JOHS Provider Conference
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Notes from Session: A Perfect Storm: SUD, Psychosis and Housing Insecurity – HealthShare's Ecosystem Data Analysis

Presenters: Cat Livingston, Sean Hubert
Moderators: n/a
Notetaker: Anna Johnson, Freja Lyons

-Key Points from Session Overview/Presentation (info not captured in presentation slide deck):

Cat Livingston:

- Moral distress is a pervasive phenomenon taking place in the healthcare industry. This term does a better job of describing systemic issues than burnout, which is an individual experience.
- Intersecting crisis-SUDS, affordable housing, untreated mental health from decades of underfunding
- One thing Health Share has worked very hard to make opiate use disorder treatments available and increase naloxone
- Importance of coordination–houseless folks are not seeking care at just one hospital, so the issues can't be solved in just one area or hospital.
- The Health Share housing pilot took place over 18 months and provided up to 12 months of rent/utility assistance, move-in, etc. That pilot is wrapping up now and learnings will be used to inform Health Share's housing waiver benefit strategy.
- Looking at what they can do strategically with addressing intersections
- Pretty profound fragmentation–both inequity and opportunity
- Healthcare and housing relationships are fairly new. We are just starting to merge these and trying to bridge the fragmentation in the system.
- Health Share has claims data for 450k people–they can see where and how folks are accessing the system. This can help facilitate collaboration across sectors through data sharing, and help us think about how to shift utilization trends to primary care doctors and treatment.
- Who we want to focus on– let's look at a cohort of folks experiencing opiate use disorder, unintentional overdose, psychosis, stimulant use disorder, etc. People who are withdrawing from stimulants and/or opioids and experiencing psychosis–this is an especially acute population that needs specialized services.

- The ecosystem cohort has higher rates for medical inpatient admissions (on top of psychiatric admissions).
- Data: Health Share used an ecosystem analysis that honed in on psychosis and housing intervention
- Hospitals are in crisis–people in ERs for days
- Don't have great data around housing and incarceration
- 1 in 12 or 8% of people in health share has one of four above conditions
- White, Black/AA, Native American are over represented in these categories
- 8% with these conditions represent 38% of hospitalizations
- Primary diagnosis, #1 skin infection, schizophrenia showing up in cohort for ER
- Chronic disease management follows- hypertension and diabetes
- Health Share uses claims data and the homeless indicator from the Oregon Health Authority to create a picture of housing insecurity amongst the ecosystem cohort.
- Some of the admissions among the cohort were maternity related. This indicates an opportunity to support pregnant people with substance use disorders and psychosis and create generational stability via housing.
- Providing care for wounds and chronic disease for folks experiencing homelessness is a significant way to prevent emergency room visits.
- Where are services located geographically, using opioid use disorder as an example? Health Share can look at a map and see where the need is highest and cross-reference this with what resources are available in that area. If there aren't enough resources, they can create a targeted approach to fill the gaps. Where are we seeing a spike? Do they have a van or narcan team?
- The pilot project was the first time Health Share was able to step into the housing world in a meaningful way. Health care is complicated and housing is complicated–we are all breaking new ground and there aren't necessarily built in frameworks to get to our goals. Even basic things like data agreements have to be created to make this work.
- 3 groups to look at- clinical, care management, risk model
- Health Share Workgroups
    - Clinical models–What are the clinical models we already have in our region that we can expand, scale, and spread?
    - Care coordination–How can we better coordinate care to get people the services they need?
    - Risk models–How do we find and shift the resources across systems to best meet needs?
- Street medicine team performing inreach in hospitals–there is a model in another state that does this.

- Different hospitals may not approach things the same way. We are working to identify core components that will function smoothly across multiple health care settings.
- Project Nurture was started by Health Share 10 years ago–integrated maternity care and SUD care– 2 providers were hour and 40 minutes away
- Health Share's Project Nurture integrates maternity care and addiction care in a trauma-informed way.
    - Has been found to decrease foster care placements
    - Decreases the risk of child maltreatment
    - 92% sustained recovery a year after treatment
- Project Nurture Expansion
    - Launch a Project Nurture site in Washington County to meet the growing demand
    - Six months of housing support for eviction prevention
    - Dedicated housing for Project Nurture families?
- The 1115 Waiver will provide 6 months of support and the learnings from the pilot (in terms of the biggest needs) are informing what goes into the benefit.
- There has been a call to action at Health Share to align clinical and financial models to support the ecosystem cohort and connect housing and medicaid systems.
- Still trying to figure out how to pay for services given 15 minute time constraints

<u>Sean:</u>

- Most of the issues are community issues not individual ones–we need to come together as a system to address them.
- Our SUD continuum of care is very undersized relative to the need. There are gaps in both outpatient and inpatient care. When you add housing instability it's exacerbated. We need to be thoughtful around but how and where we intervene.
- We are thinking through how to accelerate outflows out of homelessness and target the drivers of chronicity. How do we think about a strategy that supports the most difficult-to-house participants?
- We need to disrupt returns to the street from systems such as health care and community justice settings as well as from our housing continuum.
- Thinking about outflows we should lean more in to employment as a key intervention. It accelerates outflows from homelessness and improves both health outcomes and housing stability – leading to more lasting success and few inflows back to homelessness.
- People with complex needs need immediate, low barrier and supportive landing places.
- We need to build systems with flexible dollars to intervene successfully.

