Multnomah County FUSE Report

May 2021
Prepared by: CSH

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Project Overview

Funded in large part by Meyer Memorial Trust, this effort was a collaboration among the Corporation for Supportive Housing (CSH), Health Share of Oregon, the Local Public Safety Coordinating Council, the Joint Office of Homeless Services, and the Multnomah County Sheriff's Office.

CSH

health share

LPSCC
Local Public Safety Coordinating Council
MULTNOMAH COUNTY, OREGON

Multnomah County JOINT OFFICE OF HOMELESS SERVICES

About FUSE

FUSE is a signature initiative of CSH that helps communities break the cycle of homelessness and crises among individuals with complex medical and behavioral health challenges. These individuals have frequent touches with emergency departments, jails, shelters, and acute care settings that are often costly and prevent people from thriving in their communities. For more information, please visit www.csh.org/fuse.

Background

FUSE (Frequent Users Systems Engagement) is a proven model that uses data to determine how highly impacted people who often cycle through and are over-represented in jails, shelters, hospitals, and other crisis services would benefit from supportive housing. While it is systems and data driven, the ultimate goal of this effort is to improve lives through long-term solutions such as supportive housing.

Supportive housing is an evidence-based solution that leads to improved health and other beneficial outcomes for people with complex needs including experiencing long-term homelessness and having disabilities. Deeply affordable housing with wraparound support services stabilizes lives and significantly reduces returns to jail and homelessness, reliance on emergency health services, and improves overall quality of life.

With significant support from Meyer Memorial Trust, CSH was able to conduct FUSE in Multnomah County. As many people have pointed out in presentations of the Multnomah County work, FUSE should be renamed. Using "frequent users" puts the onus on people rather than the systems that are failing them. For consistency, this acronym will be used in the report to describe the effort, recognizing that the name does not accurately describe the way Multnomah County leaders see the role of systems in contributing to peoples' adverse outcomes. The results of this FUSE analysis call for change and collaboration as well as increased units of supportive housing for the highly impacted population.

Nationally, CSH has been involved in FUSE in over 35 communities. Each is distinctly based on the systems engaged in the effort, focus population, and programmatic and policy needs.

Systems in the City of Portland and Multnomah County involved in the effort represent homeless services, health care, and public safety. Specifically, the partners are:

- Health Share of Oregon
- The Joint Office of Homeless Services (JOHS)
- The Local Public Safety Coordinating Council (LPSCC)
- The Multnomah County Sheriff's Office (MCSO)

This report represents a major milestone for systems engagement and cross-sector data analysis. It is also intended to be a springboard for future analysis and action, not a final product.

Analysis

As part of the planning phase for FUSE, the partners convened the Data and Equity Workgroup, which drew analytical and equity expertise from colleagues working in the health, homeless, and housing and justice system, particularly the Sheriff's Office. The workgroup combined and analyzed these systems' data to initiate dialogue, generate questions, and complete a quantitative analysis informed by system leaders. The graphs and figures in this report are a selection of the workgroup's efforts outlining disparities as well as opportunities for supportive housing to make the maximum impact on changing those disparities.

As the Data and Equity Workgroup recognized, the experiences of individuals are inequitable. These imbalances influence who shows up in data and in what ways.

Examples of this include:

- Institutional and systemic mechanisms that distribute power and resources to disproportionately benefit white people
- BIPOC (Black, Indigenous and People of Color) over-representation in systems and disproportionately impacted by economic, food, and housing instability
- Underrepresentation of people of color with decision-making power in the health care, homeless services and corrections systems
- Inequities in access to quality and adequate services in the health care and homeless services systems
- Increased stress and prevalence of disease for BIPOC
- Inherently racist data systems and data collection methodologies
- Policies and laws that disproportionately harm BIPOC

The quantitative data in this report is important to help build a case for responses to the system failures, individually and collectively, described, but they do not represent the full or only story. Additional quantitative and qualitative work must be done to fully understand how racial inequities shape the data before making policy and resource allocation decisions.

Dr. Frank Franklin, Ph.D., JD, M.P.H and Director of Community Epidemiology Services at the Multnomah County Health Department summarizes the FUSE systems and data leaders' sentiments in this statement:

> "The data quantify the magnitude of harm that is in conflict with our values."

These findings are intended to initiate dialogue, generate questions and identify opportunities to add qualitative data to tell a more comprehensive story.

Crossover Population

To analyze the population between systems, the partners developed legally binding data-sharing agreements that allowed the Multnomah County Health Department (a HIPPA covered entity) to have access to each sector's person-level data set containing identifying fields for matching purposes as well as system interactions. The data sets were matched to one another and then de-identified. Demonstrating the size and system utilization patterns of the crossover population between the systems is a major step forward for the community and becomes the foundation for further analytical questions, as well as program and policy conversations and decisions.

The system crossover diagram (Figure 1) shows the counts of people enrolled in health and homeless services with either or both Health Share and JOHS, as well as those who were booked with MCSO. The base population of the diagram are 155,874 adults who were enrolled in Medicaid (regardless of whether they received a health care service), engaged with homeless services, or were booked in the Multnomah County Jail in 2018. In this data match, less than 1% (1,371) touched all three systems. Of that crossover population, 85% (1,162) had at least one health care claim in 2018; and of those, 6% (74) were in permanent supportive housing (PSH) for at least a year. These data then reveal a set of 1,088 adults who were engaged in the health care system, booked in jail at least once and not in PSH, and still needed those services.

