Health Share HMIS Analysis Updates: October 2025

Health Share of Oregon

Agenda

- Introduction
- HMIS/Health Share analysis
- Summary of findings
- Implications and next steps

Background

- **"Ecosystem" Analysis for High Acuity Behavioral Health** conditions began in 2021 – Health Share members with psychosis, opioid use disorder, and or stimulant use disorder. Unstable housing emerged as a major influencer of health indicators
- **Data Use Agreement 2025** – allowed Multnomah County HMIS data to be added to Health Share's health and healthcare utilization data
- **Combined data analysis**: interplay of housing status, health status, and healthcare and housing-supports utilization

Having HMIS data is a huge step forward in understanding how housing status affects health and utilization and in understanding how these high acuity conditions affect housing status and housing efforts.

Data Notes and Caveats

- This type of data sharing is novel—**few places nationwide** have reached this level of sharing across health and housing, and it is a testament to Multnomah County leadership to partner in this way.

- HMIS Data is complex—it is entered by multiple people and organizations and tracks an individual's touch points with the housing system. Health claims data is also complex, and only captures documented diagnoses and procedures.

- HMIS and Health Data do not naturally communicate with each other – matching individuals across systems is complicated.

- Many definitions about housing status need to be refined across health and housing sectors—we are working on that in collaboration with county staff.

- The data presented today should be considered preliminary. It focuses on 2023 and 2024.

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HMIS and Health Share data overview

- The HMIS data included ~56,000 individuals with name and or date of birth and an HMIS enrollment in 2023-2024.
- **70% (~39,000)** of HMIS clients matched to a Health Share member.
- **32% (~9,000)** of the ~28,000 matched HMIS *adults* are in the High Acuity Behavioral Health (HABH) cohort.
- Of note, Health Share's entire High Acuity Behavioral Health (HABH) cohort is ~27,000 members (across all three counties), so these ~9,000 members account for about one third of the full group.

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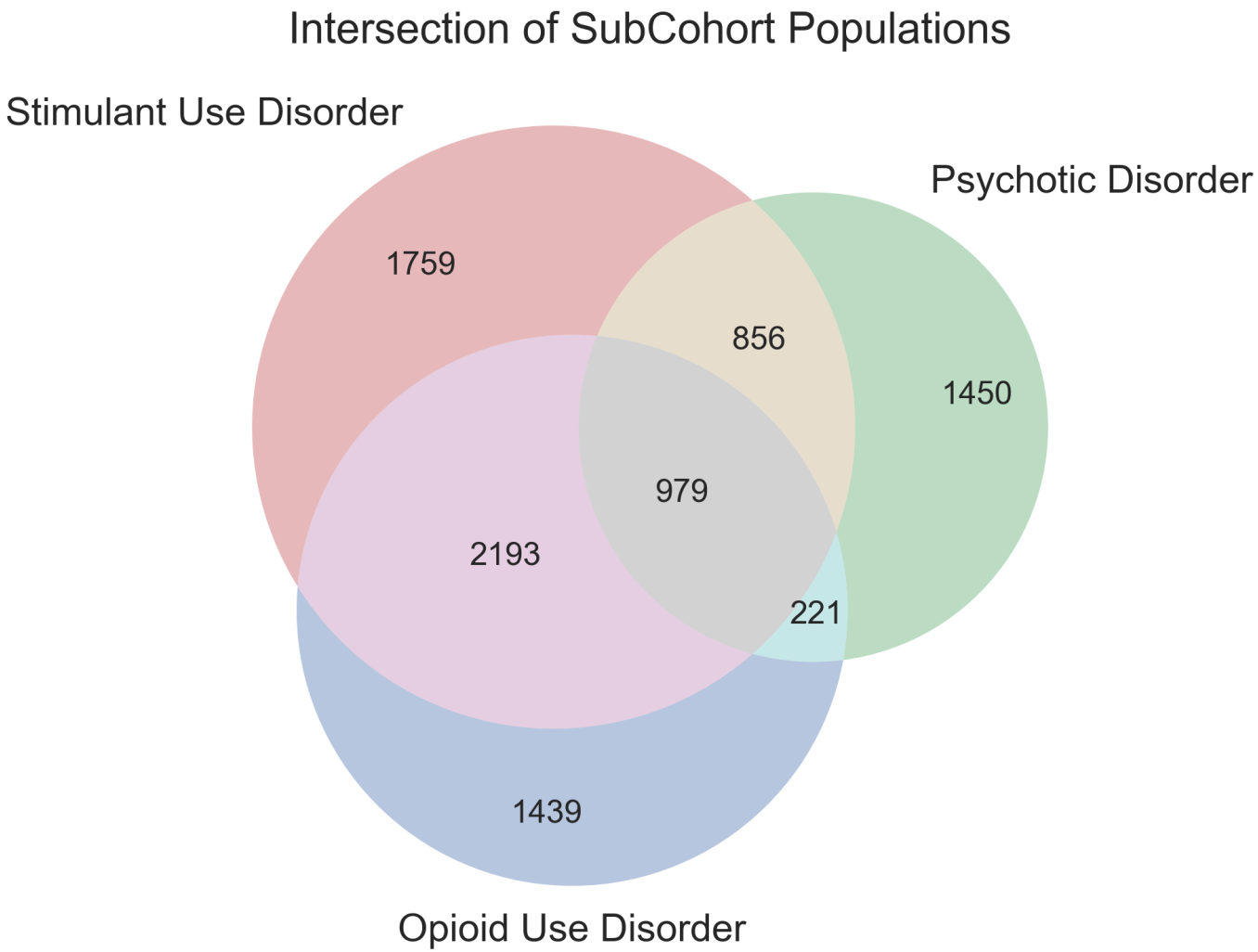
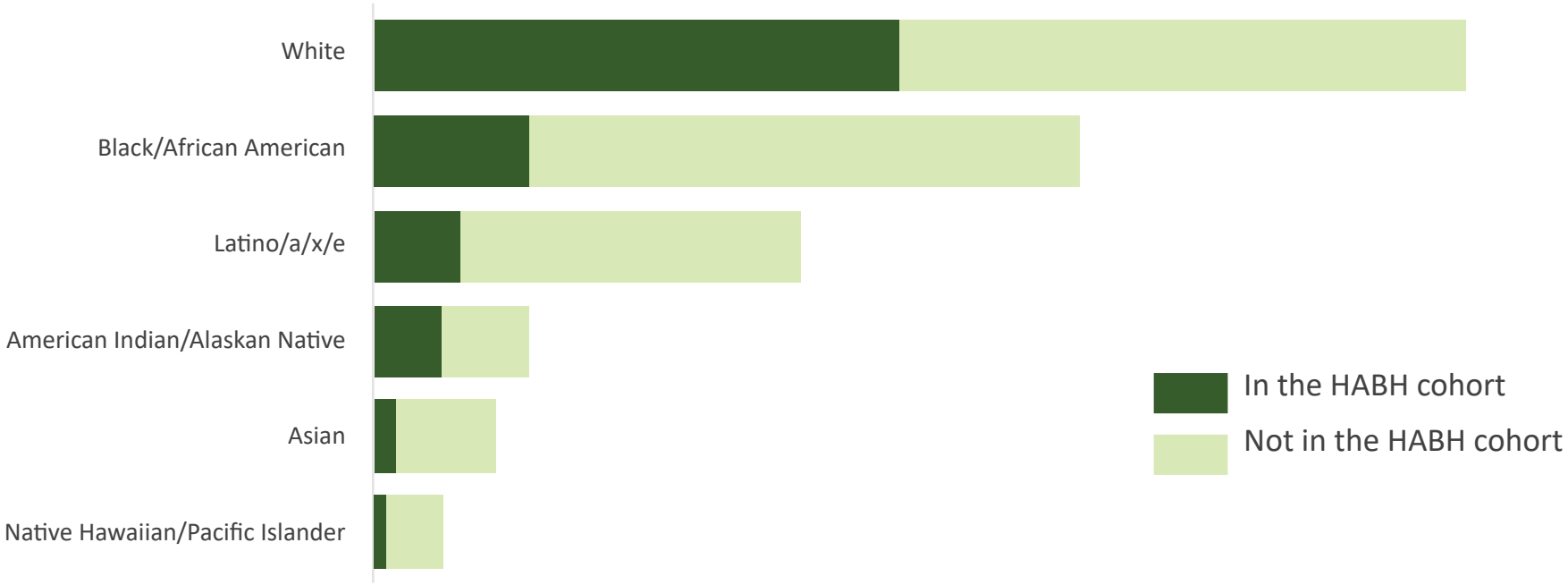
NOTE: The data presented in this presentation are preliminary.

