social services. [35] Communities of color in Multnomah County have a significantly higher rate of precarious health conditions, including low birth weights (White 5.9%; People of Color 8.1%), infant mortality (White 4.9; People of Color 7.3 deaths per 1000 live births), and death from diabetes (White 29.5; People of Color 40.8 deaths per 100,000).[36] However, communities of color are insured at

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[iv] "The clientele at NARA do not want to go to shelters and will do anything not to go there. NARA serves individuals representing 250 different tribes at their clinics. It is challenging to say there is a homogenous vision of NARA. For example, Cherokees are viewed very differently than Sioux. The one thing they all have in common is that they do not trust the federal government," said Dr. Titchener of NARA. Dr. Titchener had a 52 year old male patient on the verge of being homeless. He received a $50,000 bill from the hospital because he was uninsured, and was using food boxes to survive. He suffered from intense chest pain if he walked 70-75 feet. He didn't want to go to the hospital because of medical bills and didn't trust the Oregon Health Plan (OHP) because he "doesn't want the federal government to know his business." It took 3-4 months for staff to convince him to join the OHP and obtain disability insurance benefits (for which he qualified).

disproportionately low rates. [37] According to the 1990-2006 Oregon Population Survey, 21.7% of people of color had no health care coverage compared to 14.4% Whites. [38]

Chronic Homelessness & Disabling Conditions

Since 2011, the number of the chronically homeless – individuals or heads of households who have been homeless for a year or more, or who have had at least four episodes of homelessness in the past three years – increased by 27% among the unsheltered. More than half (53%) of the unsheltered population met the definition of chronic homelessness in 2013.[39]

The chronically homeless disproportionately access health care services. Prior to moving into Bud Clark Commons (BCC) - a residential program for homeless individuals in Multnomah County - the typical BCC resident reported a total health care cost 3.6 times higher than the average adult Medicaid member, and averaged 2.5 emergency department visits per year.[40]

A 2013 study of homeless adults in Toronto who were offered universal health insurance concluded that people who are homeless "have substantially higher rates of health care utilization than age- and gender-matched low-income control individuals from the general population, particularly for emergency department and inpatient hospital use." [41] The study cited as reasons lack of knowledge of where to obtain health care, transportation and child care, as well as perceived discrimination. The study suggested measures intended to eliminate the high usage of services, including improving long-term management of physical and mental illnesses, and addressing factors such as a lack of stable housing.[42]

Health Outcomes for Homeless Populations

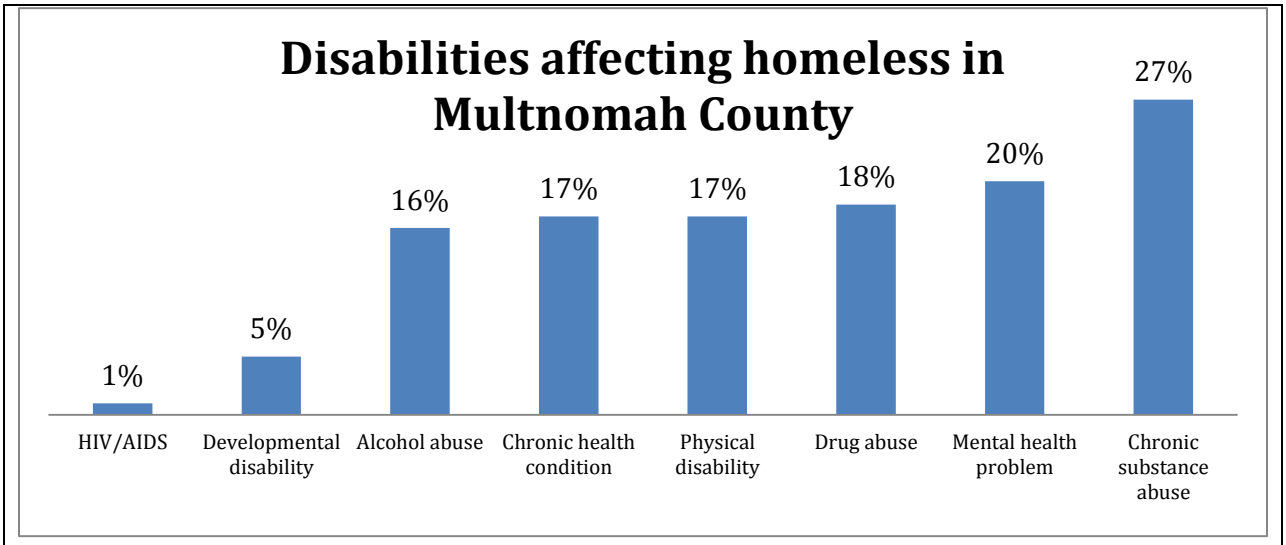
Multnomah County

National surveys have found that homeless individuals are three to six times more likely to become sick than those who are housed, and Multnomah County is no exception. More than half (53%) of the homeless population in Multnomah County were found to suffer from potentially life-threatening disabling conditions, with 17% of the unsheltered population reporting a chronic health condition.[43]

National surveys have found homeless people are three to six times more likely to become sick than housed people. [44]

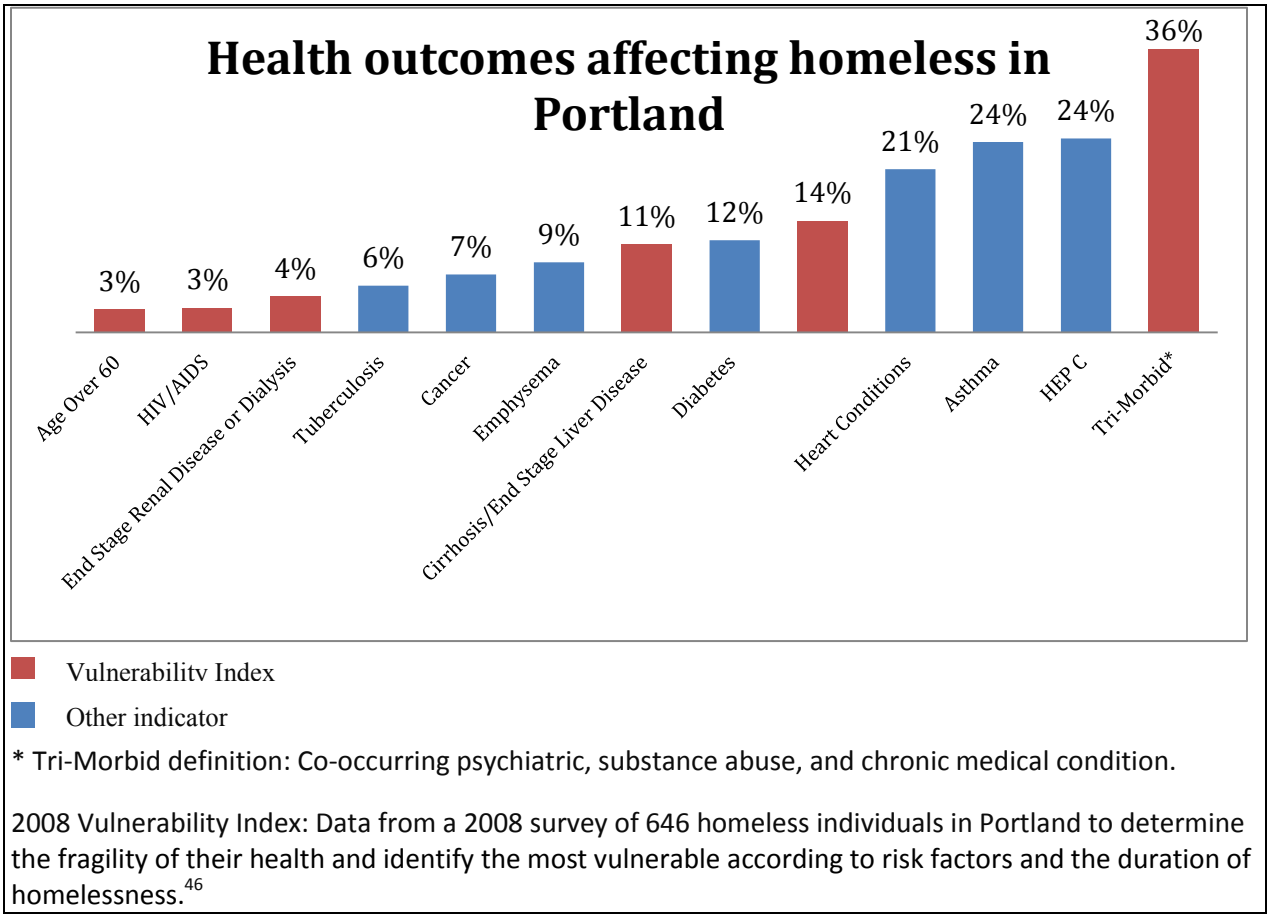
In particular, "tri-morbidity" – having a co-occurring psychiatric, substance abuse and chronic medical condition – is alarmingly common among the homeless. A study of the prevalence of selected conditions among patients who identified as homeless in Multnomah County reported a 36% occurrence of tri-morbidity.

Figure 5: Disabilities affecting homeless in Multnomah County



Health Outcomes of the Unsheltered Homeless Population, 2013 Point-in-Time Count of Homeless, Multnomah Count: Data gathered from 2013 Point-In-Time Homeless Count and Analysis of over 2,800 homeless individuals in Portland.[45]

Figure 6: Health Outcomes Affecting Homeless in Portland



* Tri-Morbid definition: Co-occurring psychiatric, substance abuse, and chronic medical condition.