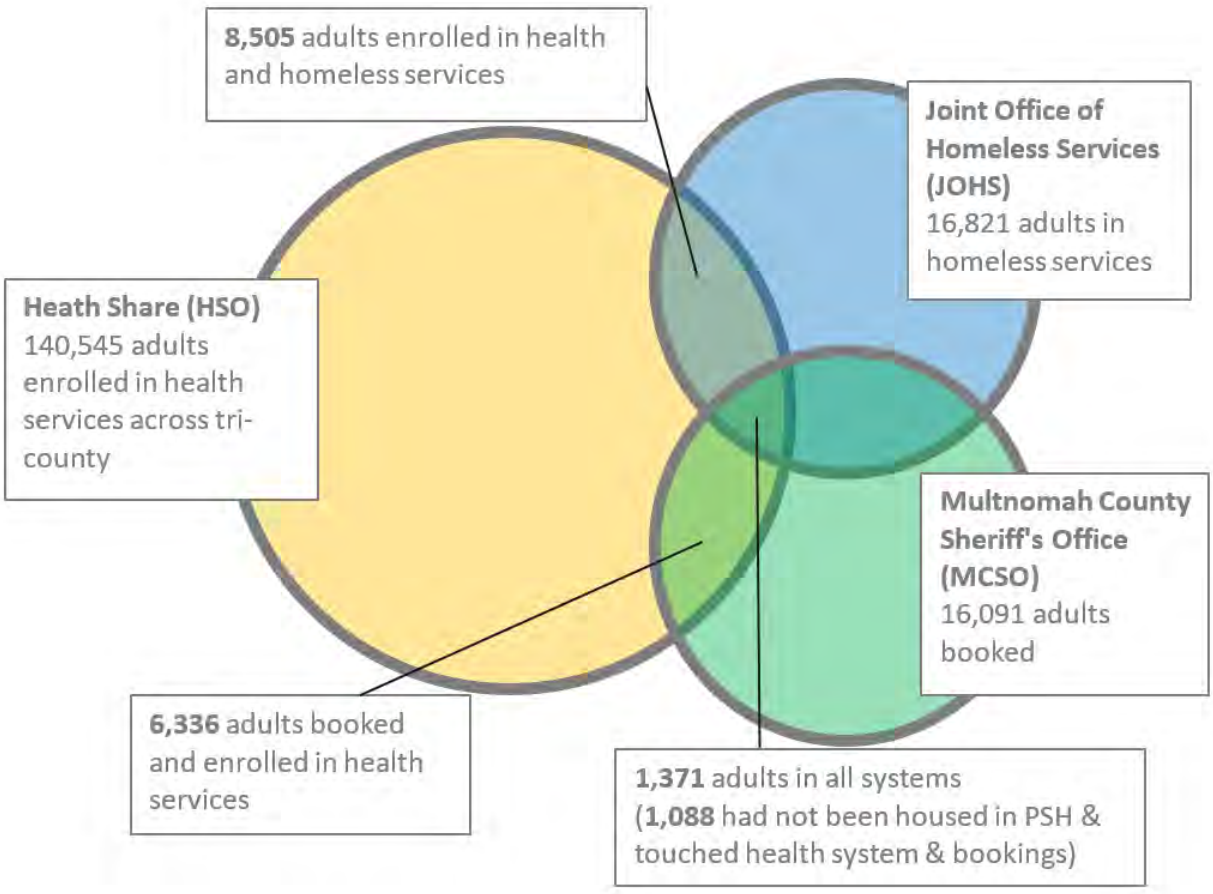


Figure 1

Impact of Tri-System Involvement

Figure 2 shows the rate of difference of health care utilization for adults in the Medicaid population who had contact with MCSO or JOHS relative to those adults who did not. The key insight is that adults who had contact with both JOHS and MCSO received *more* health services at higher rates than adults who did not have contact with either JOHS or MCSO.

This insight is most pronounced for adults receiving inpatient psychiatric care, where adults booked with MCSO accessed inpatient psychiatric care at 6.0 times the rate of Health Share (Medicaid) members with no other system interaction. Similarly, adults enrolled in JOHS services accessed these services at 5.0 times the rate, and, staggeringly, adults enrolled in JOHS services *and* who were booked with MCSO accessed inpatient psychiatric services at 10.0 times the rate of those with no system interaction. This means, for example, that if a typical Health Share member had one interaction with inpatient psychiatric care, those members who were also booked and in JOHS data would have ten interactions.

Across the different health interactions[1] in Figure 2, the adults with both a JOHS interaction and MCSO booking are more likely to experience comparatively higher rates of health care utilization and have higher associated costs.

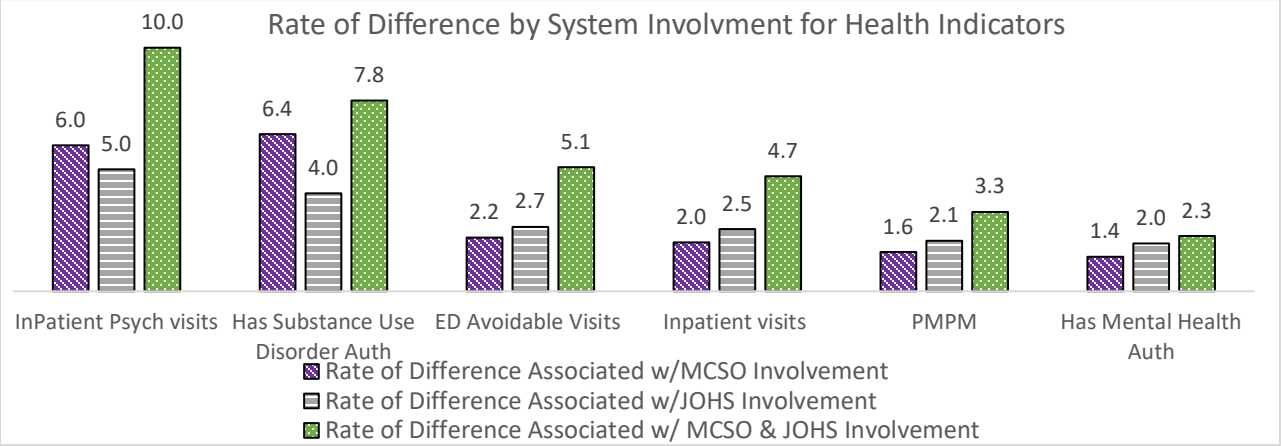


Figure 2

[1] **Inpatient Psych Visits:** hospital stays for the member during the year (the top 2% outliers were rounded to the 98th percentile) for a behavioral health reason.
Has SUD (Substance Use Disorder) Auth.: adults with an authorization for substance use disorder services at any point during the year Members can have an authorization and not receive services, and members can receive services without an authorization.
Avoidable ED (Emergency Department) visits: Emergency department visits that could have been better served in a setting other than the emergency department (based on diagnosis and procedure codes).
Inpatient visits: hospital stays for the member during the year (the top 2% outliers were rounded to the 98th percentile) for any reason other than maternity.
Per Member Per Month (PMPM): total dollars in paid claims for the member during the year (rounded to the nearest $500) divided by the number of months the member was enrolled during the year.
Has MH (Mental Health) Auth.: adults with an authorization for mental health services at any point during the year. Members can have an authorization and not receive services, and members can receive services without an authorization.