This diagram details the ~9,000 matched HMIS/HABH adults. The largest subcohort is Stimulant Use Disorder with ~5,800 members. Almost half of this group (~4,200 members) are in two or more sub-cohorts.

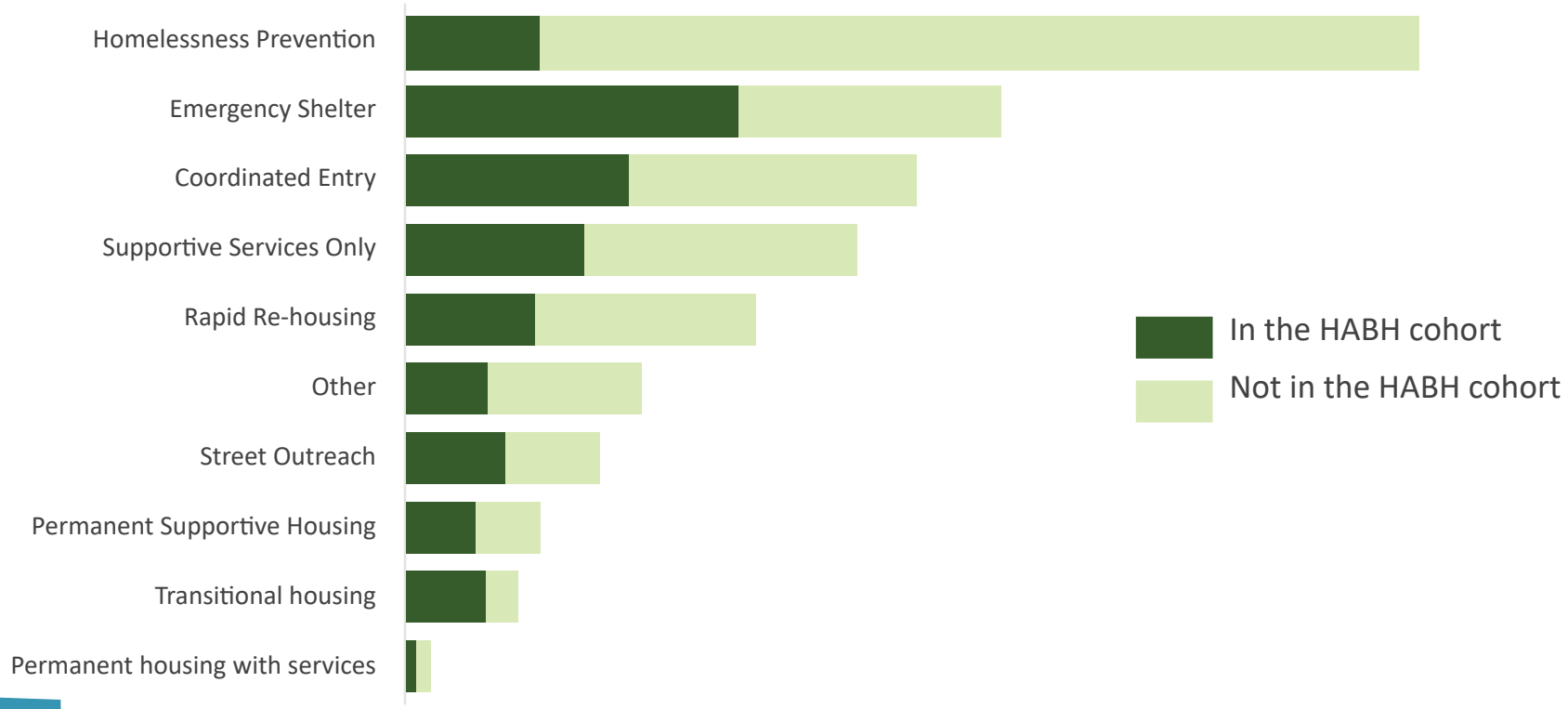


Among the adult HMIS matched clients, white and American Indian/Alaskan Native members have the highest proportion of High Acuity Behavioral Health members.



Prevalence of High Acuity BH conditions within the Housing System

More than half the population in emergency shelter (56%), permanent supportive housing (52%), and street outreach (51%) programs have a high acuity BH condition.



Notes: People can be in more than one program. Transitional housing is treatment housing, and less than 100% due to alcohol use disorder.

Takeaways from housing services and HABH overlap

- People using Emergency Shelter have high likelihood of being in HABH cohort – *how can this be an engagement opportunity*?
- Almost half of people on Coordinated Entry list are in HABH cohort; *how are they supported as they wait for housing?*
- More than 1/3 of people in Rapid Rehousing are in HABH cohort, these services are intended for less acute clients; *are there services to ensure stability when PSH is not available?*
- There are very little data about people in Street Outreach; *what should we know?*
- Need to understand PSH residents most at-risk; *and what is the strategy to prevent exit to homelessness?*

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High Acuity Behavioral Health Utilization Analysis