2008 Vulnerability Index: Data from a 2008 survey of 646 homeless individuals in Portland to determine the fragility of their health and identify the most vulnerable according to risk factors and the duration of homelessness.[46]

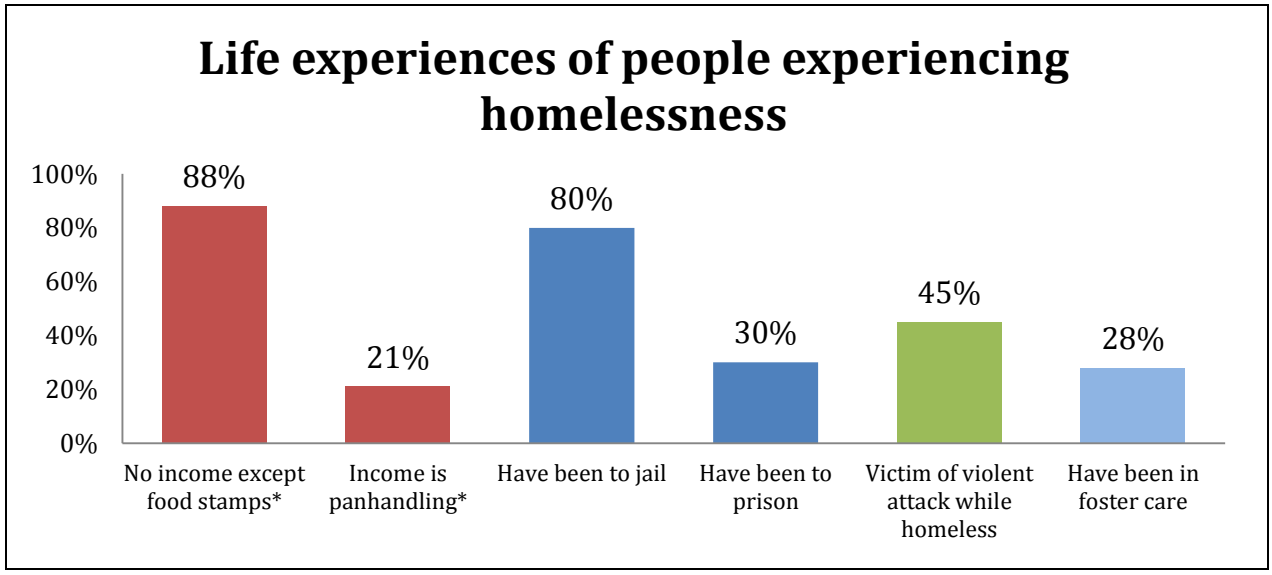
Perhaps not surprisingly, mortality rates for the homeless are disproportionately high. In 2012, there were 56 recorded deaths of homeless individuals in Multnomah County. The average age of the deceased was 45, and most were male. Causes of death were listed as natural (25%), accidental, including intoxication, and trauma (53%), suicide (18%), and homicide (4%). [47]

Specific Health Care Concerns

Trauma, traumatic brain injury, incarceration, and violence add a level of severity and complication to the lives of the chronically homeless. Almost half (45%) of all homeless individuals report being a victim of a violent attack (see Figure 7). [48]

Traumatic Brain Injury (TBI) is common in homeless populations. A study in Canada showed that 53% of the homeless population experienced TBI in their lifetime and another 12% experienced moderate-severe head injury. For 70% of respondents, their first traumatic brain injury occurred before the onset of homelessness. A history of moderate to severe traumatic brain injury was associated with significantly increased likelihood of seizures, mental health problems, drug problems, poorer physical health status and poorer mental health status.[49]

Figure 7: Life experiences of people experiencing homelessness

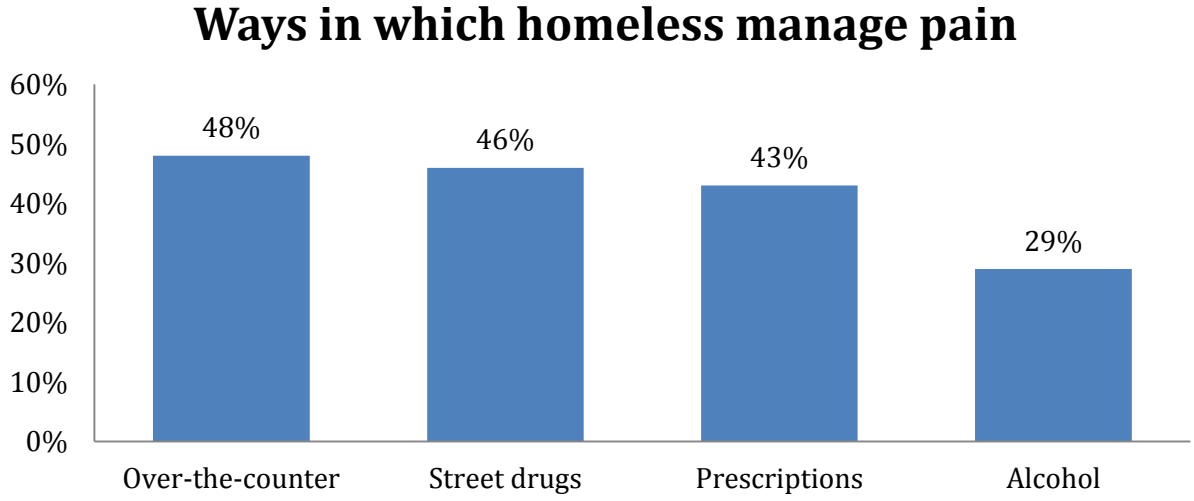


Homeless individuals also reported numerous barriers to managing chronic pain, including the stress of shelter life, poor sleeping accommodations, inability to afford medications, transportation problems, adverse reactions to medications, belief that medication is ineffective, problems with doctor/patient relationship and inability to restrict physical activity. [50] Studies show that risk factors for chronic non-cancer-related pain overlap with issues facing the homeless, including low socioeconomic status, mental health disorders, PTSD, anxiety, depression, TBI, substance use disorders, and HIV infection.[51] A 2011 study reported that, as a result of these barriers, homeless individuals use a variety of ways to manage pain (see Figure 8).[52] At Multnomah County facilities, staff reported that when people become homeless, they learn new coping mechanisms, which can include addiction.[53]

"When we go under the bridge we see the condition of people living there. It's not a clean condition. There is no porta-potty. There is nowhere for them to throw their trash when they eat. There is also no place they can take a shower or shave or clean their clothes…

"Mental or physical therapy [would help]. Sleeping on the sidewalk throws your body out. The sidewalk generates a lot of coldness and it settles in their body. They [are] young but they walk around old. I think that needs to be added into 'Obamacare' or Medicaid" [54] *- Ibrahim Mubarak*

Figure 8: Ways in which homeless manage pain



Pain management techniques: Data from Canadian study of 312 shelter residents. [55]

Health Care for the Homeless Prior to Health Care Reform

Prior to the January 1, 2014 effective date of the Affordable Care Act (ACA), it was extremely difficult for low-income and no-income individuals to enroll in Medicaid.[56] In a 2011 national study of chronically homeless adults, nearly three-fourths of individuals with incomes lower than the threshold for the current Medicaid expansion were not enrolled. More than half (53%) of the 725 chronically homeless and disabled adults were uninsured or relied on state or local assistance, while 21% had alternative coverage such as VA health care. [57, v] A dramatic improvement in availability was predicted once the ACA was in place.[58]

Medicaid Prior to Heath Care Reform

In 2008, Oregon opened Medicaid enrollment to a lottery drawing of 30,000 individuals out of the 90,000 on the waiting list. Randomly selected adults received the opportunity to enroll in Medicaid as

[v] Participants of the study were under the age of 65, racially diverse, and mostly of single adult males who had less than a high school education; all had annual incomes of approximately $15,000.

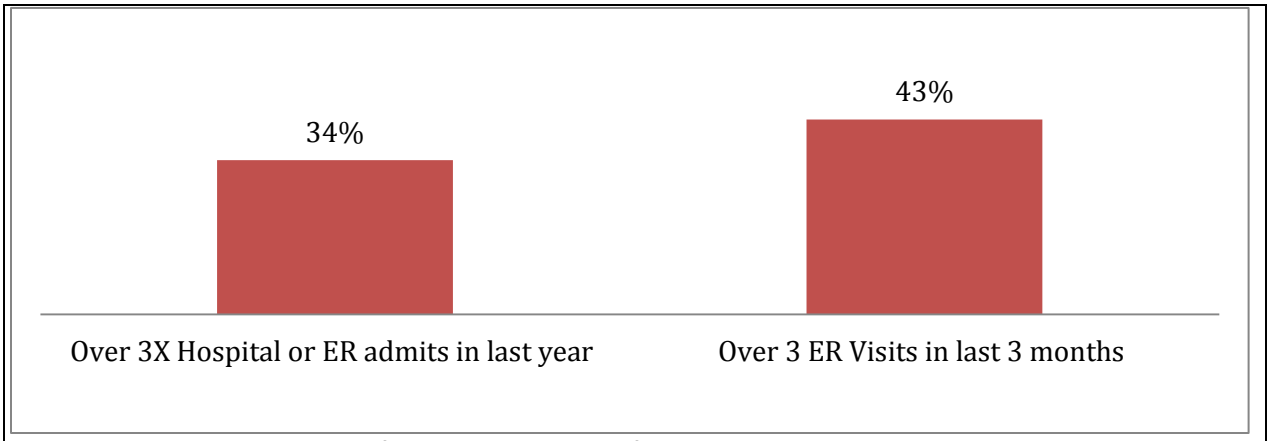
long as they met the eligibility requirements. At the time, Medicaid required that individuals be legal residents of Oregon, U.S. Citizens or legal immigrants, and that they were ineligible for other public insurance; they were also required to be uninsured for the previous 6 months and have assets of less than $2000. The plan provided "comprehensive medical benefits, including prescription drugs, with no patient cost-sharing and low monthly premiums ($0 to $20, based on income), mostly through managed care organizations."[59]

Health Care Providers

Prior to Health Care Reform, the homeless population in Multnomah County accessed health care services through hospital emergency rooms (ERs) and safety net providers, including Central City Concern, Outside In, NARA Indian Health Clinic, The Wallace Medical Concern, Multnomah County clinics, Portland VA medical center, and other wrap-around health services and supportive housing.[vi]

Emergency Rooms

Figure 9: Use of Emergency Rooms by Homeless



2008 Vulnerability Index: Data from a 2008 survey of 646 homeless individuals in Portland to determine the fragility of their health and identify the most vulnerable according to risk factors and the duration of homelessness.[60] [vii]

Hospitals absorb significant uncompensated care costs for emergency room visits. A 2008 survey conducted in Multnomah County reported 63% of the 646 homeless individuals surveyed were uninsured. Over a period of three months, a total of 730 emergency room visits were reported by the *646 respondents*, at an estimated cost of $492 per visit. This is a cost of over $1.43 million per year. The respondents reported a total of 460 inpatient hospitalizations over a period of one year.[61]

[vi] A safety net provider is generally a non-profit health care provider funded through individual donations, as well as private, state and federal grants.