Impact of Health System and MCSO Bookings

To inform issues around the relationship between jail and health disparities, Health Share-enrolled adults with no bookings in 2018 were compared to those booked into jail that same year. Adults booked into jail were divided into three cohorts: those with 1-4 bookings, those with 4-9 bookings, and those with 10 or more bookings. The data represent a snapshot in time for adults booked into jail in 2018. Their experiences such as length of incarceration, bookings before or after 2018, and reasons for release from jail were not represented by these data. While bookings data provide limited insight, they represent a broader context to explore in on-going conversations and further data analyses.

In Figure 3, looking again at the inpatient psychiatric services, the difference between booking groups is quite stark. Adults with 10 or more bookings access inpatient psychiatric services at 38.0 times the rate of Health Share served members with no bookings. Stakeholders at community presentations of these data have pointed out that this data point, though shocking in scale, is not surprising.

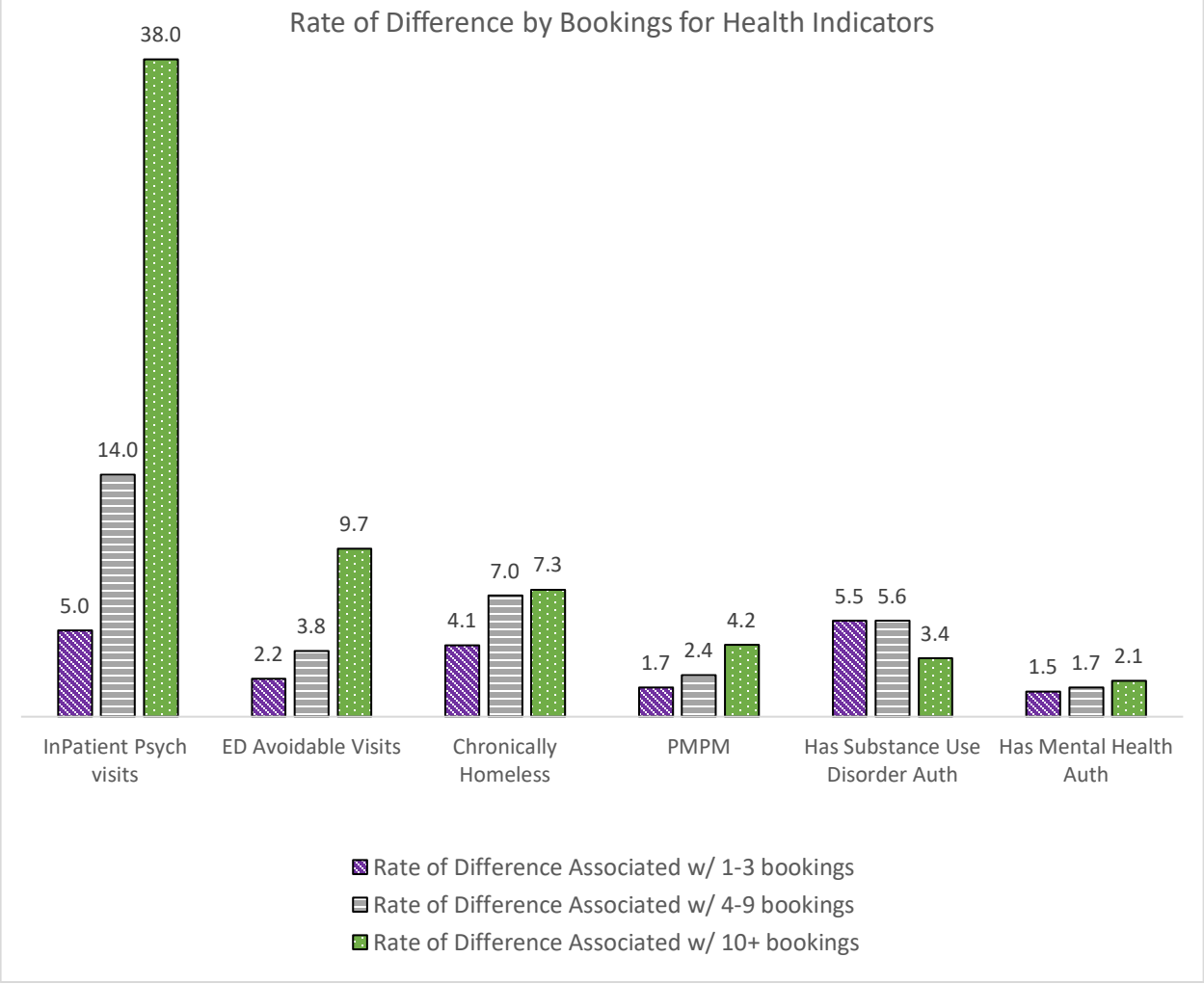


Figure 3

Housing is a Game Changer

While these data demonstrate gaps and provide insight into who is most impacted by negative system outcomes, they also provide information on the benefits of supportive housing.

Figure 4 illustrates that people who have experienced chronic homelessness generally have higher health care utilization and costs than the general Medicaid population. However, by providing supportive housing to this population, it reduces utilization across the board, significantly reducing avoidable visits to the ED, inpatient psychiatric stays, and health care costs.

This impact is seen most clearly with jail bookings. The people experiencing chronic homelessness (and not housed) had jail bookings at 7.0 times the rate of the general Medicaid population. For those who had been chronically homeless but were housed in supportive housing for at least a year, the rate of bookings was neutralized – they were booked at the same rate as general Medicaid members who did not experience chronic homelessness.