- In Oregon we have one of the highest unsheltered rates per capita in the nation because of our low bed availability–not just congregate but also alternative style. We need a wide range of options.
- Shelter can be more flexible than housing as an immediate and less-regulated option for folks being discharged from systems.
- There is a need for same day access to services such as housing & care navigation, crisis response. Need to bring these all together as a holistic strategy, bring key partners together to identify solutions, and deliver the right care at the right time.

-Questions/Answers (summarization):

- How to support people who don't fit a psychosis diagnosis and are under 65?
    - IDD is one solution. Behavioral health is woefully underfunded–trying to increase the number of psychiatric beds in the state to increase our ability to do crisis intervention. As we are designing a system for the hardest to serve, we need to be providing medical and housing resources.
- Is the data dashboard publicly available?
    - Not unless you're part of a Health Share organization. Eventually it will be, but we need to develop firewalls for protected health care information.
- The waiver is set up for only 6 months of support but the pilot showed that on average folks needed almost 10. How will you plan to cover that shortfall?
    - A number of chronically homeless folks were involved in the pilot. The waiver targets a slightly less destabilized population so there may not be a huge gap. However, this is a concern and we need to figure out how to best use our housing resources.
    - We can also use data to understand what the gaps are, and work together as a community to fill them.
- How do health plan members learn about programs, including Project Nurture? Are there avenues beyond seeing a PCP?
    - It varies depending on the program. Project Nurture is in all four of our integrated delivery systems. Hopefully would refer in the number of walk-ins who have not been connected to care– working to connect them on the back end. If someone needs maternity care and has an addiction issue, whoever does the intake will share the info about the program. We do encounter some folks at labor and delivery who would have benefited from the program, so that is an area of growth and something we need to keep working on. We need to ensure that all the clinicians who are seeing the patients, wherever they show up, are ready to offer the information.
- How do we get our suggestions to you for ways to communicate?
    - Share on the cards provided at each table, reach out to JOHS.

- I work on a mobile housing team, and know that Oregon Health Plan has money for people to help pay rent, but folks don't know how to access it. The navigation is very challenging even for direct service providers. A piece that is missing is the extra help or money for those doing the work who also need services.
    - The Health Share pilot is wrapping up–those folks are currently being transferred to PSH and no new folks are enrolled. In November all coordinated care organizations will have the 1115 Waiver benefit for eviction prevention. Who qualifies and how to access the benefit can be done through different avenues (211, PCP, website, etc).
- I used to work in emergency medical shelters and saw many of the same people over time. According to our FUSE data there are about 1,000 folks who cycle in and out of our systems. When seeking services, I heard "no" a lot–can they go to shelter? Can they get this or that resource? It was very difficult to get things like diapers, wheelchairs, or air conditioners (just a few examples) to support with chronic medical conditions. For those who are chronically homeless and have these medical diagnoses–can there be some money for resources? Can we get a line for providers to call to hear a yes?
    - Those are medicaid billable services. How do we help folks access this?
    - Case conferencing for folks with a lot of needs–getting housing people and medicaid people in the same room–that is a great opportunity to try and solve some of those issues.
- Hearing that home health care workers are struggling/hesitant to work with folks with SUDS because of safety concerns. Is there a plan for harm reduction in these situations?
    - Harm reduction and home health care models–there is not currently a plan to address that but we can talk further. The safety of staff is paramount.
- What about people who are not sober–how do they access services?
    - A continuum of street engagement, low-barrier but supported (with services) shelter and shelter alternatives, and housing first approaches.

-Main Discussion Points:

- Questions for the group:
    - Having heard the health care and systems data, where are the gaps we can lean into right now? Where do you see opportunities to align in care?
        - There is a lot of intersectionality where it's not a behavioral health diagnosis only. It may include many Multnomah County departments, like ADVSD, BH, and IDD. We need to find a way for folks with multiple diagnoses to get support. The system is set up to make it easier if you only fall into one category.

        - The state is trying to get funding to increase access by adding psychiatric beds. Along with this we would also need to do more crisis intervention.
        - A gap I'm seeing is for the 65+ group. People on a fixed income are getting priced out of their homes. Often they have been stable their whole lives and don't have the highest level of need.
        - Another gap–a father reached 60 days of sobriety and couldn't get services because he was not "newly" sober. He had to decide between relapsing and becoming homeless.
        - The state doesn't currently have a housing plan for aging Oregonians on fixed incomes; however, some workgroups are happening in the legislature to make this happen. We as a collective of providers can also do advocacy around public policy.
- My organization offers wound care and first aid, and wanted to partner with CCC to do this but the partnerships dissolved unexpectedly. We need stable places in the community for folks to access care when they need it. And it helps to have these places be located where people already spend time.
    - Yes, we need to figure out how to best partner and align additional health resources with community based organizations.
    - One challenge is that organizations doing mobile health delivery right now are trying to figure out with CCOs and health orgs how to pay for these services.
    - Health Share wants to explore different platforms that can identify where mobile health and hygiene resources are in the community and indicate if there is walk-in availability. Need to build those platforms to make sure that accessibility is emphasized.

<u>-Takeaways or Follow-Ups for JOHS (expectations/priorities/recommendations/etc):</u>

- The expectations/recommendations in this session were mostly directed toward Health Share.
- However, there may have been some recommendations shared on the physical cards provided to conference attendees, especially regarding how to best communicate about Health Share programs. There was an expectation that JOHS would share this feedback with Health Share.