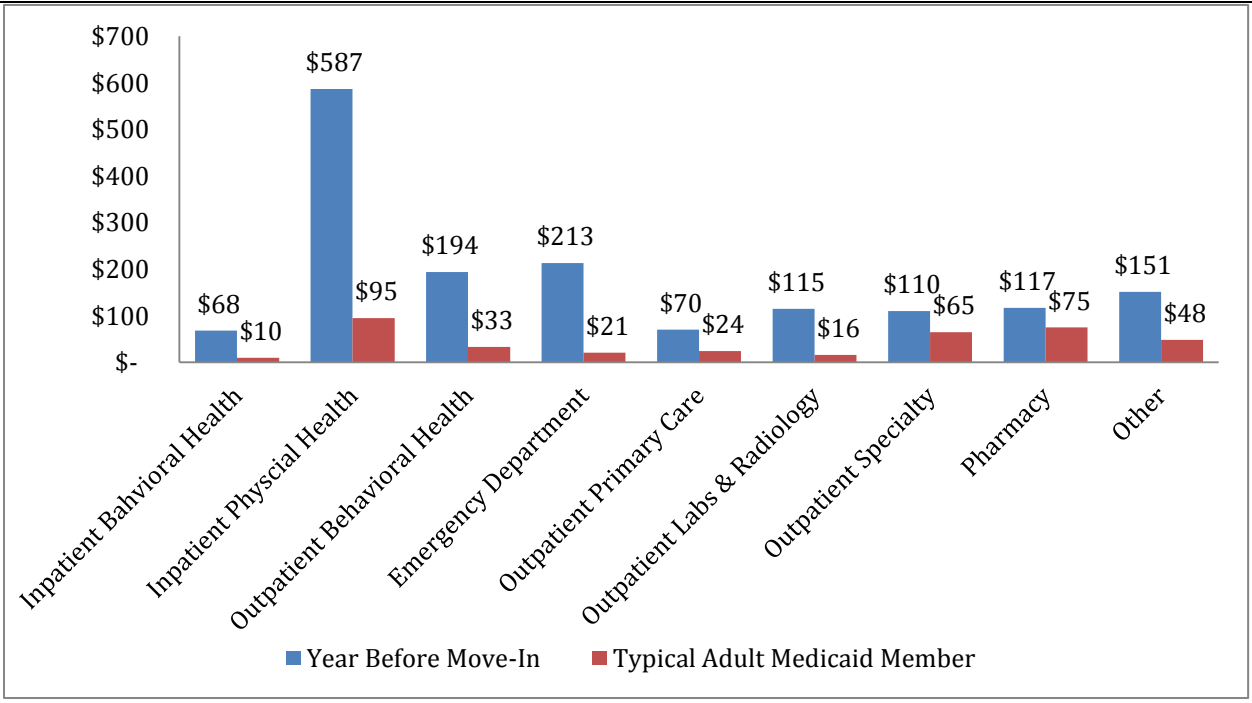
[vii] The Vulnerability Index identifies the health conditions that cause homeless individuals to be most at risk for dying on the street. Homeless individuals' health and social status are ranked based on risk factors and those with the most severe health risks are prioritized for housing and other support.

A study by Providence CORE about the homeless population with Medicaid at Bud Clark Commons found that the year prior to move-in, the residents spent nearly ten times as much on emergency department visits as the typical adult Medicaid member (see Figure 10).

Central City Concern

Central City Concern (CCC) is a nonprofit agency serving single adults and families in the Portland metro area who are impacted by homelessness, poverty and addiction. Founded in 1979, the agency has developed a comprehensive continuum of affordable housing options integrated with direct social services including integrated health care services, supportive peer relationships, recovery and assistance in obtaining income through benefits or employment. CCC currently has a staff of over 600, an annual operating budget of $47 million and serves more than 13,000 individuals annually.

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



Bud Clark Commons Study, Heath 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. [62]

Outside In

Outside In was founded in 1968 with a mission to help homeless youth and other marginalized people move toward improved health and self-sufficiency. It includes service providers and advocates (including experts in understanding adolescents), a Federally Qualified Health Center, licensed mental health agency and leading services to LGBTQ youth. Health services are provided at its onsite clinic, as well as through mobile van sites offered at multiple locations. The vans have two to three exam rooms, a dispensary, and a lab. The care teams include a provider, nurse, medical assistant, behaviorist, and

referrals coordinator. [63]

NARA: Native American Rehabilitation Association

NARA was formed in 1975 as a residential addictions treatment site by a group of Native American men in recovery. It has a child and family services program, youth program, community and culture program, and 3 health clinics (Indian Health Clinic, Wellness Center, Totem Lodge Site). It focuses on culturally specific services and integrated treatments including mental health, addictions, medical, primary care and psychiatric care.

Multnomah County's Homeless Youth Continuum System

The Youth Continuum System is an integrated multi-agency model, which serves about 1,000 homeless youth per year. The primary partners are Janus Youth Programs, Outside In, New Avenues for Youth, and NAYA (Native American Youth And Family Services). [64] The program provides homeless youth with basic safety and developmental needs. [65]

Multnomah County Clinics

Multnomah County Clinics provide medical and dental health care to low-income families throughout Multnomah County. They are the largest safety net medical and dental provider in the state, and offer services at 8 medical clinics, 13 school-based health centers, and 6 dental clinics. In 2013, these clinics provided care to about 2,000 homeless clients. In 2013 they received approximately 5,800 medical visits, 550 dental visits, 3,100 mental health visits with psychiatrists, psychologists, social workers, or other mental health providers, 450 substance abuse services visits, and 1,100 visits with case managers.[66]

Multnomah County has partnered with other agencies including Cascade AIDS Project, Outside In, Multnomah County Sheriff's Office, Urban League, Asian Health and Services, Central City Concern, Home Forward (formerly Housing Authority of Portland) and Transition Projects, Inc.. Multnomah County partners with mental health and addictions social services to cover treatment, engagement, treatment readiness, and supportive services for those in treatment.[67] Housing agencies also refer clients to the clinics. [68]

In addition to the clinics, the Multnomah County Mental Health Addiction Services Division operates the local mental health authority, which is responsible for ensuring access to publicly funded mental health services and provides a health plan for the indigent. The Division also contracts with Health Share of Oregon to provides a mental health plan services for Health Share members needing mental health treatment in Multnomah County.[viii] This division primarily contracts out both services and administration.

[viii] When the OHP moved into managed care, all counties had right of first refusal to operate the mental health component. Multnomah County exercised its right and now operates a health plan and operates a mental health plan for OHP members in Multnomah County for many years. When CCOs were formed, Multnomah County subcontracted with Health Share to continue to provide those services for Health Share members in Multnomah County.,.130,000 individuals are insured through this plan post expansion.

Portland VA Medical Center[69]

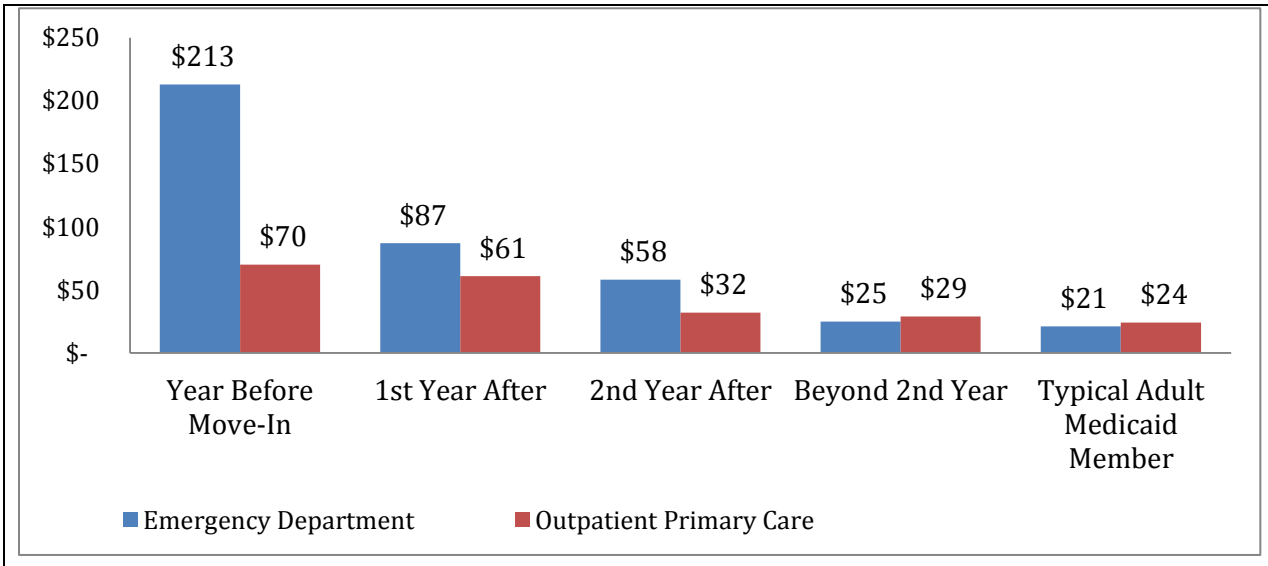
The VA medical center's Community Resource and Referral Center (CRRC) serves 5,000 Veterans. The CRRC provides the primary access point for all homeless programs at the Portland VA Medical Center. The CRRC has an annex on the Vancouver campus that offers a walk-in clinic twice a week and outreach to Veterans located in remote areas. Other services provided through the CRRC include the Homeless Hotline, Homeless Consults, Homeless-Primary Care Team (HPACT), Shelter Plus Care, Central Park Place, and Project-Based Community Partnerships, including Supportive Services for Veteran Families (SSVF). In addition, the HUD-VASH program is responsible for providing oversight and case management for 713 formerly homeless Veterans and their families with Housing Choice vouchers, which includes 360 vouchers to Home Forward, based in Portland.

Bud Clark Commons – a Case Study

One innovative delivery model, The Apartments at Bud Clark Commons (BCC), was built in 2011 by Home Forward (formerly Housing Authority of Portland). BCC has 130 studio apartments, including the Transition Projects men's shelter. Counselors see residents for behavioral health services; there is also a wound clinic with weekly visits by a health care provider.

The goal of BCC is to connect each resident to physical and behavioral health care, with a target population of the most vulnerable members of the homeless community in Multnomah County. Some are current substance users; BCC is not a drug-free facility, and focuses first on "harm reduction."