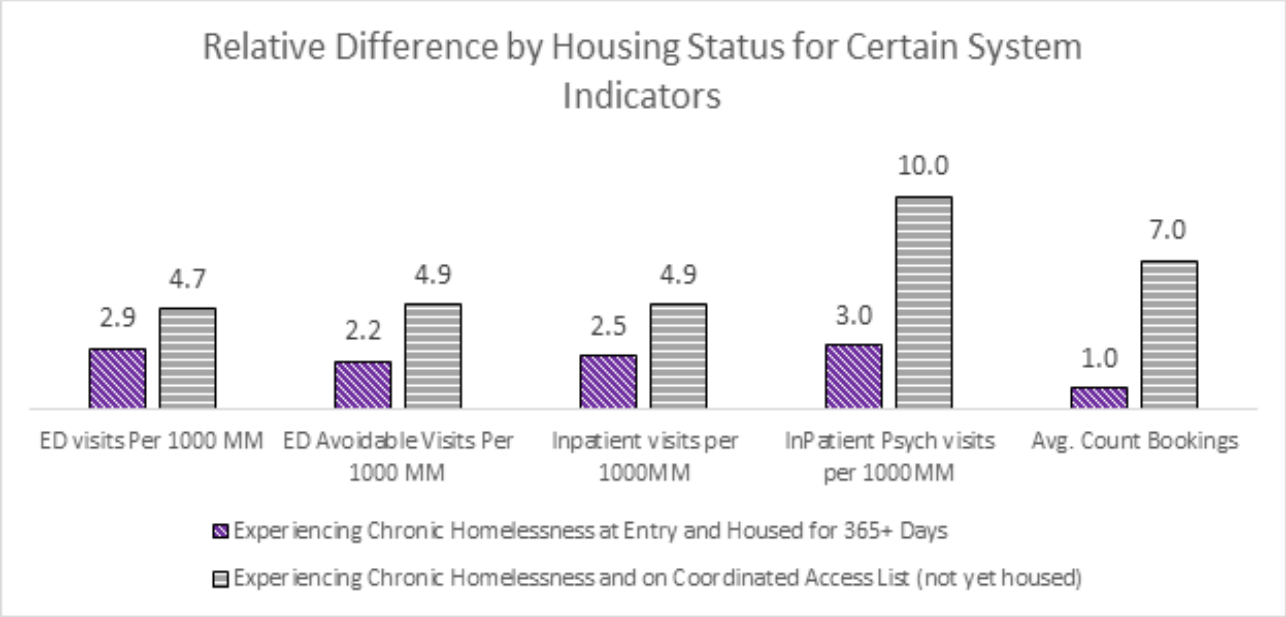
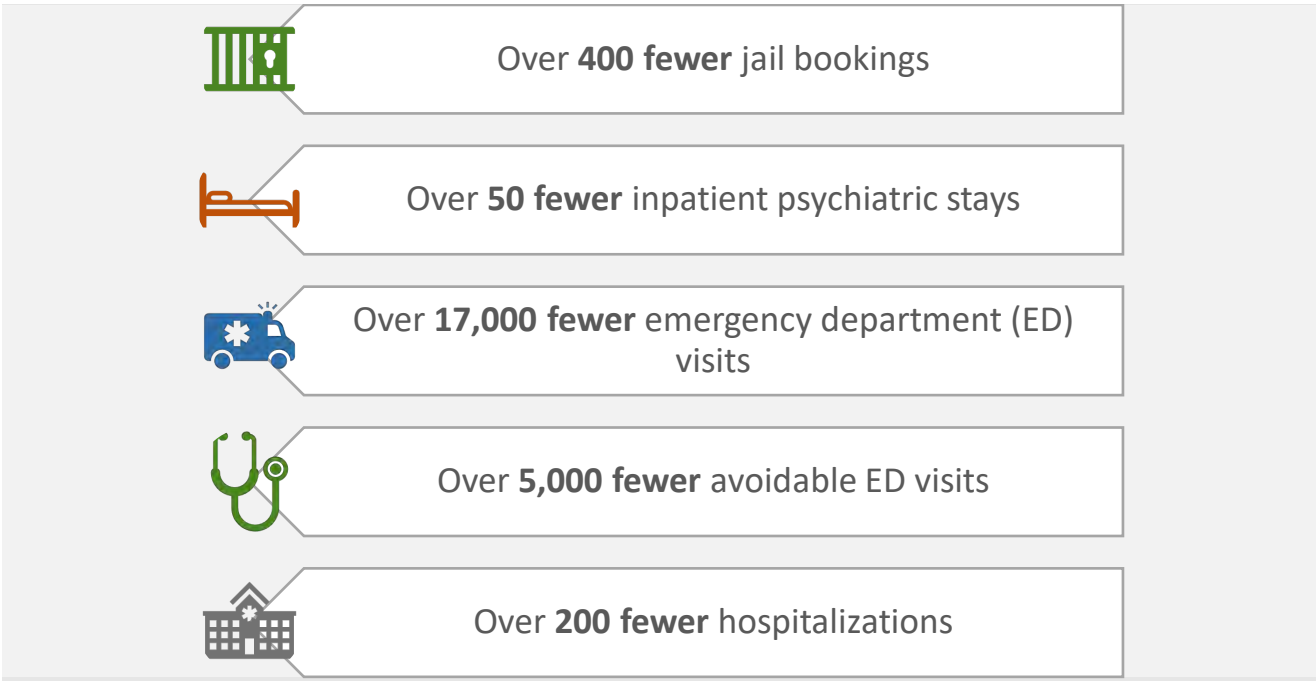


Figure 4

What the data suggest is that, as a group, those who had been chronically homeless but were housed in permanent supportive housing for at least a year experienced substantially fewer adverse system interactions than they would have had they been unhoused. Specifically:



Not only do the data suggest improved outcomes due to supportive housing for those experiencing chronic homelessness, they demonstrate cost savings to Medicaid. In 2018, analyzing the 1,138 chronically homeless adults in the JOHS dataset, 862 were unhoused, and 276 were housed. Based on the reduced costs to Medicaid because of the supportive housing intervention, it is estimated that in 2018, if all 862 unhoused chronically homeless adults had been housed, there would be $3.6 million in savings, and if all 1,138 people had never become chronically homeless, that savings goes up to $10.2 million (Figure 5).