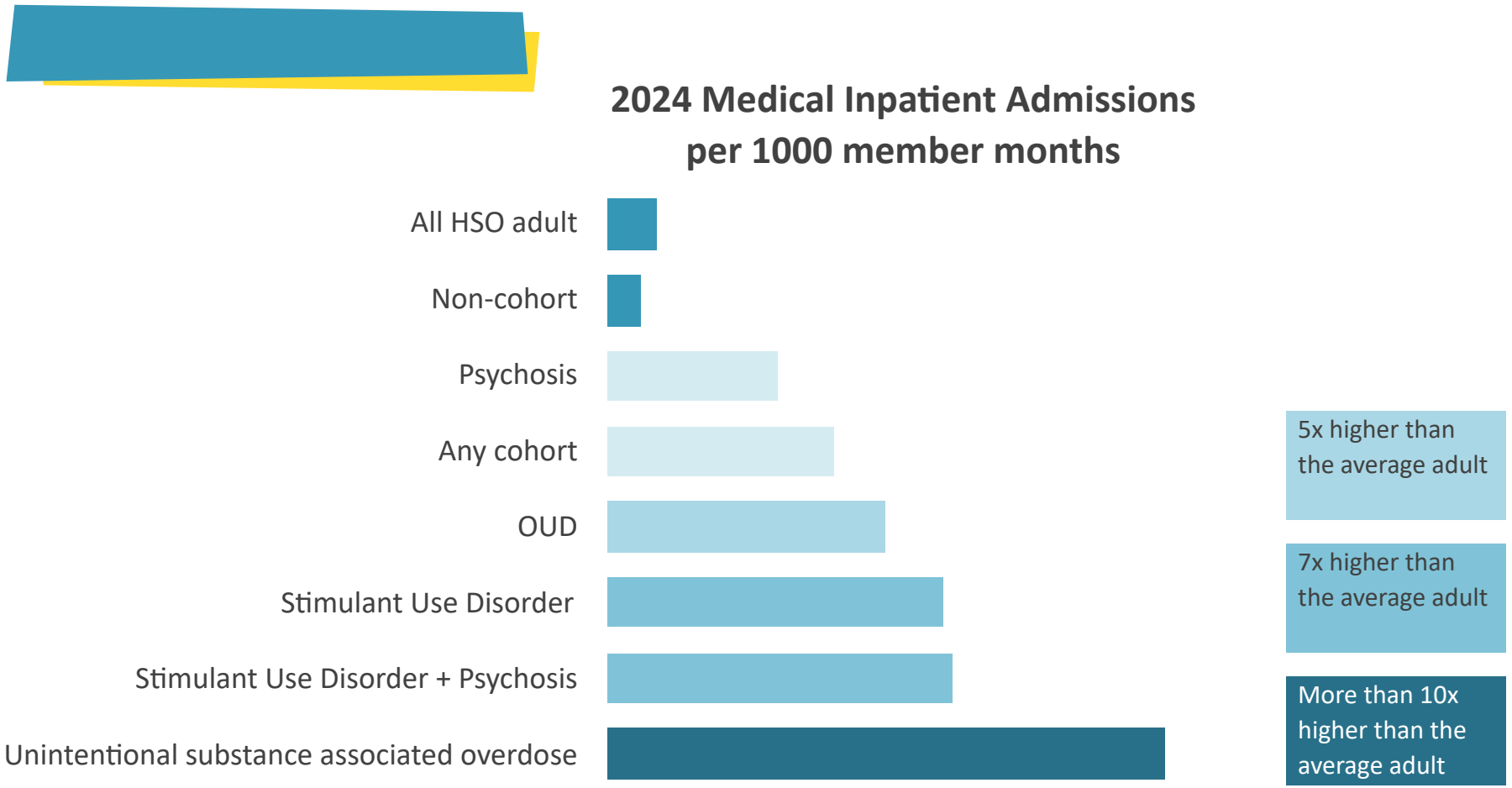
People in the HABH cohort have:

- Higher rates of medical inpatient utilization
- Higher rates of psychiatric hospitalization
- Higher rates of Emergency Department visit and preventable ED visits
- Much higher rates of mortality

People in the HABH and HMIS have:

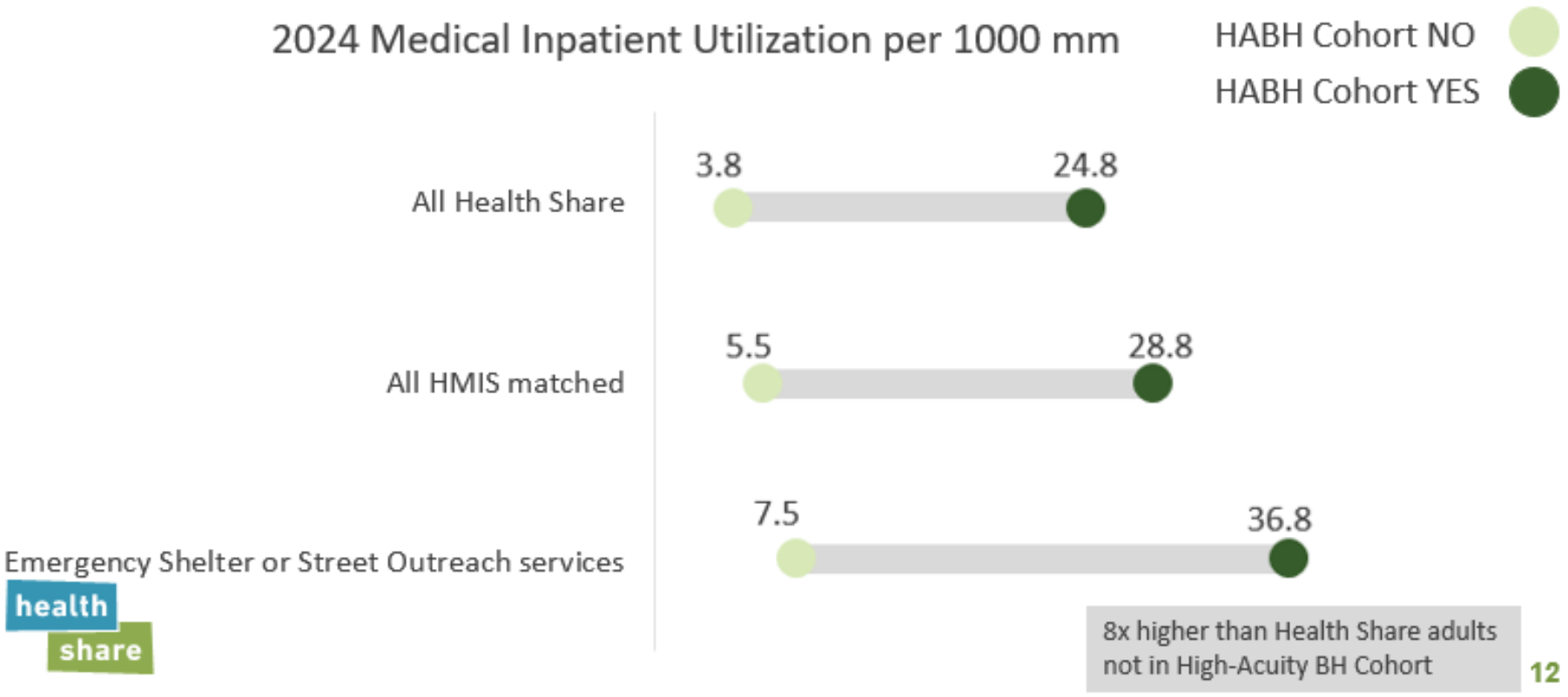
- 8 times higher medical inpatient utilization than the Health Share average
- 12 times higher avoidable ED utilization than the Health Share average