Figure 11: Costs Associated with Utilization of Health Care Services, Bud Clark Common Residents with Medicaid

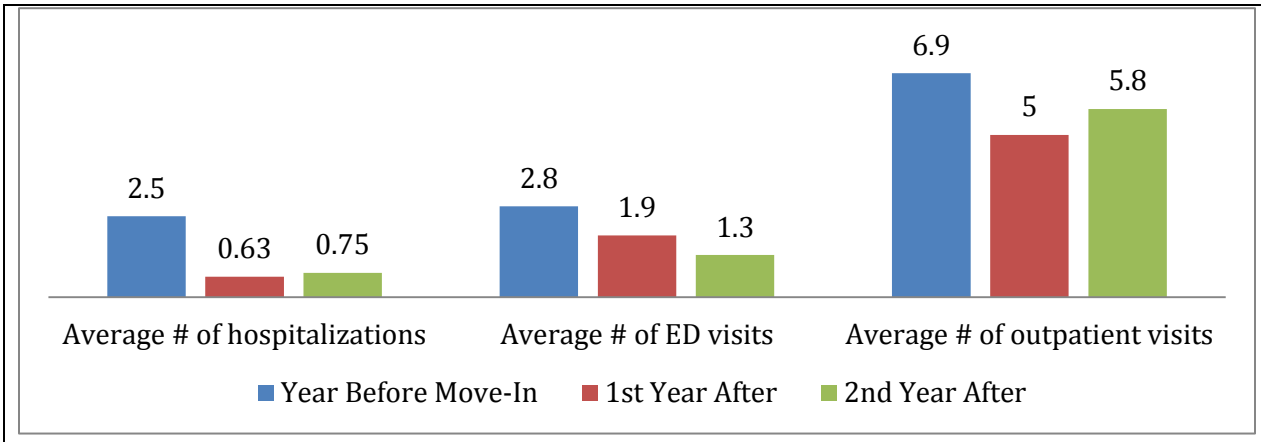


Bud Clark Commons Study, Heath Service Utilization: Data based on surveys conducted for Home Forward in winter 2013. 76% of 130 residents participated. Cost data based on analysis of Medicaid claims data for participating residents who were on Medicaid (58 of the 99 individuals interviewed). [70]

A 2012 study by Providence CORE demonstrates the change in health care utilization before and after being housed at BCC. Health care costs and number of both emergency department visits and

outpatient primary care visits were radically reduced in the first three years of residence (see figures 11 and 12). [71]

Figure 12: Self-reported health care utilization, Bud Clark Common Residents

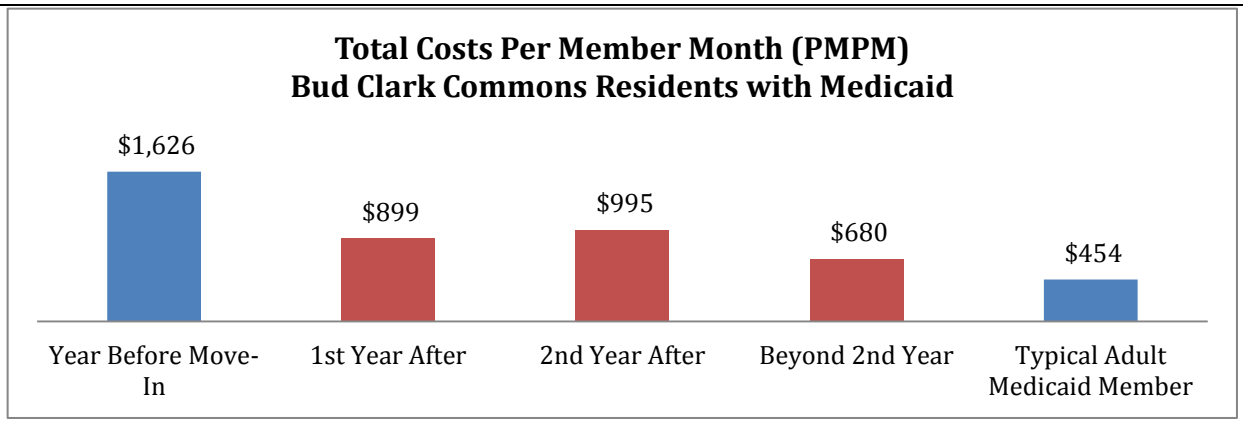


Bud Clark Commons Study, Heath Service Utilization: Data based on surveys conducted for Home Forward in winter 2013. 76% of 130 residents participated. [72]

For example, in the year prior to move-in, BCC residents on Medicaid averaged $1,626 per month in total health care costs. These were reduced by 45% ($899/month) within the year after move-in. The total Medicaid cost reductions were over one-half of a million dollars in the first year following resident move-in (see figure 13). [73]

The cost savings among BCC residents came from efficiently managing health care in appropriate settings, helping to reduce acute health crises and avoiding more expensive types of utilization.

Figure 13: Total Costs per Member per Month (PMPM), Bud Clark Commons Residents with Medicaid



Bud Clark Commons Study, Heath 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. [74]

After moving into BCC, the average resident had reduced annual claims by $8,724. The annual cost to house a resident at Bud Clark Commons is $11,600. Cost savings among the BCC residents came from efficiently managing health care in appropriate settings, helping to reduce acute health crises and avoiding more expensive types of utilization.

Implementation of Health Care Reform in Multnomah County

In 2014, nearly all homeless individuals qualified for Medicaid coverage. [75]

Oregon Health Plan

Cover Oregon, the company charged with managing the state's portal to fulfill the exchange requirement of the Affordable Care Act, provided access to Medicaid, also known as the Oregon Health Plan (OHP), Oregon Healthy Kids, and private insurance plans that can be purchased by individuals separate from one's employer. Anyone who enrolled through Cover Oregon was directed to three options: private insurance with or without a tax subsidy, Oregon Health Plan, and if qualified, to Oregon Healthy Kids.

The Affordable Care Act (ACA) expanded Medicaid eligibility for those with incomes at 138% percent of the federal poverty level,[ix] which includes nearly all homeless adults without dependents and those not currently eligible for Medicare. As a result of the expanded eligibility requirements, 26.1% of Multnomah County residents are now eligible for Oregon Health Plan (Medicaid) coverage. [76]

Enrollment of individuals into the Oregon Health Plan is regarded as a success by providers and health care professionals alike.[77] From January 1, 2014 to June 30, 2014, an additional 361,935 Oregon residents received coverage through the Oregon Health Plan. As of June 30, a total of 975,717 residents were enrolled on the OHP.[78] With 4 million people currently living in Oregon, Medicaid became the biggest provider of health coverage in the state in its first year alone. [79]

In Multnomah County, any individual who signs up for the OHP will select between the area's two CCOs: Health Share of Oregon and FamilyCare. Health Share members will then select a physical health provider network from among a list of four options. Patients are able to remain with primary care providers with whom they have a relationship; if a patient does not select a provider, one will be assigned. And if an individual has a preference for a particular physical health provider network, the Health Share will assign that network if possible. For Health Share members, mental health provider networks are determined by county. FamilyCare has a single integrated network of physical and mental

[ix] In 2014, the federal poverty level is approximately $11,670 a year for an individual and $23,850 a year for a family of four. See the U.S. Department of Health & Services 2014 Poverty Guidelines for more information (http://aspe.hhs.gov/poverty/14poverty.cfm).

health providers. Members of both Health Share and FamilyCare choose a dental health network from among a list of Dental Care Organizations (DCOs).

Health Care Delivery Model

One of the biggest changes resulting from the health care transformation that accompanied the Medicaid expansion is the delivery of health care. Health coverage now includes community workers, certified health interpreters, doulas and a variety of medical and health specialists. The ACA expanded the use of medical homes or health homes. It now allows for greater integration of primary care and behavioral care, increased community-based, long-term care and includes "flexible services" that focus on maintaining health. This can include gym memberships, nutrition classes, exercise classes and community health approaches such as self-help groups for mental health. The purpose of flexible services is to maximize the health of individuals through broader strategies than clinical intervention alone while containing costs. [80]

Integrated behavioral health is an important tenet of the Affordable Care Act. A more patient-centered approach to care is intended to emphasize working around patients' schedules and not just doctors' schedules. There is also a shift in population disease management. Patient-centered care still requires individualized care, but the ACA allows health providers the opportunity to look at a broader population.[81]

In January 2014, Multnomah County instituted a new program that applies funds more flexibly in order to take help take issues of housing into account for families. It offers a new service for homeless families with children, which includes a mobile facility. When necessary, the county general fund has paid to help obtain housing for families and it has helped return a family to another location if stable housing exists in that locale. Lastly, it has been applied to clear debt in order to allow families to access housing (e.g. pay a deposit for rental).[82]

Coordinated Care Organizations

Coordinated Care Organizations (CCOs, called accountable care organizations in other states) were implemented in Oregon as a way to replace a fragmented system of care that too often relied on silos of delivery for physical health, mental health and addictions care, and dental health care. Oregon Governor John Kitzhaber successfully argued for the creation of CCOs in Oregon in 2012 through a public process, with bipartisan support from the Oregon Legislature, in order to provide better care for people on the Oregon Health Plan.[83]

The CCOs are a network of different health care providers that include physical care, addictions and mental health care and dental care.[84] The key features of CCOs are as follows:

1. They are locally governed.
2. They have one budget that grows at a fixed rate.
3. They are accountable for the health outcomes of the population they serve.
4. They are governed by a partnership among health care providers, community members and stakeholders in the health system that carries both financial responsibility and risk.[85]

Of the sixteen CCOs in Oregon, two – Health Share of Oregon and FamilyCare - are charged with managing the care of people covered by the expanded Medicaid program in the tri-county area.[86] As of September, 2014, Health Share of Oregon had an enrollment of 238,517 people in the tri-county area and serves most of Multnomah County's Oregon Health Plan participants. FamilyCare has an enrollment of 115,423 people in the tri-county area. [87, 88] Prior to the advent of CCOs, Medicaid payments went to separate managed care plans for physical, mental and dental health. Now Medicaid payments go through the centralized CCO.[89]

CCOs are intended to unite previously unaffiliated hospitals, physicians, dental and mental health agencies under one contract, and emphasize preventative and holistic health services for the people covered by Medicaid. The hope is that CCOs will be successful in creating a more unified and economical health care delivery model and that eventually other Oregon residents, including public employees, will be able to access to their services.[90]

To provide quality care at lower cost, CCOs have the flexibility to manage preventive care as well as chronic disease care, coordinate care to limit unnecessary tests and medications and integrate physical and mental health and addictions support into basic health care programs. One witness described this structure as a semi-single-payer system in a multi-payer world - it creates an organization that shares risk across all groups.[91] The primary goal for CCOs is to increase health equity in order to ensure that everyone in Oregon has the care they need to stay healthy.[92]

Effect of Health Care Reform on the Homeless Population – Early Results

The Oregon Health Plan (OHP) expansion occurred in January 2014 and comprehensive data showing its impact on health outcomes and health services utilization is not yet available. However, previous studies of health outcomes among OHP enrollees and early results from the CCOs on their metrics demonstrate patterns of progress and positive outcomes.