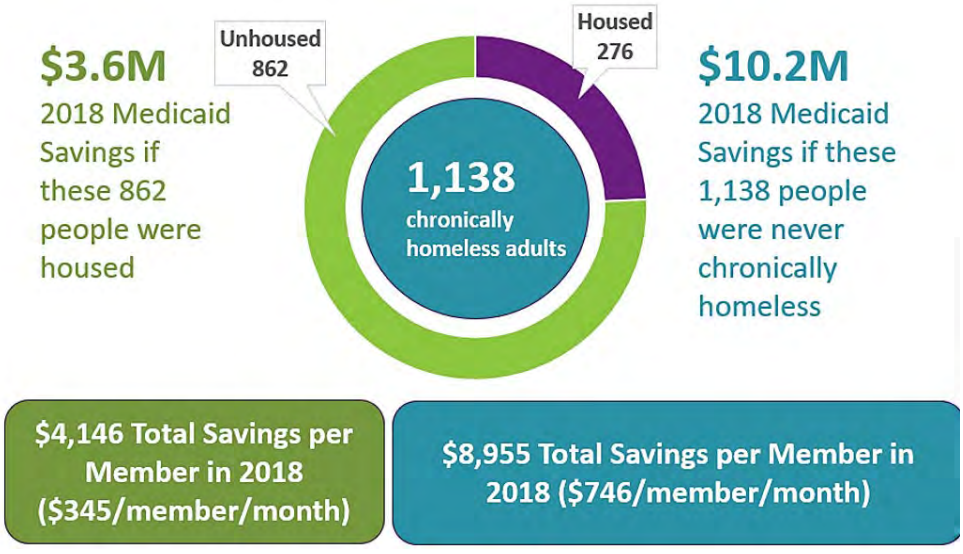


Figure 5

Indicators by Race/Ethnicity

Analyzing the experience of people in systems by race and ethnicity is critical in order to identify disparities and opportunities for systems to promote change that result in more equitable outcomes. As Figure 6 displays, the rate of difference in certain outcomes heavily impact BIPOC. The most acute rates of difference are among those who are American Indian or Alaska Native. Compared to all other race and ethnic groups combines, they experience chronic homelessness at 6.1 times the rate, go to the ED for an avoidable visit at 2.1 times the rate of and are booked at 1.7 times the rate.

While these data are instructive, they are not conclusive; nor do they incorporate the voices, perspectives, and critiques of those who have lived expertise with these systems. Engaging with these data along with these qualitative insights are necessary for systemic and programmatic change. Such quantitative analyses help the FUSE process tailor questions and solicit feedback to contrast data points and conduct root cause analysis. Though quantitative data and analysis show a certain due diligence, it is important to recognize (as the workgroup does) that these data are only part of the story.

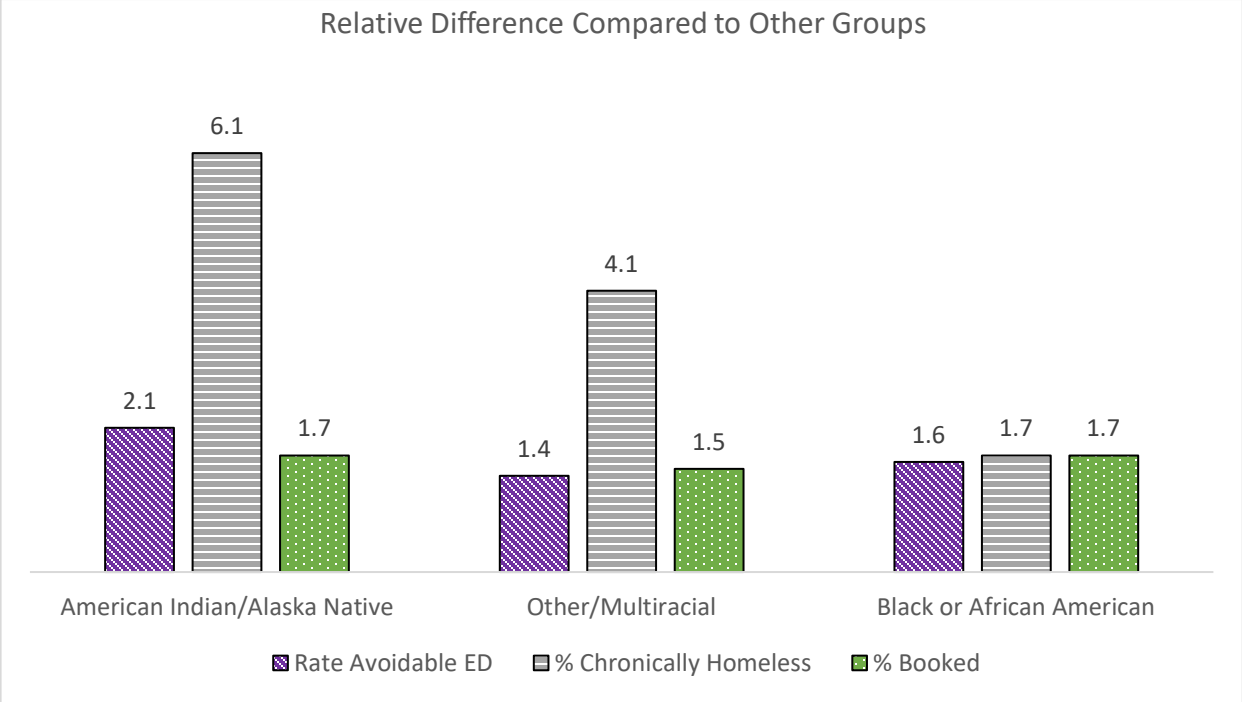


Figure 6

Additionally, certain system indicators were selected to be broken out by race and housing status. Data suggest that supportive housing improves outcomes for persons who experienced chronic homelessness and were housed for 365+ days relative to persons experiencing chronic homelessness and not yet housed, as shown in Figure 4. While these graphs and analyses illustrate that overall outcomes are improved, those benefits do not impact all race or ethnic groups equally, nor does it account for access to or exclusion from supportive housing resources.

Caution is urged in reviewing these data. It is important to note that they are not statistically tested and should not be used to definitively interpret system challenges or experiences of persons. Especially for results from race groups with fewer records, particularly the Asian population. While those individuals' experiences in PSH are real, with so few records, it is difficult to determine if those data are completely representative of that group or may just represent one or two people, for example. For ease of reference, the population totals (n=) are noted for each race group and housing status population in each of the following figures.

As mentioned before, more data are necessary, as well as a comprehensive conversation with community stakeholders, persons with lived expertise, and BIPOC. We present these findings as a way to open the conversation and explore, perhaps, new questions.

Figure 7 and Figure 8

Figure 7 observes the relative difference by race and housing status of Emergency Department (ED) visits and figure 8, avoidable ED visits.

The graph is ordered for by the highest relative difference among those who are housed in supportive housing for more than a year. Do note that the Asian population for those who are housed are less than 5 individuals and, again, may not be representative of that group. For service indicators in these figures, "0.0" values are indications of no data, meaning that there were no persons from that race group and of that housing status who interacted with systems for those measures. Conversely, other groups with fewer records could swing the average quite wide and show a large relative difference. An example of this would be the Asian population in figure 10. That population group consists of 11 people and may not be representative of the average experience in a different year.