Utilization Comparisons: Inpatient Admissions

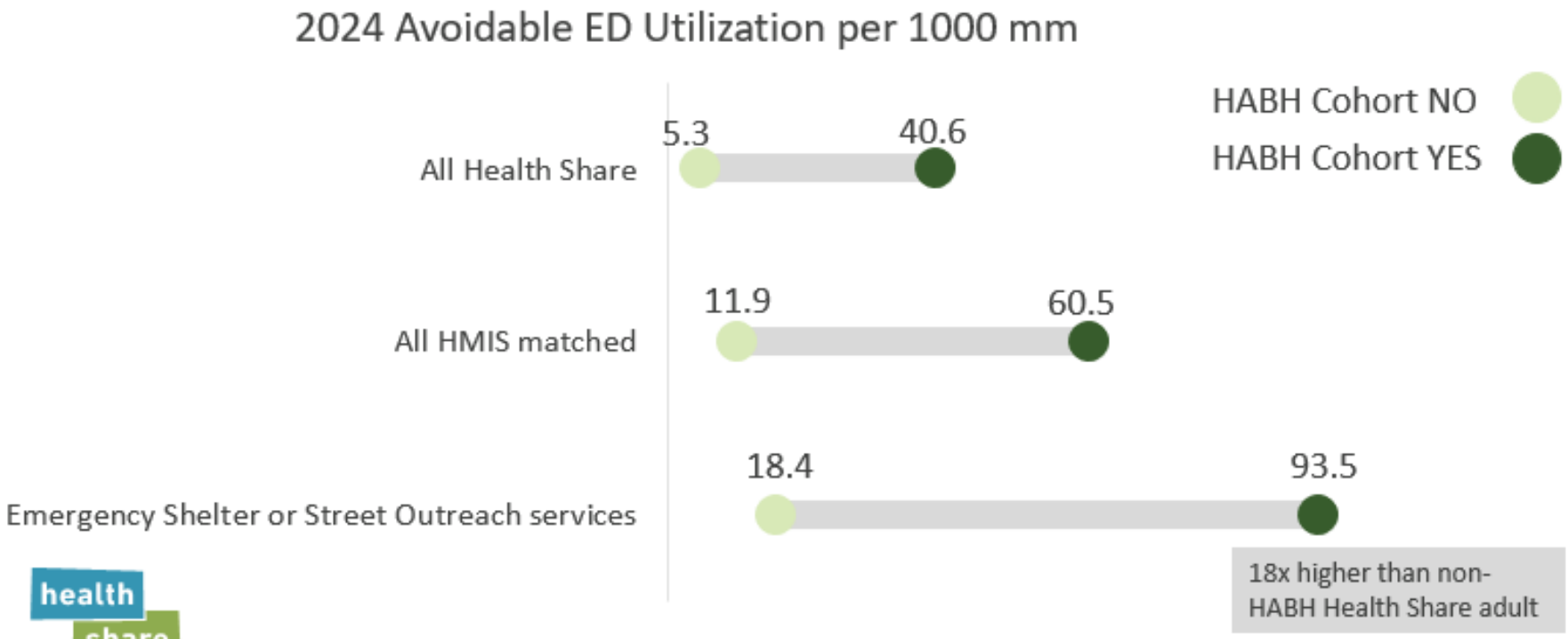


Data source: 2024 Health Share claims data, current as of June 2025

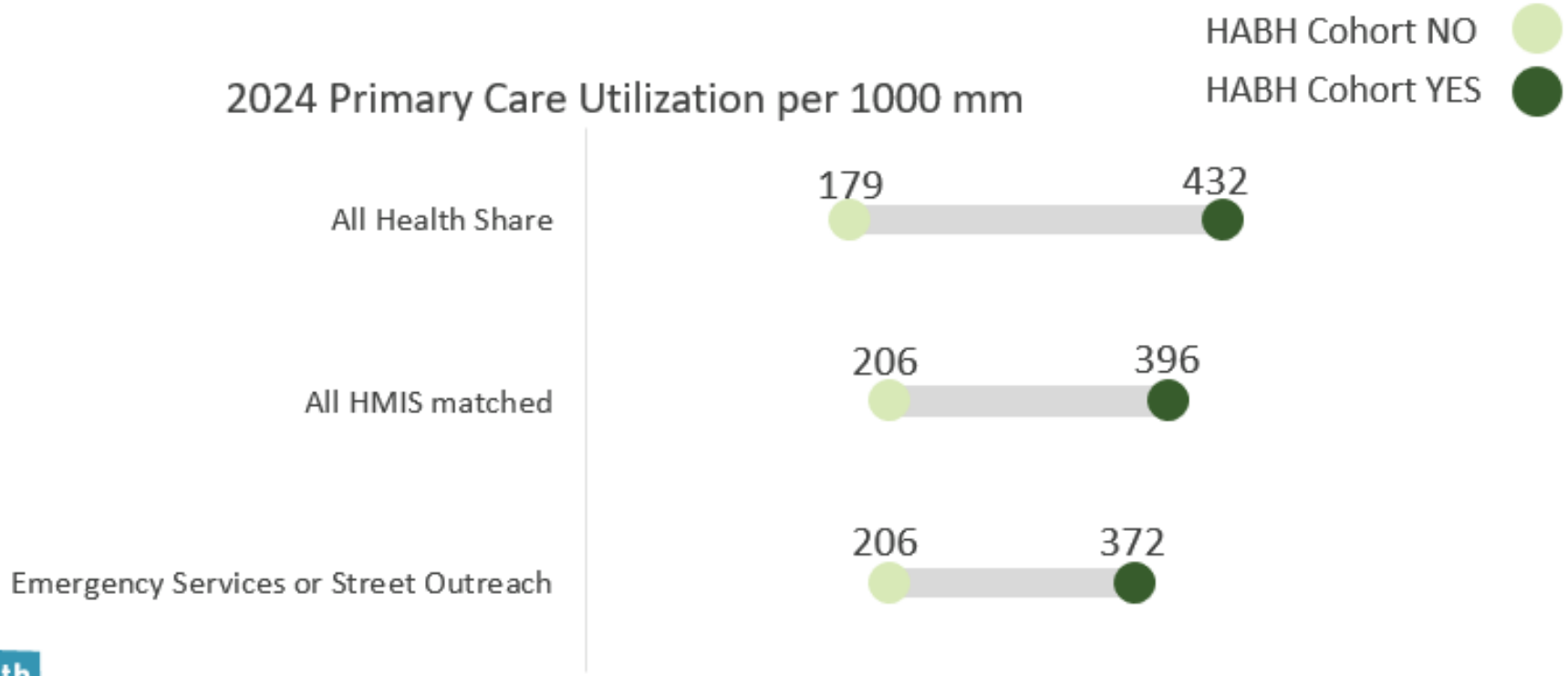
People in the High Acuity BH cohort have **higher rates of medical inpatient utilization** than the Health Share average. The **sub-group of people receiving emergency shelter or street outreach services has higher inpatient utilization** than the overall HABH group average.



People in the High Acuity BH cohort have much higher rates of avoidable ED utilization than the Health Share average. The sub-group of people receiving emergency shelter or street outreach services has higher avoidable ED utilization than the HABH group average.