Potential Benefits of Expansion for the Homeless Population

Health Services

For homeless individuals, Medicaid expansion offers the potential for more consistent treatment for medical conditions, including alcoholism, drug addiction, chronic pain and depression. For Oregon, it will mean a more effective safety net, and perhaps even a cheaper one. Individuals are now able to access preventative care as well as specialists at low or no cost, shifting the burden of treatment from expensive emergency department visits to federally qualified health care programs.[93]

> *"What has changed for NARA because of the Affordable Health Care law? In 2013, 23% of individuals had Medicaid and today its 59%. Mental health coverage was at 40% and now its 74%. Addictions treatment was at 37% and now its 91%."* [94]

Housing

Medicaid expansion does not directly help homeless people find housing. However, officials at federal agencies, national housing organizations and local nonprofit organizations argue that Medicaid expansion could reduce rates of homelessness. Possible benefits include reducing homelessness due to

medical debt or untreated illness, helping homeless individuals become eligible for and remain in housing, and freeing up money for nonprofit groups to spend on residential programs rather than on health care.[95] "We really feel like [Medicaid expansion] is the last piece of the puzzle that we need to end chronic homelessness," said Steve Berg, the Vice President for programs and policy at the National Alliance to End Homelessness.[96]

The expanded coverage may make it easier for homeless people to find and stay in housing. Some assisted housing units require prospective tenants to have Medicaid. Further, the expanded Medicaid program is able to "pay for services that help people become stable so that they can remain in housing."[97] Portland has had success in leveraging financial resources for housing, including The Apartments at Bud Clark Commons, Federally Qualified Health Clinics and Central City Concern's Recuperative Care Program.[98]

Oregon's Federal Waiver Allowing Flexibility in Medicaid Spending

Oregon was the first state to request and obtain a federal waiver, which allows its CCOs exceptional flexibility in how they allocate Medicaid services. The state received $1.9 billion in 2011 from the Center for Medicaid & Medicare Services to fund this transition. In exchange, Oregon promised to cut per capita growth of Medicaid spending from 5.4% to 4.4% within the first full year, and to 3.4% in the following three years. It must demonstrate progress on 17 quality and access measures, including reducing preventable hospital admissions for asthma, diabetes and heart failure. If Oregon fails to uphold its end of the bargain, it will lose up to $511 million in federal funding.[99]

Preliminary data shows "slow, but relentless progress" in Oregon, according to Governor Kitzhaber. Early reports, prior to Medicaid expansion, show that those enrolled in Medicaid use less inpatient and specialist care. Willamette Valley Community Health, for example, showed a 12% drop in emergency department visits.[100]

Coordinated Care Organizations: 2013 Performance Report

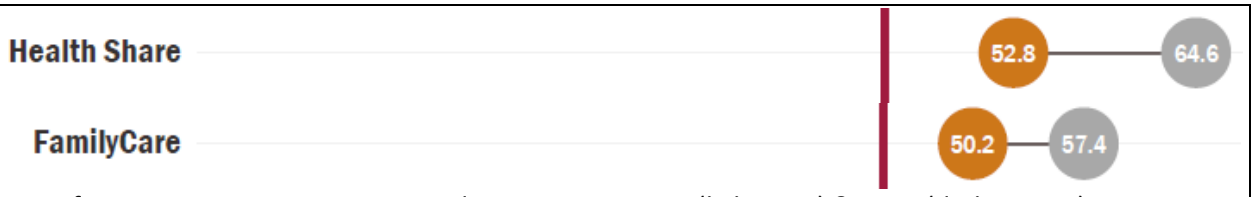
Coordinated Care Organizations were instituted in 2012, in anticipation of the federal expansion of the ACA. In June 2014, The Oregon Health Authority Office of Health Analytics released a performance report on the sixteen CCOs in Oregon, tracking the 17 CCO incentive metrics, as outlined by the federal requirements, as well as 16 state performance metrics.

Between 2011 and 2013, emergency department visits decreased by 17%, and the cost of hospitalization for chronic conditions decreased by 19%. Hospital admissions for congestive heart failure were reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%. Primary care usage has increased. Outpatient primary care visits increased by 11% and spending is up over 20%.[101]

The report also noted that more gains need to be made in screening for risky drug or alcohol behavior as well as adequate access to health care providers. Access to care is particularly important, with more than 340,000 new OHP members joining the system since January of 2014, including much of the homeless population in Multnomah County. [102]

A sampling of the key indicators of progress for the two Coordinated Care Organizations serving Multnomah County, Health Share of Oregon and FamilyCare, are shown in the figures below:

Figure 14: Use of Emergency Department by Health Share of Oregon and FamilyCare members



Rate of patient visits to an emergency department in 2011 (light grey) & 2013 (dark orange)

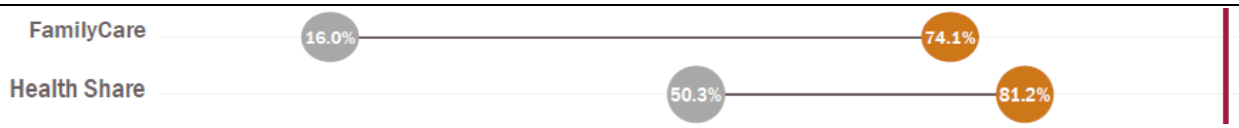
Benchmark: 44.4

Data for Emergency Department utilization based on the 2013 Performance Report.[103]

Figure 15: Use of outpatient services by Health Share of Oregon and FamilyCare members

Rate of patient visits to a doctor's office or urgent care in 2011 (light grey) & 2013 (dark orange)
Benchmark: 439/1,000 members
Data for outpatient utilization based on the 2013 Performance Report[104]

Figure 16: Enrollment in patient centered primary care home by Health Share of Oregon and FamilyCare members



Percentage of patients who were enrolled in a recognized patient-centered primary care home in 2012 (light grey) & 2013 (dark orange)
Benchmark: 100%
Data for patient-centered primary care home enrollment based on 2013 Performance Report.[105]

Initial Outreach to the Homeless as a Result of Health Care Reform[106]

Despite issues with the Cover Oregon website, new Medicaid enrollments of the homeless population were high.[x] Participants were enrolled in the OHP by social service providers, housing and health care workers, the police and others in law enforcement. The Oregon Health Authority assisted with enrollment through "fast-track enrollment" which pre-screened individuals enrolled in the Supplemental

[x] Undocumented workers are not eligible for coverage, regardless of income level.

Nutrition Assistance Program (SNAP). These individuals were sent single-page enrollment forms by mail.[107]

Multnomah County employs twenty-eight eligibility specialists located in health care centers and other public locations, such as libraries, to sign up members of the public.[108] If an individual does not have a permanent address, specialists work to create a plan to ensure they are enrolled. One common solution for homeless individuals is to register them using their health center's mailing addresses as their own personal address. [109]

Vulnerable young people in Multnomah County have been sought out for enrollment for social services through a targeted program called Street Outreach. This program is usually conducted in outdoor and non-traditional environments such as sidewalks, parks, abandoned houses/buildings, under bridges, in shopping malls, public schools and other public spaces. Increasingly outreach includes the internet and social media.[110] The main challenge of enrollment, according to some health care providers, is navigating the federal bureaucratic system.[111]

Challenges to Enrollment

Despite all of the successes, Medicaid enrollment has its share of logistical challenges. Homeless individuals often do not have an email address, phone number or permanent address; many are still unaware of the health care changes, or are skeptical of public programs. For transient individuals in particular, the fact that some states have not signed onto the Medicaid expansion is particularly challenging, as they will not receive consistent health coverage if they move to another state. Advocates and social workers across the region are now on a major push to inform the remaining members of the homeless populations that they are eligible for Medicaid, and to enroll them.[112] Eligibility for Medicaid does not necessarily result in enrollment, particularly for disadvantaged populations, including the chronically homeless who face a variety of access barriers such as illiteracy, lack of documentation and stable contact information.[113]

Discussion, Analysis & Conclusions

Health Care for the Homeless

Conclusion 1: **Medicaid expansion through the Oregon Health Plan has made available services that were not available previously.**

Prior to 2014, the limited availability of health care coverage for low-income individuals in Oregon had a disproportionate impact on people experiencing homelessness. More than half of people sleeping on the streets of Multnomah County were found to suffer from potentially life-threatening medical conditions and, prior to 2014, had no medical insurance to adequately care for these conditions.[114] Most people experiencing homelessness do not have the money to pay out of pocket for care, and without coverage their medical conditions have largely gone untreated.

All of the organizations that serve this population are in the same moment of awakening. Prior to the ACA, [Outside In] served the homeless and uninsured. Then eligibility kicked in January of 2014. In December of 2013, 83% of our clients were uninsured. Now, 70% are insured.[115]

- John Duke, Clinic Director, Outside In

Prior to the enactment of the ACA and the Medicaid expansion, eligibility for Medicaid was limited to individuals living at or below 100% of the federal poverty line (FPL). Now coverage is available to people who earn up to 138% of FPL. With this expanded eligibility, Medicaid enrollment is expected to increase nationwide to nine million by 2015, including thousands of homeless individuals. Approximately 1.2 million homeless Americans, including 110,000 considered chronically homeless, are among those who are now eligible for expanded Medicaid coverage.[116] The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or other considerations such as sex. Additional reforms aim to reduce costs and improve health care outcomes by shifting the system towards quality over quantity through increased competition, regulation, and use of incentives to streamline the delivery of health care. By virtue of the requirements of the ACA, the expansion of Medicaid through the Oregon Health Plan has made available medical services that were not previously available to many low income and homeless Oregonians.

Jeffrey

Jeffrey signed up when he applied for food stamps. He said it is easy to get coverage for primary care and prescriptions, but not for screenings. He is unsure just what Medicaid covers.[117]

Conclusion 2: **Within the homeless community, the combination of negative institutional experiences and disproportionate trauma rates exacerbates the problem of obtaining health care.**

Through first person interviews with persons who identify as homeless,[xi] the committee discovered a common thread of mistrust toward health care institutions. Bias-inducing experiences included issues with law enforcement and perceived prejudice due to hygiene or mental health issues.[118]

Also, the incident rate of traumatic injuries is much higher among the population of homeless persons than among those who are housed. Traumatic brain injury (TBI) rates have been shown to be as high as 53%.[119] Among those with TBI, 70% reported suffering their first head injury before they became homeless.

[xi] Several members of the research committee went out and spoke to homeless people as part of the outreach conducted by Right 2 Dream Too and Night Strike.

Those with TBI have increased pain, decreased mental and physical health and increased likelihood for seizures. As a result of this, homeless persons often turn to coping strategies. Forty-six percent of homeless persons report utilizing street drugs as a way to manage pain, and 29% report using alcohol.[120]

The incidence of post-traumatic stress disorder (PTSD) among the homeless population is 41%. This is in dramatic contrast to a rate of 1.5% among the general population.[121] Old Town Clinic in Portland, which serves primarily homeless persons, reports that 24% of their current patients have been identified as having PTSD.

The intense psychological trauma that results from domestic violence is also a factor. Among the female homeless population, 41% were shown to have experienced domestic violence.[122]

In addition to problems associated with trauma, many individuals are not confident in a complex healthcare system. Without a consistent address or ability to contact their providers, they will need increased education about their options. [123] Some excellent educational resources exist for providers and are already used by organizations serving the homeless. Several organizations in the Portland area offer community trainings on homeless outreach, such as Janus Youth Programs' Yellow Brick Road, and Outside In.