Note the Grand Total category, which is the overall average relative difference, including all race groups. It indicates that unhoused persons (gray bar) visit the ED for avoidable and non-avoidable visits more than 4x the rate of the Medicaid only population, while those in supportive housing for a year or more (purple bar) visit the ED around 2-3x more. That seems to indicate that supportive housing reduces ED visits generally – perhaps due to residents of supportive housing having access to appropriate preventative services.

Disaggregating these data by race is instructive to determine how race groups experience supportive housing as a positive outcome, in this case, through ED visits. One way to view this would be to look at groups on either side of the Grand Total. Generally, those to the left have more negative experiences than the average, and groups to the right generally have more positive experiences. In both figures, Other and Multi-Racial as well as Hispanic or Latinx appear to have more of a relative difference than the average, even with supportive housing.

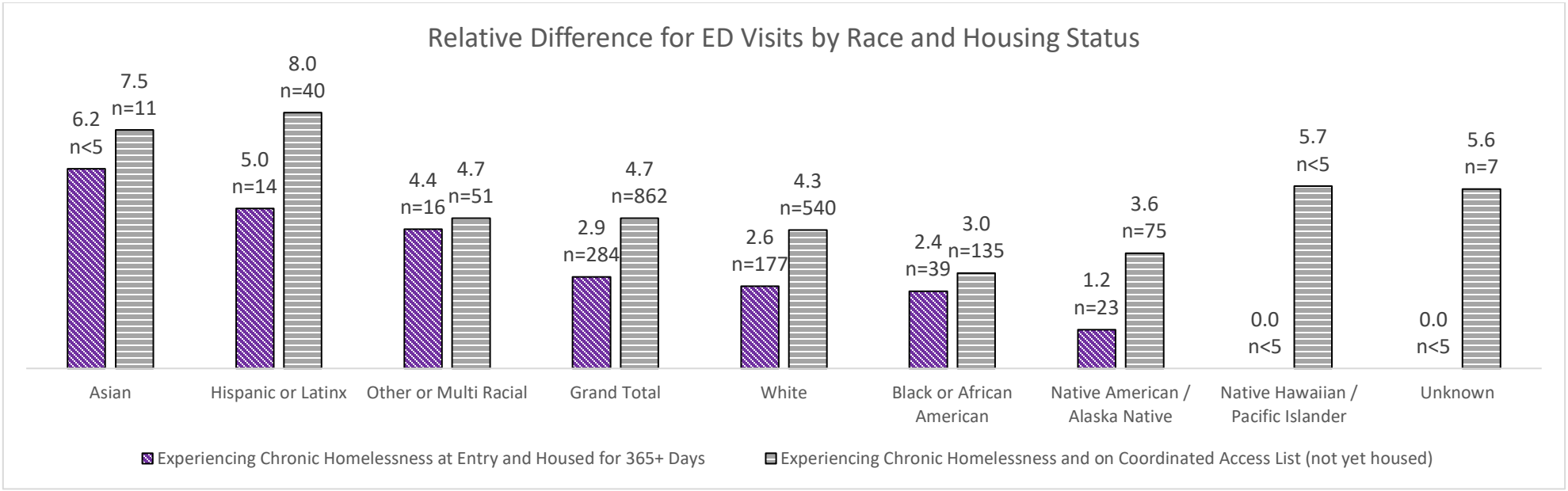


Figure 7

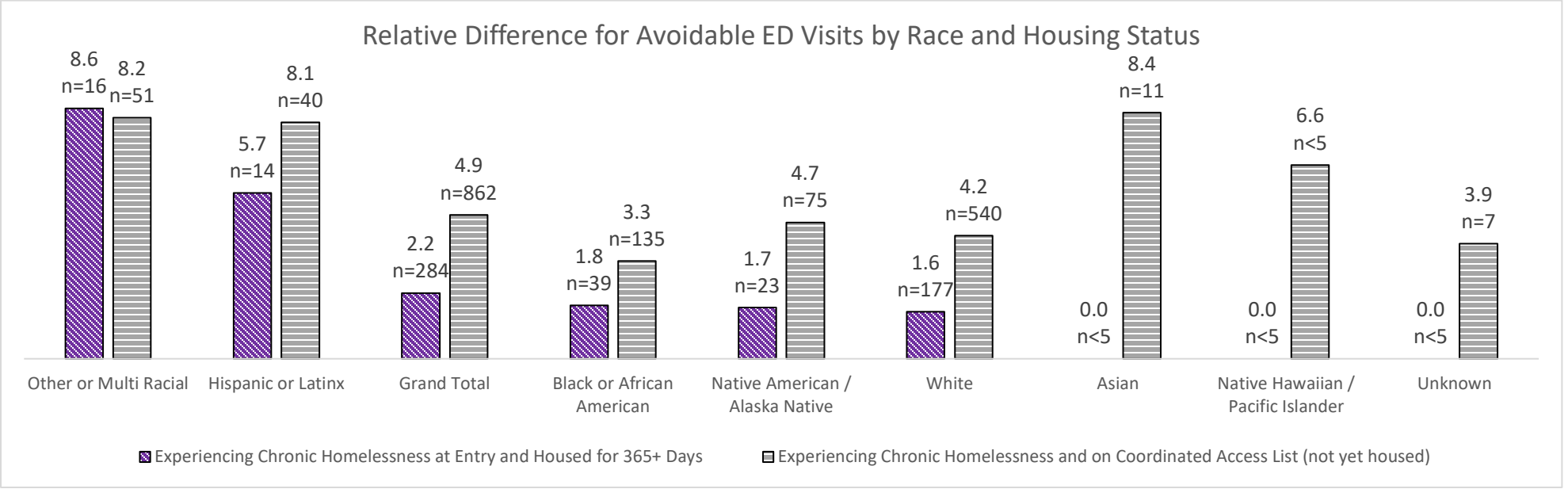


Figure 8

Figure 9 and Figure 10

The same caveats put forward for figures 7 and 8 apply to figures 9 and 10, which show the relative differences associated with inpatient hospital and inpatient psychiatric hospital visits broken out by race and by housing status.

