Add it up

Health Share looks at ways to merge health care and afforable housing

BY AMANDA WALDROUPE
STAFF WRITER

There's a lot of money – and lives – resting on Oregon's grand experiment in restructuring health care through Medicaid. Portland metropolitan area's largest coordinated care organization, Health Share of Oregon, like others across the state, have a mandate to serve more, serve better, and do so with less.

With that on their plate, social-service agencies and advocates are hoping to compel Health Share's board of directors to include in its programs and health services something that has rarely been part of conversations about health care: affordable housing

Ed Blackburn, the executive director of the social-service agency Central City Concern, is spearheading the effort. He and other housing providers and advocates are making the case that a person's housing status can drastically affect a person's ability to lead and maintain a healthy life.

"It's not the job of jurisdictions to transform health care. It's not the job of health care to end homelessness," Blackburn says. "When there's an intersection of common goals, they can be more successful by coordinating."

The opportunities go both ways.

"I'm hopeful that health care becomes a more prominent element of housing," says John Miller, executive director of the Oregon Opportunity Network, a coalition of affordable housing advocates, builders and managers. "There's a lot more efficient ways we could be working together."

Coordinated care organizations, or CCOs, are the backbone of the state's newly overhauled Medicaid delivery system under the Oregon Health Plan.

Created by the Legislature in the 2011 session, CCOs are charged with coordinating and integrating the physical, mental and dental health of Oregon Health Plan patients. The coordinated model of care is meant to create a patient-focused system that efficiently provides more effective and streamlined health care, but also save money and stop Medicaid expenses from rising. Instead of a fee for service structure, CCOs will have to operate with a capped budget that they can control – provided they cut costs.

Health Share of Oregon is one of the two CCOs serving the Portland metropolitan area, but it is by far the largest. It comprises a partnership among 11 health organizations – including Legacy, Kaiser and Providence hospitals, Central City Concern, and the health departments of Clackamas, Multnomah and Washington counties.

Because of its mandate to cut costs, Health Share has prioritized a group of Medicaid patients known as "high utilizers," including people who are homeless or impoverished, have chronic diseases such as diabetes that go unmanaged, who suffer from mental health or addictions issues, or have a high-risk pregnancy and pre-natal issues.

While such patients represent only about 20 percent of the Medicaid population, they are most likely to delay primary care, not prevent their illnesses or conditions from worsening, use the emergency room as their primary source of medical care and only use it when circumstances are dire.

"These populations are very expensive," Blackburn says. "If you could address their issues more effectively, you could save some money."

When Blackburn was asked to become a member of Health Share of Oregon's board of directors, he knew from experience what was at stake.

Central City Concern is one of Portland's largest social-service agencies, and the organization's reputation is built on the strength of its wraparound services for formerly homeless individuals: substance abuse treatment, peer counseling, case management, and its Old Town Clinic, which provides primary physical and mental health care to low-income people.

In 2005, Central City Concern began partnering with area hospitals and created its Recuperative Care Program, which houses low-income and homeless individuals after they've been discharged from the hospital. People in the program also continue receiving medical care and are connected with services to help them stay in housing.

On average, the program saves approximately $80,000 per year, per patient in reduced hospitalizations, emergency room visits, and medical costs. It's a startling amount of money, and Blackburn and others say the savings are due to one simple reason: ensuring those unhealthy homeless or low-income individuals are stably housed.

"For these populations, housing is critical," Blackburn says.

Blackburn created a workgroup made up of affordable housing providers and Health Share board members. The workgroup's purpose was to show Health Share how integral housing is to a person's health and create ways that Health Share could work with housing providers to create programs that help people become healthy and remain housed.

Health Share of Oregon received a three-year, $17.3 million grant from the national Center for Medicare and Medicaid Innovation (CMMI), which funds projects designed to provide more effective health care. Approximately $100,000 is being used for short-term rent subsidies and other services that help people remain stably housed.

The workgroup met for nine months and presented information to Health Share's board of directors on June 19. In the coming months, the workgroup will develop a list of recommended programs and services that Health Share could then begin operating.

As Traci Manning, the director of Portland's Housing Bureau puts it, "If you're homeless, getting health care is almost impossible."

People with diabetes, for instance, need to refrigerate their insulin. That's difficult, if not impossible, for homeless people to manage. Because of the stress, mobility and lack of any regularity in their daily lives, remembering and getting to medical appointments, taking medication at the right time of day (or at all), eating regularly and other tasks regarded as routine become difficult. Health problems become exacerbated and go untreated.

Before CCOs were created, Oregon Health Plan providers were paid by a "fee-for-service" billing system. There was little incentive to emphasize preventive or coordinated care, and like the rest of the health care industry, patient interaction was strictly medical.

"The way the system is set up is that the interaction is someone coming into their office," Miller says. "They see the part of someone waiting in their waiting room or office with a particular [medical] need."

All CCOs in Oregon were granted a waiver from the federal Medicare and Medicaid administrators that allow them to use their budgets more nimbly. This includes in some cases to pay for services or equipment that improve a person's health, but are not medically related. Gov. Kitzhaber has illustrated the situation with his oft-told air conditioner story, that for want of a $200 air conditioner a woman suffered congestive heart failure, a costly and dangerous condition.

It's not clear if short-term rent assistance would qualify under the waiver. "There is a limit to what Medicaid can pay for and what CCOs can do," Blackburn says.

But New York has received such an exception. In 2012, the state received a waiver from federal Medicaid and Medicare administrators that allowed the state to direct $86 million of its Medicaid budget directly toward funding supportive housing programs. The state also applied for another waiver that would generate $150 million each year that would be used for expanding the availability of supportive housing. "There is strong and growing evidence in New York and around the country that a lack of stable housing results in unnecessary Medicaid spending," the state's Medicaid Redesign Team wrote in a report.

Closer to home, Health Share of Oregon received a three-year, $17.3 million grant from the national Center for Medicare and Medicaid Innovation (CMMI), which funds projects designed to provide more effective health care. Approximately $100,000 is being used for short-term rent subsidies and other services that help people remain stably housed.

Cindy Becker, director of Clackamas County's Health, Housing and Human Services and a Health Share board member says that the increasing awareness Health Share has of the connections between a person's housing and ability to be healthy is also an example of how Health Share is moving toward a model of healthcare that is not focused exclusively on medical care and doctor visits.

"We're still in that education period," she says. "People are beginning to understand that your health is not determined by your visit to a doctor's office, but also by whether you have a place to live? Do you have healthy behaviors? Are you isolated? Those things contribute more to your health than the time you spend in a doctor's office."

Blackburn also points out that people with multiple health needs may have been seeing a doctor, but not all of their health problems were being addressed. He gives the example of someone who has anxiety and asthma. An anxiety attack can trigger asthma. If the person is receiving mental health treatment for anxiety, their therapist or doctor may not know they have asthma – a physical health condition – and may not think to ask.

As part of the workgroup's work, Health Share staff conducted a survey at three properties – the Martha Washington, Musolf Manor and the apartments above the Bud Clark Commons.

Between January and March, 171 out of 332 tenants were interviewed. The survey identified tenants health conditions and illnesses, identified how many medications they took and what they are for, the last time they had seen a doctor, and how often they use the health care system. The survey also asked how their life generally had changed since moving into housing and specifically if their health had improved.

Sandra Clark, a program manager with Health Share who worked directly with the affordable housing workgroup, says the data is still being analyzed. But she says she

See HEALTH CARE page 9

Many thanks to all of our volunteers who contribute their time and energy toward Street Roots! Inquire about volunteering at www.streetroots.org/volunteer.