Conclusion 3: **Access to seemingly "little things" is tremendously important in providing complete health care for people who are homeless.**

When treating the homeless population, there are a number of confounding variables that emerge that can make a significant difference in the quality of their care as well as their health outcomes. These are factors that are typically overlooked as they are challenges unique to those who lack stable housing.

What begins as a simple treatment when caught in the early stages can quickly worsen into something more costly and serious when left untreated.[124] For instance, foot conditions and skin infections are highly prevalent in the homeless community, and yet the lack of wound care available can turn an ordinary infection into life-threatening sepsis. Ibrahim Mubarak described what could essentially be called "trench foot" as a daily challenge for the homeless in the Pacific Northwest.[125] Even when individuals do receive medical care, they lack the appropriate facilities in which to recover. Your committee heard several examples of homeless people who discharged from hospitals after having been treated for pneumonia or recovering from a serious surgery – despite having no shelter. These issues are compounded further due to the lack of sanitary conditions for those living on the streets. As Ibrahim Mubarak notes, "There is no porta potty. There is nowhere for them to throw their trash when they eat. There is also no place they can take a shower or shave or clean their clothes…. We haven't found a homeless-friendly laundry mat yet."[126]

Disease management is another concern that is more difficult for the homeless population. They are at higher risk for acute and chronic medical and psychological conditions, including seizures, diabetes, frostbite, TB, HIV, and so on, which are made more challenging without proper control and management. For example, imagine managing diabetes effectively without a fridge in which to store

insulin.[127] Access to what might be considered "little things" to an average housed patient make a tremendous difference in health outcomes.

Dexter

Dexter, 57, has not had insurance for 10 years. He was laid off from his last construction job in southern California in 2009 where he worked in the aerospace industry. His retirement fund was insolvent and he has been on the streets since the layoff, living on $189 in food stamps. Last winter he had a major throat infection and Dexter said he could not afford aspirin or cough syrup. Finally he was admitted to Good Samaritan Medical Center where he was diagnosed with a staph infection and signed up for Medicaid. Dexter said he was near death when admitted and received good care. He stayed at Good Samaritan for 10 days before he was released back onto the streets. Dexter is looking forward to turning 62 so he can get social security and possibly afford housing. Hospitalization through Medicaid is a plus for Dexter, but access to earlier treatment could have reduced or prevented his hospital stay. [128]

Conclusion 4: **Comprehensive wraparound services are insufficiently available for persons experiencing homelessness**.

Challenges in the homeless community that arise from a lack of understanding of the health care system, perceived discrimination and cognitive impairment can be better addressed through wraparound services, [129] ("intensive, individualized care planning and management")[130] which often provides less costly and more appropriate treatment for chronic medical conditions.[131]

Affordable housing is also a huge issue in this community and not just housing for the chronically homeless. We need to use the extra money that is freed up and aim it at health – basic needs of housing, food, etc. There is enough money in this community – it's a matter of distribution. - Janet Meyer, Dr. David Labby, Health Share of Oregon [132]

CCO representatives expressed hope for more funding for wraparound services. Though Medicaid expansion requires that unspent funds be returned, prior Medicaid requirements still allow the use of unspent funds for wraparound services including health education, integration of services, and short-term help with bills that could aid people in retaining their current housing. [133]

One national model is the Recuperative Care Program (RCP), which involves temporary housing for recovery. Central City Concern created an RCP where hospitals can discharge individuals to temporary housing and buy a portion of the housing. RCPs are funded out of health care dollars so hospitals benefit from their creation.[134]

Patient-centered health homes have also been recognized for delivering the diverse care needed by persons suffering from chronic homelessness. Medicaid now provides a 90% match rate to states that implement health homes for the first eight quarters of operation.[135] Some states have implemented health homes by using a voucher system that allows localities and providers greater flexibility in their approach to care. [136]

In a presentation to the City Club of Portland and in an interview with your research committee, nationally recognized homelessness advocate Nan Roman talked extensively about issues of funding health care and social services for the homeless. According to Roman, most homeless services are funded by grants, but health care generally does not use grant funding. Roman argues that the charitable sector needs to adapt to changes occurring in funding sources. Citing projects in Cleveland, Columbus, and Chicago as model projects, [137] Roman sees Medicaid expansion as an opportunity to free up dollars that could be used to address homelessness.

Barb

Prior to enrolling in Medicaid in late 2013, Barb, 57, accessed services through the Emergency Room at Providence Hospital.

Barb, who has been diagnosed with a bipolar disorder, is newly enrolled with Medicaid coverage. She can now receive mental health service through Cascadia Behavioral Health and her prescriptions are free. Barb needs physical therapy but is confused on just what Medicaid covers.

"The majority of people on the streets who want [health insurance] are signed up for it" because they have gone into various agencies and it has been offered, she said.

Her biggest challenge is transportation to Cascadia on the eastside of Portland, which is a long bus ride from where she lives downtown.

"Bus passes through different agencies are drying up. If you have a phone or address it is easier to apply for help.

"It is frustrating because I can't figure things out when I can't call people. Since I have been on the streets I don't have access to the media to find out stuff that is going on." [138]

***Conclusion 5:* A lack of data exists about the capacity of health care providers to care for new Medicaid patients.**

CCOs track many aspects of patient care, including the number of members with Medicaid benefits who are currently inactive in the system, the use of only physical health or mental health services, and how many days until a member's first primary care physician appointment.[139] However, information about the capacity of Medicaid providers was not readily available.

CCOs stated that they have adequate capacity to serve their membership." [140] [141] However, your committee did not readily find supporting data.

According to recent national reports, concerns continue about access to care for Medicaid enrollees;[142] 11% of new Medicaid participants had difficulty making an appointment, and 3% could not make an appointment at all. [143] Locally, witnesses remarked anecdotally on the capacity of the health care system to accommodate the influx of Medicaid patients.[144] [145] A shortage of mental health providers leads to longer wait times for addictions treatment. Specialty care can also be hard to find for homeless patients; it can take up to six weeks for a referral to a cardiologist.

The health care capacity for Medicaid patients is limited by the Medicaid reimbursement rates.[146] However, Medicaid expansion included an increase in funding for primary care visits for 2014 with possible extensions which may help to address this issue. [147]

Conclusion 6: **The power to be a consumer of health care provides both freedom and confusion.**

Prior to the Affordable Care Act, homeless individuals had few options other than the emergency department or safety net clinics. Now enrollees can pick their own primary care provider or health home.[148] As Outside In's John Duke reported to your committee, "The very exciting [thing] about the expansion of the ACA is customer power, the same as a person with private or employer insurance." [149]

This change provides choice to those who are accustomed to having no choice at all, creating both opportunity and challenge. Homeless individuals can now be active consumers and make their own decisions regarding their medical care. However, the homeless population often has had limited experience in making such choices.

This is evidenced by Kirsten's testimony. When asked how the change in Medicaid has affected her health care coverage, she responded, "It hasn't. I don't use Medicaid services [despite having them]. Do they offer eye care?" Despite the power of consumer choice, the homeless population lacks the knowledge to take full advantage of that power.

Mike

Mike, mid-50s, has been homeless for 16 months and lives with his longtime girlfriend, Trish, in the R2D2 complex off Northwest Burnside. Mike said he stopped working when he began taking care of his terminally ill mother and he hasn't found steady work since. He has Medicaid now, but Mike has not accessed services and said he really doesn't know what is available."

"I just can't bring myself to go. I am healthy, overall, but do have some things that should be taken care of. I'm not gonna lie—mental health issues are a factor." [150]

Billy

Billy, 23, signed up for insurance this spring and has moved to Portland from Corvallis. He said he hasn't had insurance since he was "booted out" of the foster care system. Recently his service dog was stolen. Billy has nerve damage to his feet and needs health care. He was distraught and did not want to take the time to go to a doctor until his dog was found. [151]

Implementation of Health Care Reform

Conclusion 7: **Within Portland and Multnomah County, excellent models exist.**

The most effective strategies for providing health care for the homeless incorporate housing into the model.[152] Supportive housing, as exemplified by Portland's Apartments at Bud Clark Commons (BCC), provides housing while creating access to physical and psychological care for residents[153] and has been shown to dramatically reduce health care costs. Savings average $1000 per year per patient, after the second year of housing.

Another local agency which serves as an example for addressing homeless health care issues is the Old Town Clinic, operated by Central City Concern (CCC). The Old Town Clinic has been recognized nationally for its availability of wraparound services for homeless persons.[154]

Conclusion 8: **Health care literacy is a barrier to access.**

Representatives from CCOs noted the importance of connecting homeless members with nontraditional health workers and peer support workers to engage them in establishing and maintaining a relationship with a primary care provider and to set, when necessary, individual health plans for specific needs. [155]

Many local organizations are taking steps to help this process along. The staff at Bud Clark reminds residents of doctor appointments by putting notes in their boxes and notices on their doors. Then, they may walk residents to their doctor appointment to show them where it is.

Health care literacy is taught at NARA's Totem Lodge during a 30-minute visit, which may include the patient, physician, and case manager. The case manager serves as the liaison to the fully integrated team of providers and may accompany the patient to specialty appointments. In addition, tribal elders attend the NARA orientation program to keep patients connected with culture as part of their "culture is healing" ethic. [156]

"For vulnerable communities, it's not just enrolling them, its holding them by the hand and making sure they get the care they now have access to."[157]

Sandy

Sandy, 48, is confused about Medicaid enrollment and says she wants no part of it. In the past Sandy received her health care through Outside In and said she this access works great and she likes her doctor. Sandy hasn't signed up for Medicaid because she believes she would be charged a co-payment, which she can't afford and she doesn't want to pay for prescriptions. She has been on the streets since 2008. [158]

Conclusion 9: **Information sharing among care providers, the Oregon Health Authority and CCOs could be improved**.

Despite the creation of CCOs to replace a fragmented Medicare system that too often relies on different groups to provide physical health, mental health, addictions care, and dental care, a lack of information sharing among care providers still exists. [159]

Health care, housing and social service providers are beginning to communicate more regularly. Examples include CCO meetings, the Home for Everyone Coordinating Board and Executive Committee,[160] a subcommittee on health including mental health and addictions,[161] the Multnomah County Beyond Enrollment Health Charrette,[162] Oregon ON Portland Public Forum,[163] and the Annual Coordinated Care Model Summit.[164]

Still, CCOs struggle with knowing who in their population is homeless. Representatives told your committee that "our primary difficulty in serving the homeless population lies in identifying and contacting them." [165] There is no "homeless indicator" from Oregon Health Authority that labels a person who is homeless, despite the fact that this is a question on the OHP application. CCOs largely rely on their providers to give them that information.