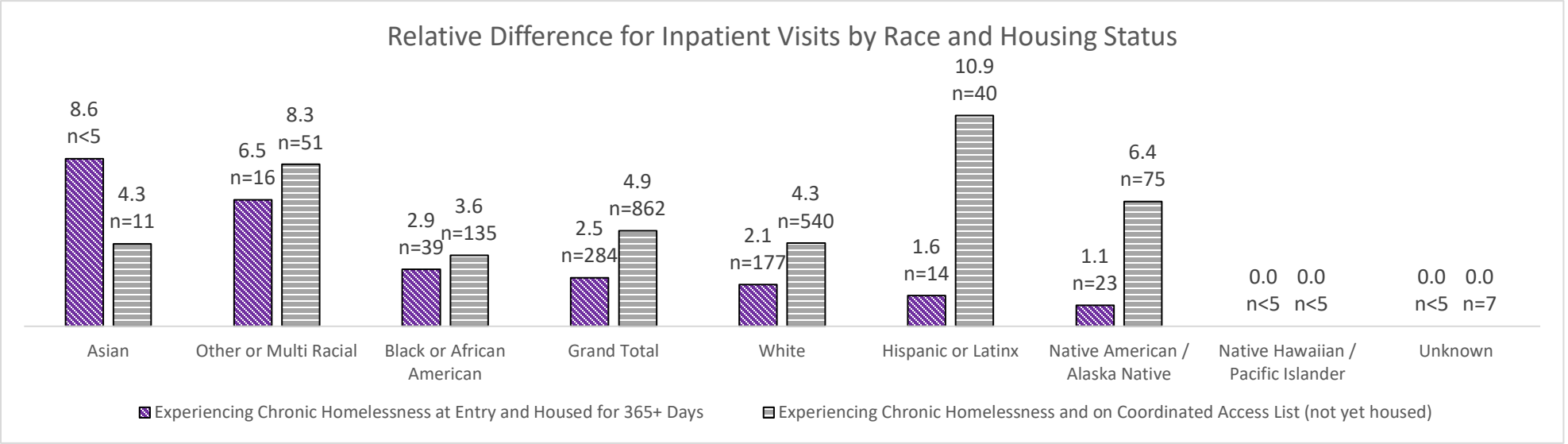


Figure 9

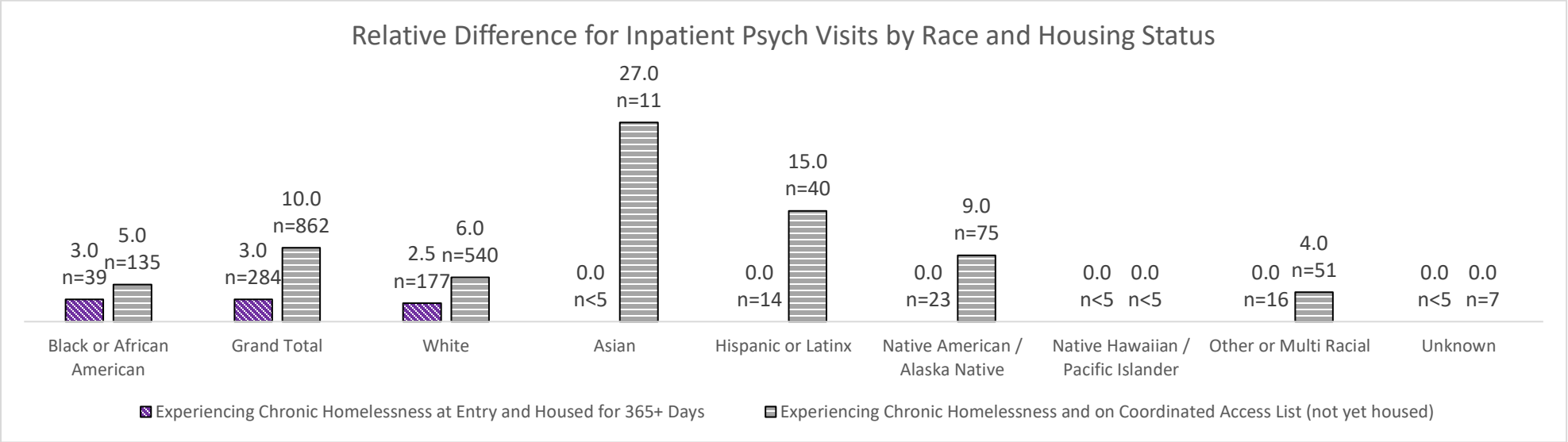


Figure 10

The chart below shows the data source for the graphs above. In this chart, details regarding the number and percentage of people, by race and ethnicity, are captured in this analysis.

RACE GROUP / POPULATION	POPULATION	# POPULATION	% POPULATION	ED VISITS	ED AVOIDABLE VISITS	INPATIENT VISITS	INPATIENT PSYCH VISITS
ASIAN	Health Share Only	8,092	9%				
	PSH (365+)*	<5	<2%	6.2	0.0	8.6	0.0
	CH-CA	11	1%	7.5	8.4	4.3	27.0
BLACK OR AFRICAN AMERICAN	Health Share Only	9,666	10%				
	PSH (365+)	39	14%	2.4	1.8	2.9	3.0
	CH-CA	135	16%	3.0	3.3	3.6	5.0
HISPANIC OR LATINX	Health Share Only	5,260	6%				
	PSH (365+)	14	5%	5.0	5.7	1.6	0.0
	CH-CA	40	5%	8.0	8.1	10.9	15.0
NATIVE AMERICAN / ALASKA NATIVE	Health Share Only	1,053	1%				
	PSH (365+)	23	8%	1.2	1.7	1.1	0.0
	CH-CA	75	9%	3.6	4.7	6.4	9.0
NATIVE HAWAIIAN / PACIFIC ISLANDER	Health Share Only	429	0%				
	PSH (365+)*	<5	<2%	0.0	0.0	0.0	0.0
	CH-CA*	<5	<1%	5.7	6.6	0.0	0.0
WHITE	Health Share Only	49,299	53%				
	PSH (365+)	177	64%	2.6	1.6	2.1	2.5
	CH-CA	540	63%	4.3	4.2	4.3	6.0
OTHER OR MULTI RACIAL	Health Share Only	1,219	1%				
	PSH (365+)	16	6%	4.4	8.6	6.5	0.0
	CH-CA	51	6%	4.7	8.2	8.3	4.0
UNKNOWN	Health Share Only	18,585	20%				
	PSH (365+)*	<5	<2%	0.0	0.0	0.0	0.0
	CH-CA	7	1%	5.6	3.9	0.0	0.0
GRAND TOTAL	Health Share Only	93,603	100%				
	PSH (365+)*	284	100%	2.9	2.2	2.5	3.0
	CH-CA*	862	100%	4.7	4.9	4.9	10.0

*Population categories with fewer than five records are suppressed and totals adjusted.