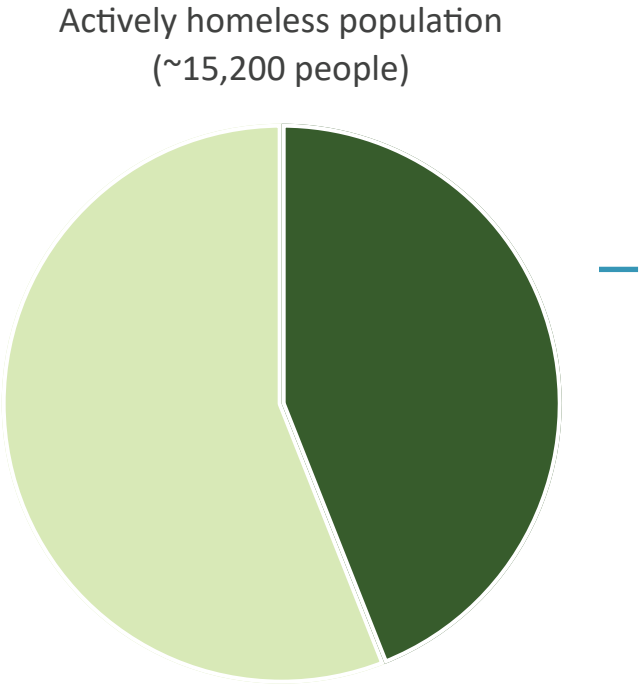
People with matched HMIS records in the High Acuity BH cohort have lower rates of primary care utilization than the overall High Acuity BH cohort.



Subgroup:
People who were actively homeless (~15,200 adults)

- **Almost half** (44%) of this population is in the High Acuity Behavioral Health cohort (~6,700 people).

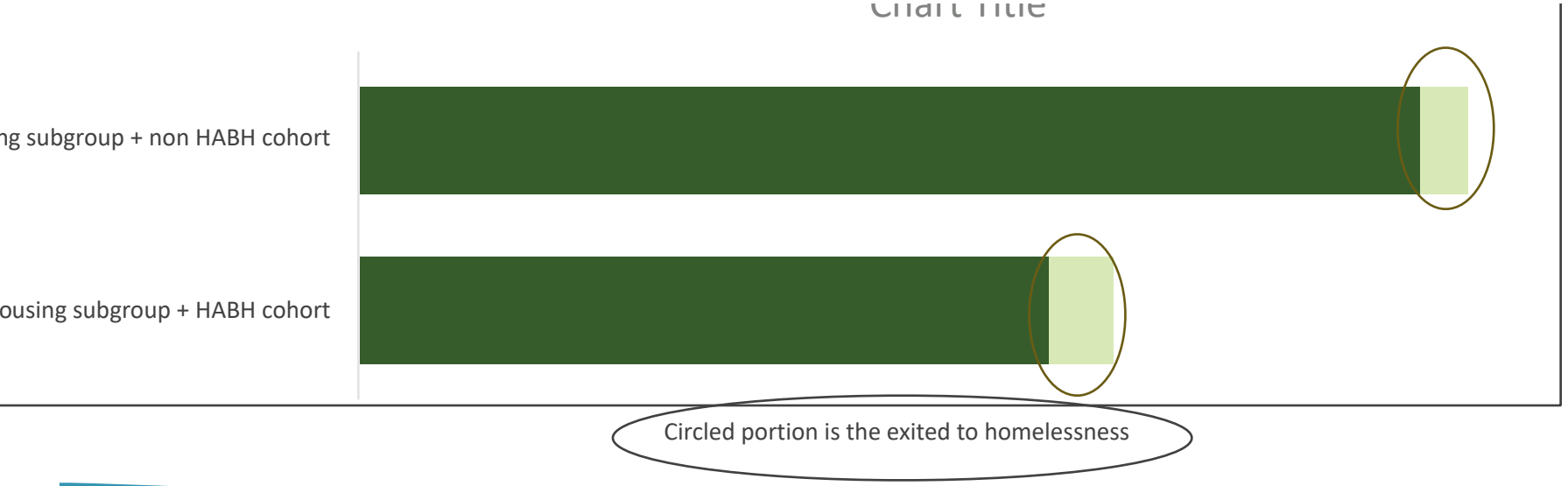
- Within this population, High Acuity Behavioral Health members have more frequent program touches than the group average.



Actively homeless subgroup = People who received any of these services during the 2023-2024 timeframe: emergency shelter, coordinated entry, supportive services, street outreach, or other services.

Subgroup: People receiving permanent housing services (~6,200 adults). **40%** of these folks are in the HABH cohort.

Within this subgroup, 6% of people will have an exit to homelessness (i.e., an exit to an emergency shelter or a place not meant for habitation). People in the HABH cohort are almost twice as likely than others in this subgroup to have this type of exit.



Permanent housing subgroup= People who received any of these services during the 2023-2024 timeframe: Rapid re-housing, Permanent supportive housing, Permanent housing.

Subgroup: People receiving permanent housing who also have an exit to homelessness. (~400 people)

Among the ~400 people in this subgroup, 56% (~200 people) are in the HABH cohort.

Among this group of ~200 in the HABH cohort: :

- 71% have a Stimulant Use Disorder
- 58% have an Opioid Use Disorder
- 24% Stimulant Use and OUD
- 13% have a Psychotic Disorder

Permanent housing subgroup= People who received any of these services during the 2023-2024 timeframe: Rapid re-housing, Permanent supportive housing, Permanent housing

Summary of Findings

- People in the HABH - OUD, stimulant use disorder, overdose and/or psychosis:
  - Have high rates of avoidable ED use and hospital admissions
  - Made up almost half of people who were actively homeless
  - Made up 1/3 of people in rapid re-housing and more than 40% of people in coordinated entry
  - Are twice as likely to exit from permanent housing and rapid re-housing to homelessness
  - Are more likely to engage in MOUD when stably housed
- Stimulant use disorder is especially prevalent in this matched cohort.

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Implications/ Next Steps

Care coordination

Potential foci of care coordination efforts:

- **Permanent housing** – engaging HABH folks during placement to decrease risk of exiting to homelessness
- **Pre-engagement** of actively homeless people and HABH who are in Coordinated Entry
- Continue our **Housing and Behavioral Health service collaboration** and expand on promising programs such as **cross-sector case conferencing**. Commit to clearly defined, population-specific strategies for individuals identified within HMIS/High acuity BH members.
- **Post acute care discharge** and **discharging from treatment housing** with cross sector partnerships in place prior to discharge.