Communication among the CCOs is another area where a deficiency is recognized. Every CCO in Oregon is required to have a Community Advisory Council which collaborates with advocates in the community. These advocates help to identify health-related flexible services that are not covered by Medicaid, but which the CCO might add to the services it provides. However, 16 separate CCOs in Oregon, each with 10% set asides for flexible services, are all trying to figure out how they can receive authorization for each new service.

The result is that despite the newly identified best practices in outreach, communications and delivery of service, many individuals may simply fall through the cracks, and flexible services are limited.

Conclusion 10: **Medicaid expansion, combined with low Medicaid compensation rates, has put pressure on providers' capacity leading to access challenges for new enrollees and longer wait times for specialized care.**

With the higher-than-anticipated increases in OHP enrollment since January 2014, many have predicted that the medical system would lack the capacity to absorb this sudden growth resulting in long wait times for services, and in some cases, no services available at all. Your committee found it difficult to assess the impact this has had on the access and availability to health services for the homeless population in Multnomah County. Here are some of the stories we heard:

- News anecdotes cite long wait times throughout the state for new patients seeking care. In rural areas, doctor shortages presented a challenge prior to the Medicaid expansion. In two counties, CCOs have stopped accepting new patients altogether.[166]

- A recent report by the U.S. Department of Health and Human Services states that, "state standards for access to care vary widely and are rarely enforced. As a result, Medicaid patients often find that they must wait for months or travel long distances to see a doctor."[167]
- Due to low reimbursement rates, many specialists impose low quotas on the number of Medicaid-reimbursed patients they will see. This is proving to be a particular problem with regard to dental care.[168]
- In Multnomah County, an employee of an agency that provides medical and substance abuse treatment for the homeless told us that demand for mental health services has increased, and overall specialty care cannot keep up with the demand.
- In August, Janet Meyer, CEO of Health Share of Oregon, stated "I don't know about other CCOs but we're all very full, near capacity. It's not surprising. But we've been able to assign. Our partners are working with us. Enrollment is leveling off." [169]

Your committee is not in a position to predict how quickly or whether these access/capacity issues can be addressed. Our overall observation is that homeless people who were already being served by clinics, such as the Old Town Clinic, Outside-In and NARA, have the advantage of being linked into an integrated care structure that will meet many of their health care needs. For these people, many of whom are newly enrolled in the OHP, the concerns about access or lack of capacity are not as acute. Newly-enrolled OHP members who have not been connected to a care network recently are more likely to encounter the challenge of accessing primary care or specialty care in a timely fashion.

Your committee learned of several approaches being used with some success:

- Recruit and train more doctors with incentives to work with underserved populations.[170]
- Change the delivery model, making more use of physician assistants, health navigators or caseworkers.[171]
- Prioritize care to serve the most needy cases or most important care needs first.[172]
- Allow market forces to effect changes that will meet the new needs and demand on the system.[173]

Conclusion 11: **Homeless-specific data is necessary to design and deliver services to the homeless population.**

Data on health outcomes has helped us understand how housing projects facilitate cost savings and improve the physical and psychological wellbeing of homeless clients with complex and costly health issues. A study of Portland's Apartments at Bud Clark Commons (BCC) showed that the average resident reduced his annual medical claim by $8,724. The annual cost to house a resident at Bud Clark Commons is $11,600. Cost savings among the BCC residents came from efficiently managing health care in appropriate settings, helping to reduce acute health crises and avoiding more expensive types of utilization. Accumulating additional financial data for innovative efforts will help us understand whether savings can be achieved through the Medicaid system while improving health and quality of life for the homeless.

However, the availability of shared homeless client information targeting sub-group populations and for tracking usage and service needs is hampered on two fronts.

First, within the homeless community, there is a deep-seated fear of confidentiality and privacy violations. Second, social service and health care providers are reluctant to share medical information due to HIPAA requirements and Health Information Management Systems Society (HIMSS) regulations.

A database that provides a better picture of the prevalence of various conditions and specific needs across the homeless community could be used to make a stronger case for targeted flexible services reimbursable by Medicaid.

Additionally, the division of responsibilities among different local governments influences efficiency in the coordination of services. Multnomah County and the City of Portland have different roles serving the homeless within the metro area. According to Deborah Kafoury, Chair for the Multnomah County Commission, "the county is primarily responsible for homeless families and youth [while] the city is responsible for homeless adult individuals."[174] The State of Oregon also has its own role in funding local efforts.

Multnomah County, the City of Portland, and local CCOs are working to improve coordination to maximize cost-saving opportunities. The County and Health Share of Oregon are working to resolve issues related to the County's new administrative role. Recommendations from a consultant hired by the County include "hiring an actuary to review utilization data" and "identifying those services currently being funded with state or county general fund dollars that could become Medicaid reimbursable." These actions could facilitate future cost savings for the growing number of homeless Medicaid enrollees and yield improved Medicaid reimbursements for flexible services.[175]

Initial Outreach to the Homeless

Conclusion 12: **Despite early challenges, efforts to enroll Oregon's newly eligible Medicaid population have been, and continue to be, a success.**

In a 2013 New York Times article, author Annie Lowry identified issues in enrollment, including the fact that homeless individuals often do not have an email address, phone number or permanent address, and many remain unaware of the health care law or are skeptical of any public program. Advocates and social workers across the country are now on a major push to inform impoverished and homeless people that they are eligible for Medicaid in the states that are expanding the program and to enroll them.[176]

Despite the controversial failure of the Cover Oregon website and logistical challenges mentioned by Lowry, enrollment of individuals onto the OHP has generally been referred to as a great success. As of

September 1, 2014, nearly one million Oregonians are on the Oregon Health Plan, 380,600 of whom have received coverage since Jan. 1, 2014.[177] [xii]

Francis, Zach, Dinosaur[xiii], Greg, and, Glen

Newly enrolled clients who are homeless signed up for Medicaid a variety of ways: through food stamp applications, hospital admissions and even while serving jail time.

Francis and Zach, both 21, signed up for insurance when they filed for food stamps, but they have not used it yet. Zach needs an inhaler for asthma and said he hopes his insurance will provide this.

Dinosaur, 39, also signed up for insurance when he applied for food stamps, and has not used it. In the past, he used the emergency room for all health care and is glad to have broader access now.

Greg, 47, said he started life on the streets when his business failed because of his brother's embezzlement. He signed up for Medicaid when he was hospitalized at Emanuel in June, where he said he received good treatment for an infection.

A self-described "speed freak," Glen, 26 signed up for Medicaid when he was in jail this spring. He has since been admitted twice to Portland hospitals. He was taken to Good Samaritan Medical Center this spring, when he passed out on the waterfront and a passerby called paramedics. Glen said he was at Good Sam for two days before being released back to the streets. He was later admitted to Providence Medical Center for an arm infection. He said he received excellent care. However, he said he couldn't afford a $4 follow-up prescription. [178]

A large part of this enrollment success was the Oregon Health Authority's effort to "fast-track" the enrollment process for individuals who were already receiving certain state assistance benefits. About 300,000 adult Oregonians were pre-screened for the OHP prior to January 2014, and did not have to

[xii] The enrollment process has been such a success for those people who qualify for OHP that many people who would have qualified for coverage under the old rules but never sought enrollment have now enrolled. For example, Health Share of Oregon has enrolled an additional 12,000 children since the start of 2014. Janet Meyer and Dr. David Labby of Health Share refer to these individuals as the "woodwork population" because with the great efforts put forth by the state to enroll eligible individuals, others have literally come "out of the woodwork." Since this population has always been eligible for Medicaid and is not part of the ACA expansion, the corresponding federal match is the standard rate rather than the enhanced rate that is attached to the expansion population.

[xiii] Many street-dependent youth have a street name or alias to help them shed their "victim identity" and survive on the streets, by developing a separate persona. Sometimes the name is given by an older or more experienced homeless person and other times they are self-chosen. This name is crucial to a youth's identity and purpose of maintaining a survival identity. Therefore, your research committee did not ask for given names.

apply for OHP through Cover Oregon. These individuals were sent single-page enrollment forms through the mail.[179]

Another part of the enrollment success was due to Multnomah County's 28 eligibility specialists, who have worked to sign up clients and members of the public in Multnomah County health centers, libraries public health outreach sites, and enrollment fairs across the county.[180]

Lastly, Multnomah County Clinic, Old Town Clinic and other medical clinics that have traditionally served homeless and/or low-income populations have helped with enrollment. John Duke of Outside In commented that, "the main complication of enrollment is the bureaucratic situation, which can be overcome. Many agencies, such as Outside In, who serve eligible people, have developed skilled abilities to get through bureaucratic glitches."[181]

Homeless Health Issues Are Housing Issues

Conclusion 13 **– Medicaid expansion provides an opportunity to reallocate funds that would otherwise have been spent on health care to addressing root causes of such health problems, namely homelessness.**

One of the greatest social determinants of health is housing. Individuals with housing are better able to care for their medical concerns and engage in healthy habits. Nearly every witness and report on homelessness identified housing as an integral strategy to improving health outcomes and reducing health care costs for the homeless.[182] As Dr. Rachel Solotaroff of Central City Concern stated so well, "Housing is the sixth vital sign[xiv] [for the chronically homeless].[183]

Unfortunately, housing the homeless population in Multnomah County remains a challenge. Today, waiting times to get into public housing in Multnomah County is typically 3 or more years. All waiting lists are currently closed; i.e. one currently cannot get onto a *waiting list* for public housing. When lists become open for new registration, they typically are only open for a couple of days and then they close again.[184]

The arrival of the ACA and Oregon's expansion of Medicaid, along with experiments at state, county, and city levels, offers the opportunity to redirect spending from higher-cost health services to permanent housing.[185] Housing for the homeless has been a longstanding goal of Multnomah County and the City of Portland; the 2004 "Ten Year Plan for Ending Homelessness" initiated jointly by the City and County prioritized "housing first." While Multnomah County remains short of its Plan goals, Medicaid expansion may yet offer a chance to make further progress towards housing the homeless.

One emphasis among housing agencies and health and housing providers in Multnomah County is on housing facilities that include multiple, centralized health service providers. With higher populations of

[xiv] Respiration, pulse, skin, pupils, and blood pressure are traditionally thought of as the five vital signs.

the homeless now enrolled in Medicaid, the most vulnerable may best be served in a housing-and-care-services model commonly referred to as permanent supportive housing (PSH).

Bud Clark Commons (BCC), a partnership between the Portland Housing Bureau, Home Forward, Transition Projects, Inc., and Multnomah County, is now a well-recognized national model for supportively housing the neediest among the homeless population, and has been emulated by experiments in cities such as Minneapolis and New York.[xv]

The key to further implementation of the permanent supportive housing model will be a shift in provider compensation models. As Janet Meyer, CEO for Health Share of Oregon stated, "It's going to take some focusing of attention on how we pay providers to do things differently." According to Meyer, Coordinated Care Organizations will need to use creative adjustments in the ways they follow Medicaid's restrictive eligibility criteria for reimbursement to providers and health services.[186] Dr. David Labby, Chief Medical Officer at Health Share of Oregon, suggests further, "Preventive care includes moving from a service system to an outcomes system."[187] A positive health outcomes model emphasizes integrated and coordinated care, which can yield high cost savings and efficient treatment programs. This may result in the greatest benefit to the health and wellbeing of residents within a permanent supportive housing setting, whose high level of need may be best supported by coordinated housing and medical care.

These points are key to ensuring efficient delivery of services that will potentially result in Medicaid reimbursement for the most vulnerable, while reducing overall medical costs. The Health Commons Grant is one of several promising financial tools that may create savings for CCOs and providers, while addressing the medical needs of high utilizers who would benefit most from more coordinated care. The Health Commons Grant is $17.3 million to be used over three years from the Center for Medicaid and Medicare Services (CMS). It is intended to create a regional system to better serve the Medicaid population in the Portland Metro area.[188] [189] This could lead to more support for enhanced services offered in supportive housing programs to benefit this population.

Along with a shift in provider compensation models, finding a way to get Medicaid to cover at least some of the cost of PSH is key. A 2014 article published by the Corporation for Supportive Housing (CSH) identifies common themes between Medicaid and permanent supportive housing models. It states, "Supportive housing residents who obtain eligibility due to mental illness have the most comprehensive

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[xv] According to an article written for the U.S. Department of Health and Human Services, a number of model supportive housing projects have been implemented in cities across the U.S. including Washington, D.C., Chicago, Los Angeles, San Francisco, Columbus, Boston, and Portland, Maine. Programs identified by the U.S. Interagency Council on Homelessness also include programs in Pittsburgh and New York. These programs make permanent supportive housing central to their policies, with new incentives that allow them to pay for funding for both Behavioral Health Service and Case Management.

Medicaid benefits package compared to other Medicaid recipients." This means Medicaid is most likely to reimburse *at least* a portion of a supportive housing resident's services. However, of the long list of services required by PSH residents, Medicaid is least likely to cover benefits such as pre-tenancy support, tenancy support services (i.e. crisis intervention, eviction prevention), general case management as well as transportation to appointments. When reimbursable, supportive housing services are currently either structured as fee-for-service payment arrangement or as a single case rate, which is often too low for high-need populations. Individuals without dependents and/or those do not meet SSI requirements often do not have a health-benefits package that includes the services provided through permanent supportive housing. Lastly, PSH providers often do not have the infrastructure and do not meet the provider qualifications to receive Medicaid reimbursement.[190]

CSH is currently tracking state efforts "to pursue the changes needed to finance through Medicaid the services that [permanent] supportive housing residents need to achieve both housing and health stability." As of 2014, Illinois is the only state that has integrated a PSH model into their coordinated care system. However, even in Illinois, all services currently delivered are financed through the existing Medicaid system, "so there are no new resources available for reimbursement of services delivered in supportive housing."[191]

Los Angeles recently created a new branch of the county's Department of Health Services called Housing for Health and plans to use county health funds to put 10,000 of the most vulnerable homeless people into permanent supportive housing. According to the director, Marc Trotz, "It's a very high cost for that person and their health and their well-being, but a very high societal cost as well, in terms of this constant ricocheting through hospitals, correctional facilities, back on the street and shelters." Dr. Mitchell Katz, the director of Los Angeles County's Department of Health Services, advocates for the federal government to allow the use of Medicaid expansion to directly fund thousands of additional housing units for the homeless. Currently, federal government officials do not allow the use because housing is not considered a direct health service.[192]

While research is ongoing, current strategies that attempt to address the long-term funding challenges of providing PSH are still inadequate. Much of the problem revolves around finding ways to integrate the various services needed by supportive housing tenants. Funding for services provided by PSH remains fragmented between federal, state, and local governmental entities and non-profit providers.

Stakeholders see PSH as being a fruitful avenue for continued expansion of services for the homeless. Our research reveals trends that positively impact how effectively both PSH and supportive housing services can receive funding. National trends show the potential for Oregon's own CCOs to fund such services in order to complement the needs of certain homeless people who require stability before physical care can be addressed effectively. Tools used most specifically to the advantage of the chronically homeless population for whom studies have shown supportive housing is most effective – particularly for those suffering from tri-morbidity – are now being served more successfully in other states.

Recommendations

Based on our conclusions, the committee recommends the following:

Health Care for the Homeless

A. Coordinated Care Organizations and Multnomah County should collect data on health outcomes that result from Medicaid expansion over the next five years.

Such data are currently being collected, e.g. Bud Clark Providence CORE study, but changes in population health occur over years. Actionable data reporting at 6-12 month intervals is recommended for continuous improvement.

B. Home for Everyone Coordinating Board and non-profit providers should ensure provision and coverage of the seemingly "little things" that make a big difference: wound care clinics; clean water; toilets; showers; laundry facilities, etc.

Supportive housing should include direct health care and rehabilitation services, but other, augmenting facilities have been shown to be synergistic in recovery. A single intervention, e.g., an air conditioner for a person with chronic lung disease or heart failure, or new shoes for a foot injury, may prevent an unnecessary, expensive hospitalization.

Implementation of Health Care Reform

C. In two to five years, City Club and Home for Everyone Coordinating Board should analyze and report successes and failures of health care reform for the homeless population.

The Affordable Care Act, and Coordinated Care Organizations, not only expand access to health care to lower-income community members, but are social experiments. A follow-up report from City Club will help inform future improvements.

D. Over the next two years, CCOs and non-profit providers should ensure that every newly enrolled Medicaid beneficiary receives sufficient training on accessing services.

In general, Medicaid-eligible citizens have lower health literacy, and may find access to be unclear, or daunting. Our research indicates that many homeless persons are even less familiar, and require more direct education and the guidance of others to join Medicaid and access care.

E. By the end of 2016, CCOs and health care providers should ensure that all health care providers have been trained to address the special needs of homeless populations, which derive from the high incidence of physical and psychological trauma.

Your committee has reviewed the research into the effects of negative emotional inputs to persons who become homeless. Such psychological, physical, and spiritual devaluing is a major contributor to the

lamentable life course of many homeless persons. Health care providers, particularly those not receiving mental health care, are often unaware of the effects of such early and continuing trauma. Better understanding and adoption of trauma-informed practices should result in more effective interaction between provider and homeless patient – and improved outcomes.

F. By the end of 2016, CCOs should require all hospitals' discharge plans to include housing or shelter upon discharge, with follow-up appointments for care.

Prior to discharge, all inpatients should receive social work and nursing services to determine optimal future care, such as medication reconciliation with their prior medications, follow-up appointments, continuing counseling, and social support. Many of these expected and necessary resources are not available to persons living on the street. Homeless persons should not be discharged until housing, shelter or supportive guidance is determined. Creative or alternative hospital fee reductions for extra inpatient days should be developed.

G. By 2020, CCOs and the Home for Everyone Executive Committee should address the need for flexible services funding to address housing needs.

State and local funds may be allocated more flexibly than "fenced" federal appropriated dollars, such as Centers for Medicare & Medicaid Services (CMS) and U.S. Department of Housing and Urban Development (HUD). Your committee discovered, around the nation, several local experiments using medical funds for housing, and all demonstrated success. We strongly advocate for such experiments, grants, and flexibility here.

Initial Outreach to the Homeless

H. Over the next two years, CCOs, Multnomah County and non-profit providers should continue to provide multiple enrollment and re-enrollment opportunities for the homeless.

Homeless Health Issues Are Housing Issues

I. Over the next five to ten years, Home for Everyone Executive Committee, Multnomah County, City of Portland, HomeForward, and the City of Gresham should invest in supportive housing, which includes on-site, comprehensive, integrated rehabilitation and health services.

Your committee came to an early agreement that availability of Medicaid insurance is necessary, but clearly insufficient, to return homeless persons to full, productive health.

J. Over the next two years, Home for Everyone Coordinating Board, Multnomah County and others should advocate strongly for housing status as a health determinant.

After hearing the vast majority of your committee's witnesses argue for housing status as a health determinant, your committee concluded that the relatively poor health condition of homeless persons is a direct and continuing result of living without adequate housing. As an intervention, providing housing

– shelter, heat, and a place to prepare and store food, as well as rest and sleep – is equally important to offering health insurance. The Affordable Care Act has greatly increased funding for physical and mental health services; similar increases in housing availability are vital for the success of Medicaid. As of now, there is more money for health care than there is for housing. If health care and housing advocates, County officials, homeless advocates and others who work in the interest of the homeless advocate strongly for the social determinacy of housing, it will further strengthen applications to receive funding for housing from public and private foundations, granting entities, and private philanthropy sources.

Signatures

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Kristina Smock, Consultant, “2013 Point-in-Time Count" of Homelessness in Portland/Multnomah Co.

Dr. Rachel Solotaroff, Medical Director, Central City Concern

Amy Thompson, Native American Rehabilitation Association (NARA)

Christy Ward, Director of Primary Care Services, Multnomah County

About the City Club

City Club of Portland brings together civic-minded people to make Portland and Oregon better places to live, work and play for everyone. For more information about City Club of Portland or for additional copies of this report, visit www.pdxcityclub.org, email info@pdxcityclub.org or call 503-228-7231.

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Appendix A: Glossary of Acronyms

ACO – Accountable Care Organization

VA- Veterans Administration

CCC- Central City Concern

CCO- Coordinated Care Organization

OTC- Portland's Old Town Clinic

OHP- Oregon Health Plan

HIMSS – Health Information Management Systems Society. A cause-based, not-for-profit organization focused on better health through information technology (IT). HIMSS leads efforts to optimize health engagements and care outcomes using information technology.

HSO- Health Share of Oregon

HUD- Housing and Urban Development

HUD-VASH – Housing and Urban Development Veteran Supported Housing

FC- FamilyCare

RAE- Risk accepting entity

CMS - Center for Medicaid & Medicare Services

PIT – Point-in-Time Survey

FPL – Federal Poverty Line

OI- Outside In

OHSU- Oregon Health & Science University

ACA- Affordable Care Act

NAYA- Native American Youth and Family Center

NARA- Native American Rehabilitation Association

CHIERS- Central City Concern Hooper Inebriation Emergency Response Services

FQHC- Federally qualified health care center

HRSA- Health Resources and Services Administration

SSVF – Supportive Services for Veteran Families

HPACT – Homeless Primary Care Team

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