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Implications/ Next Steps
Clinical models (most underway)

- **Increased access for MOUD and addiction consult services** in hospital settings
- **Wound care services** in multiple settings including shelter sites
- Access to **Project Nurture; prioritize for housing access**; partnership with the Family System Program
- Expansion of the **Community Health Assess and Treat (CHAT)** - consider deployment to shelter sites and those in PSH
- Increased access to **contingency management programs for stimulant use disorder**; training for PSH and shelter operators for stimulant-associated symptoms
- **Clinical interventions tailored for those in the HABH group including in PSH and emergency shelters (TBD)**

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Implications/ Next Steps
Housing system

- **Ongoing strategic planning** between County and Health Share
- **Ensure BH resources** available to HABH group, including **engagement prior to and during housing**.
- **Intensify referral pathways** from emergency shelter services to BH resources and stable housing for this high priority population
- **Service design**: dedicated housing placement through rental assistance/ vouchers with ongoing support of behavioral health
    - Transitional Recovery Housing (including with intensive BH services)
    - Pairing shelter with housing vouchers for stabilization and transition
    - Permanent Supportive Housing “Plus” – PSH with dedicated BH resources

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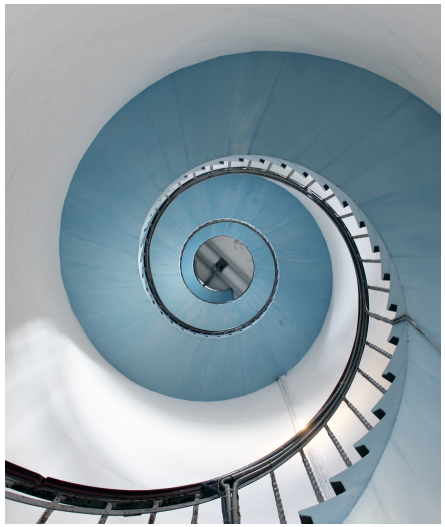
Implications/ Next Steps
Data

- Building underlying integrated data structure for full ongoing analysis of HMIS and claims data
- Further planned analysis include:
    - Inform Coordinated Entry with clinical specifics to better match individuals with housing and needed supports
    - Understand predictors of success and negative exit outcomes by housing program type +/- clinical supports and by health system engagement
    - Evaluate impact of interventions on health and housing outcomes over time



Suggested measures/outcomes

System transformation goal: ensure stabilized individuals are placed in transitional or permanent housing placements with clinical supports.

- **Housing retention** in high-acuity sub-populations, by program type
- **Health service engagement** in HABH/HMIS subgroup
  - Medication possession ratio for MOUD
  - Medication possession ratio for antipsychotic medications
  - Primary care, BH services, SUD services, care coordination
- **Decrease avoidable acute care utilization** for those touching both clinical and housing systems
  - Preventable ED visits, inpatient admissions, readmissions

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All Together, All for You.

Thank you

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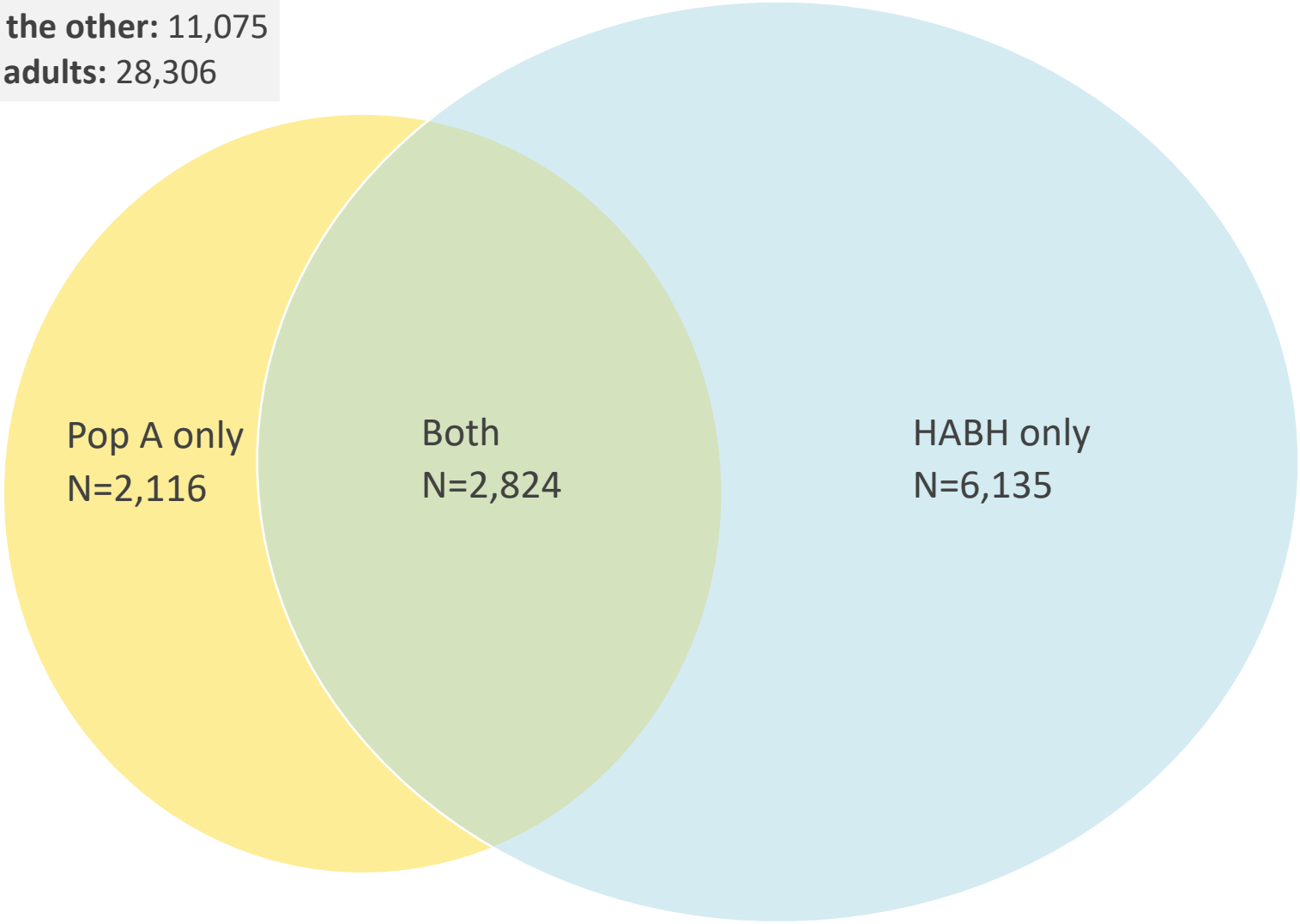
Subgroup: Overlap of Population A and High Risk BH Cohort

Total Pop A: 4,940
Total HABH: 8,959
Total in one or the other: 11,075
Total matched adults: 28,306



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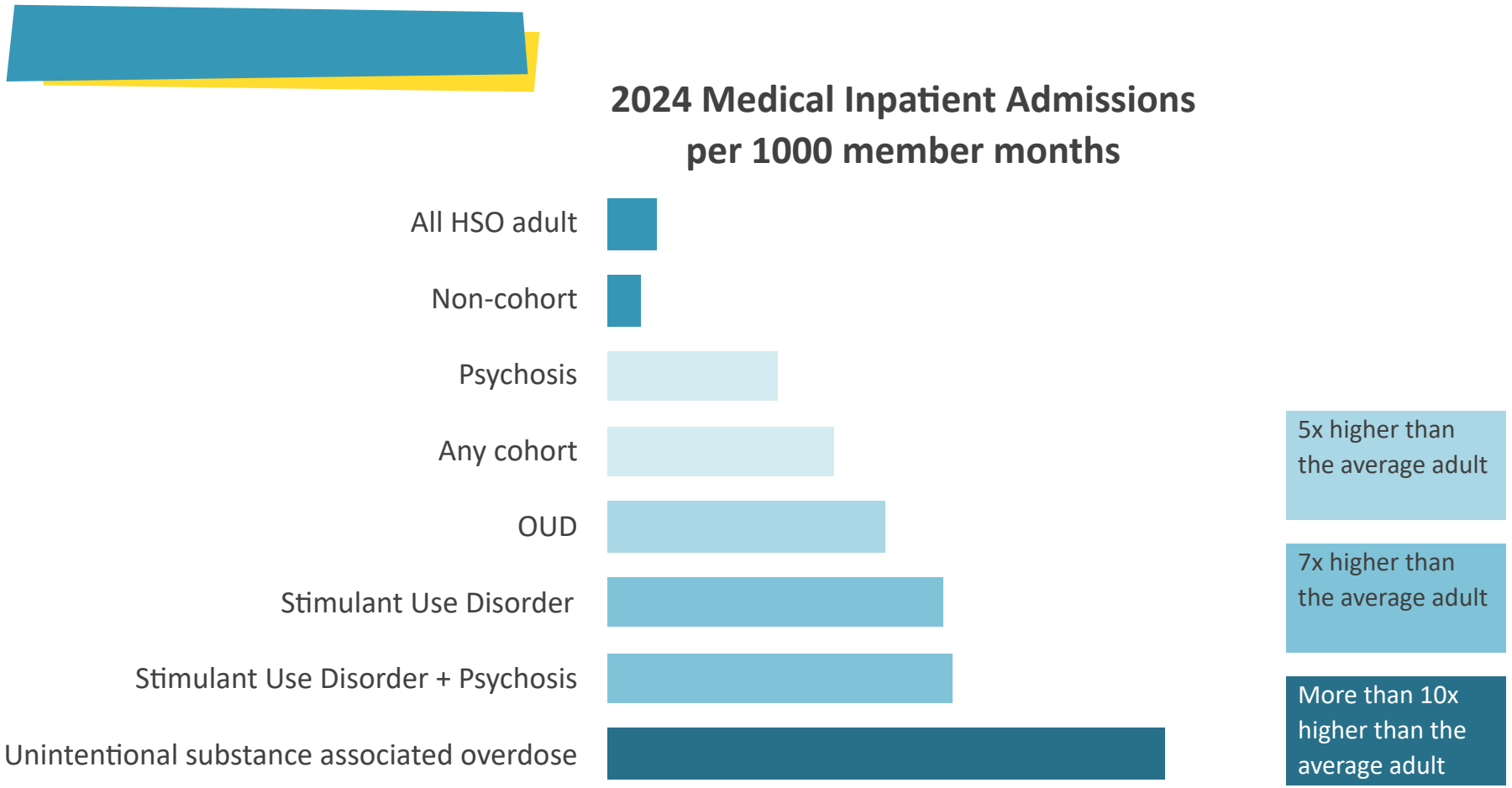

Data source: 2024 Health Share claims data, current as of June 2025

Summary of Clinical Findings

Acute care utilization (medical inpatient, avoidable ED use)

- Membership in the HABH cohort is associated with higher rates of acute care utilization. This is true across Health Share as a whole and within HMIS members.
- Matched HMIS/Health Share members have **1.5-2 times higher** acute care utilization than the Health Share average.
- The subgroup of matched HMIS/Health Share members in the HABH cohort **has 8-12 times higher** acute care utilization than the Health Share average.

Primary care utilization

- Membership in the HABH cohort is associated with higher rates of primary care utilization. This is true across Health Share as a whole and within HMIS members.
- Matched HMIS/Health Share members have **similar** primary care utilization to the Health Share average.
- The subgroup of matched HMIS/Health Share members in the HABH cohort has 2 times higher primary care utilization than the Health Share average.

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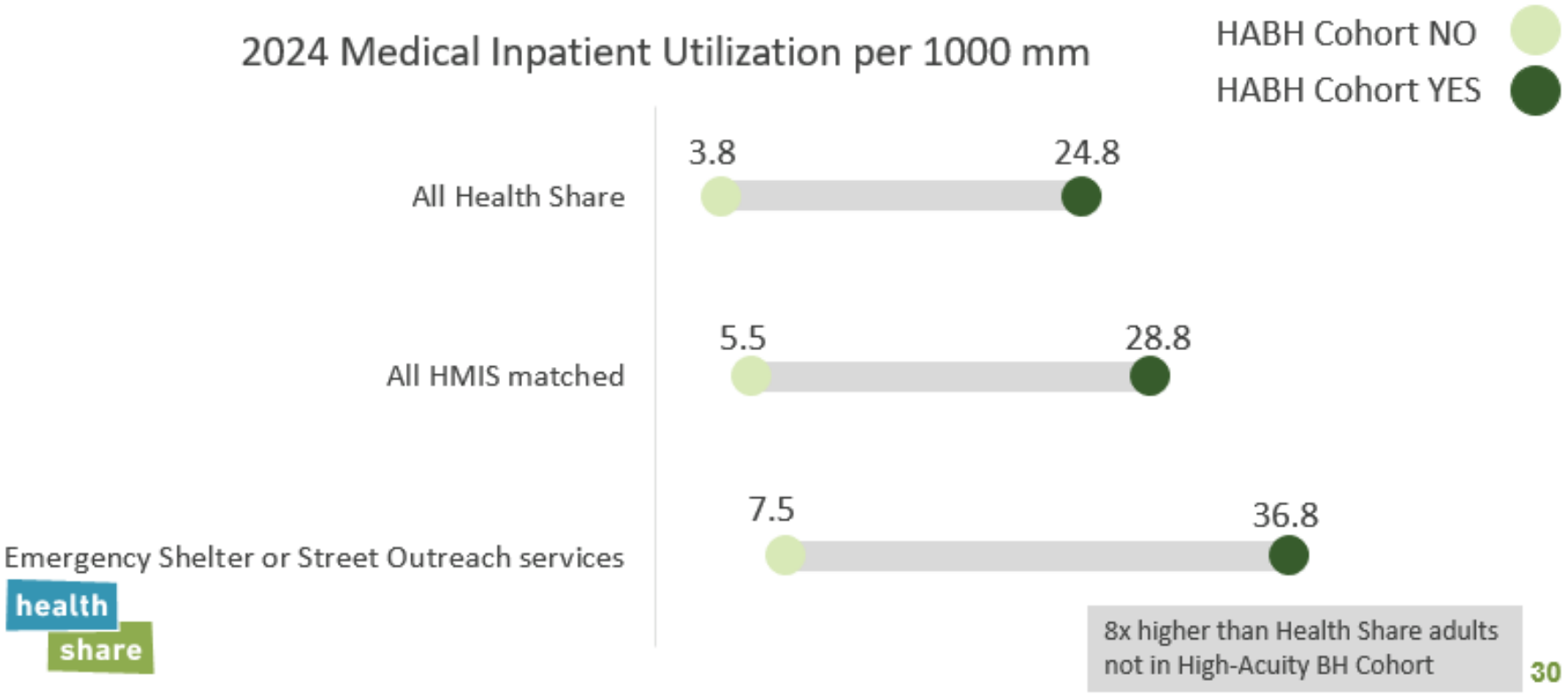

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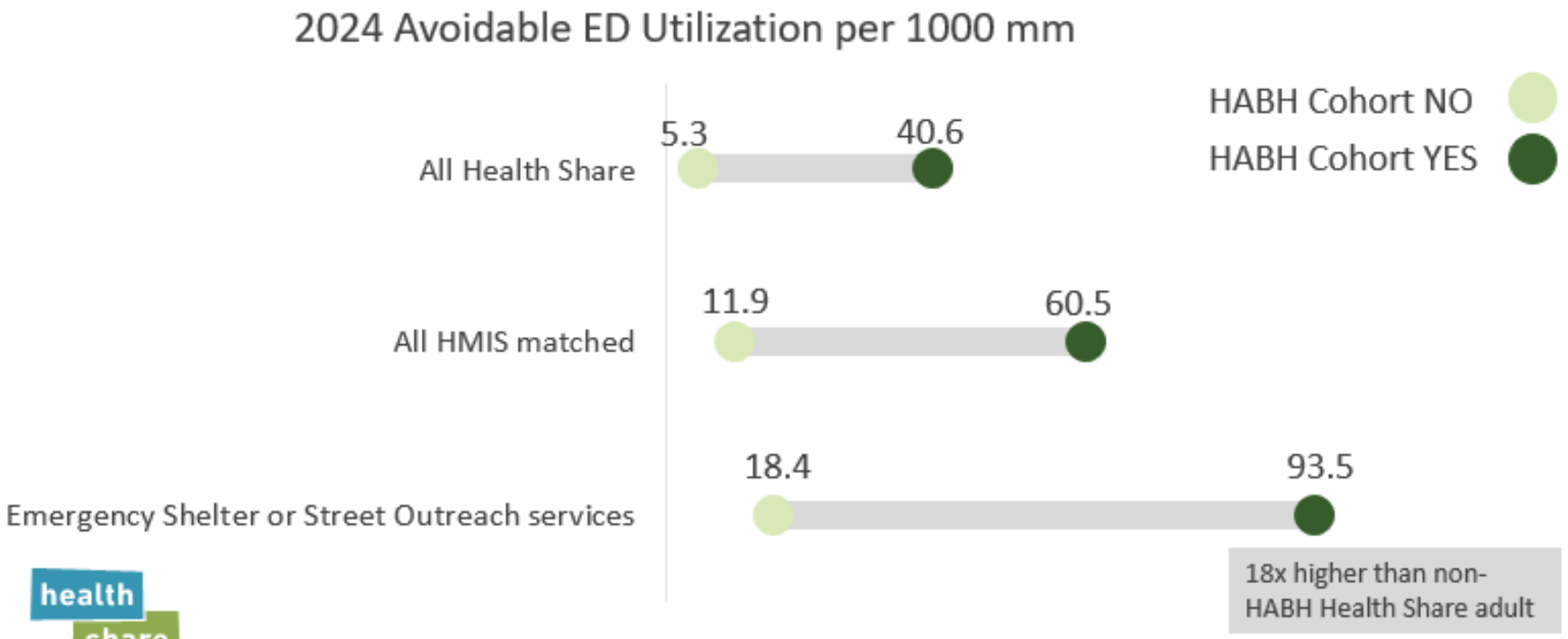

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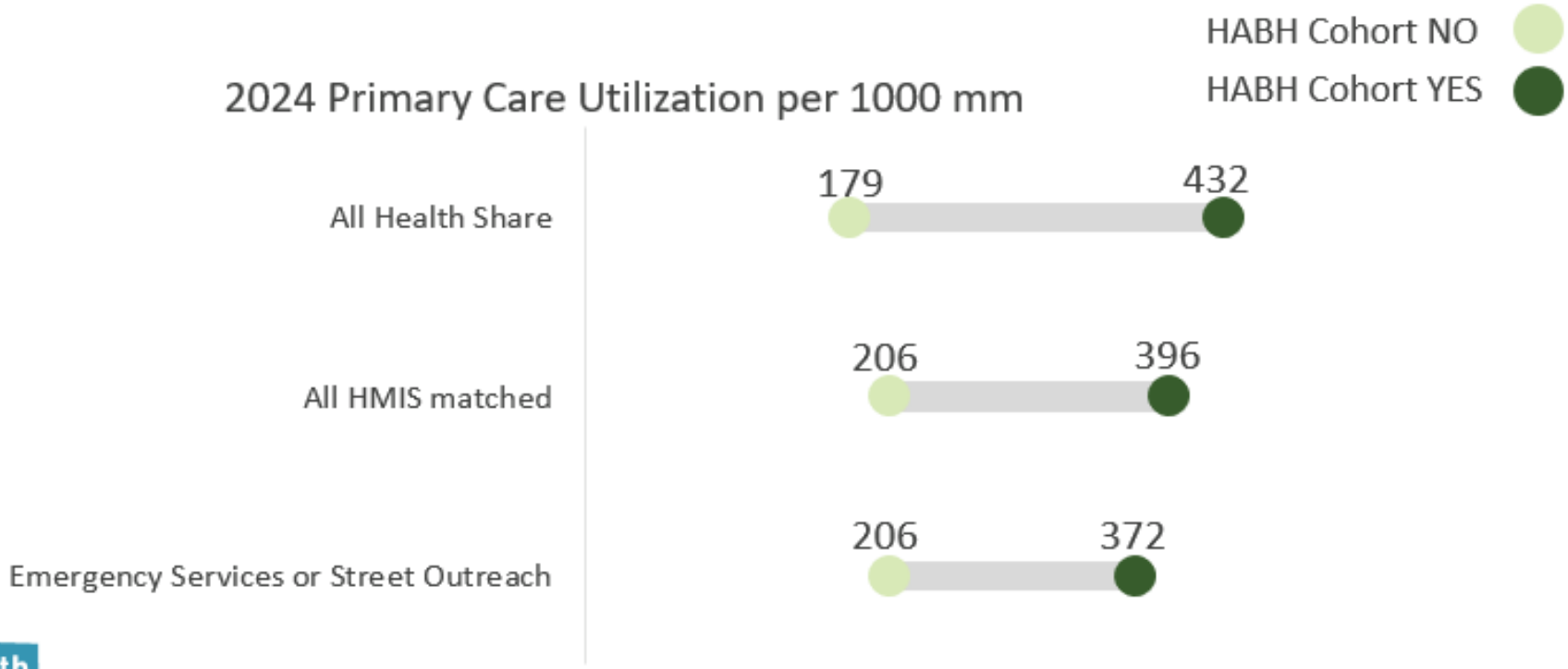

People with matched HMIS records have higher rates of OUD medication initiation and slightly higher rates of medication engagement than the Health Share average.

The subgroup of people receiving emergency services or street outreach has similar initiation rates to the full HMIS group but lower rates of engagement.