Community Engagement Scan and Racial Equity

As indicated by the data, BIPOC are overrepresented in national and Multnomah County homeless, health, and justice statistics due to the historical legacy and persistence of structural racism. With the guidance of CSH and several partner organizations, the FUSE table in Portland sought to develop an analysis that addresses frequent utilization while examining racial disparities.

From the beginning of the process, the systems leaders and the data and equity workgroup felt that it was important to engage community voice, particularly BIPOC. That said, several factors informed CSH's work to conduct a scan versus creating a separate process. These included several process barriers internal and external to FUSE, such as each system's own processes for community engagement, potential duplication, and not being able to resolve the timing of logical and meaningful engagement based on data analysis.

Once ready to move forward, the timing to engage peer staff (intended to reflect ideas from people with direct service experience and lived expertise) collided with the cumulative effect of national traumas felt by highly impacted communities, including: the Black Lives Matter movement and protests in response to police brutality, the COVID-19 pandemic, and other intersecting events. In an effort to prevent re-traumatization of persons in these communities, CSH did not conduct the direct community conversations as planned.

Therefore, representation occurred through interviewing community engagement experts in each system to document and uplift themes presented in the qualitative data sourced across systems.

The themes were:

Listening is one piece of the puzzle.

- Each system currently conducts their own community engagement largely in isolation.
- Community engagement within all three systems speak to the fact that racism and oppression are built into all systems, and the impacts compound one another.
  Key Insights:
  In conducting community engagement:
    - *Do*: Be transparent in engaging community; 'What's the specific ask? What's the feedback loop [accountability from those engaging to those from the community]?'
    - *Don't*: Engage with a group if it that engagement doesn't have a clearly defined purpose or tangible effect.
    - Foster affinity spaces, for culturally specific organizations and based on identities including lived experience, to assure safe and nuanced engagement with BIPOC, LGBTQ+ and other intersecting communities such as people with disabilities (visible and invisible).

Systems acknowledge that community voice needs to be elevated at decision-making tables; and that power sharing requires "leveling up" members of the community with technical and other supports for full participation.

- Workgroups and community advisory boards with both lived expertise and system leaders working together are present, or in development, in each system; these groups require continued and focused structural support.
- Systems acknowledge the necessity to remove basic barriers to participation such as stipends, childcare, and meals.
- An example of "leveling up," is the Justice sector facilitating "coach ups" to ensure that community members are knowledgeable of the administrative process, acronyms, and more, so persons with lived expertise can meaningfully participate in policy and programmatic discussions.

Key Insights:

- In establishing and supporting co-creation of policies and programs, be up-front and specific about the community's power to affect change.
- Acknowledge that bringing new people and more diverse representation into leadership and decision-making spaces, shifts the norms of the space;
- Successful collaborative spaces are willing and receptive to these shifts
- "Leveling up," or asset building, within communities is identified as an area of growth for all 3 systems, and an opportunity to create a cross-system structure that uplifts, prepares and resources community members.
- As stated by community members with lived expertise in an engagement conducted by the justice system around shaping a justice-funded housing program, "Give us the power."
- Invest resources in smaller community-based organizations so they can participate.

Resourcing for stable and supportive housing, requires a multi-level approach.

- Each system hears about housing in their listening sessions; Community engagement reflects that - lack of access to and availability of physical and behavioral (including relapse support) health, lack of affordable and supportive housing and lack of employment, and fair wages all lead to homelessness and housing insecurity.

  Key Insights:

  - Systems must work *together* to dismantle racism.
  - Transition resources across access and the need for 'warm hand-offs' across multiple spaces and systems should be prioritized.
  - Access to and more resourced behavioral health services for BIPOC are necessary.

Additionally, CSH, systems, and agency leaders, including those from the data and equity workgroup presented the results of the Multnomah County FUSE effort to the following entities:

- The LPSCC Executive Committee
- The Multnomah Board of County Commissioners
- Health Share's Board of Directors and several subcommittees including the Community Advisory Committee

These presentations and ensuing discussions informed recommendations are moving forward. The data and information in this report are meant to be a springboard for future action.

Recommendations for moving forward

These recommendations came from the leaders of the systems involved, as well as through the presentations and discussions listed above.

Data and Analytics

- Conduct another analysis using data that are more recent.
- Add additional Systems in the Justice Sector (beyond bookings) that include a racial equity lens to address.
- Use the FUSE (or FUSE-like) model as a platform for long-term data alignment between systems to promote more precise planning, evaluation, and ongoing quality improvement of programming.
- Measure changes in disproportionality of BIPOC represented in current analysis to indicate movement toward racial equity.
- Engage community voice to add qualitative information to the analysis.

- Continue to use a racial equity approach to the analysis; improve this approach by connecting with similar analyses and additional qualitative information.
- Identify people who are touching multiple systems to coordinate services and connect them to housing.
- Use data to inform policy and program change, not just to make the case that these should be addressed.

Advancing Programs

- Invest in long-term solutions, such as supportive housing that showed a significant decrease in systems used in this analysis.
- Apply more intensive and individualized supports (including trauma informed care) with housing to address complex needs of potential and existing tenants, especially people who touch multiple systems.
- Use information (i.e., names) from data analysis to prioritize highly impacted people for supportive housing.

Systems Collaboration

- Use FUSE to inform and help implement the following:
    - The Multnomah County LPSCC Transforming Justice Initiative
    - Health Share of Oregon's Community Health Improvement Plan
    - The Regional Supportive Housing Impact Fund under Health Share of Oregon (Strategic Framework here)
    - Metro's Supportive Housing Services Program via the Multnomah County Local Implementation Plan
- Address systemic and structural racism that exists in and among systems as evidenced by the data

Racial Equity

- Center race in resource allocation (new and existing) in the construction and expansion of behavioral health for BIPOC.
- Increase funding for culturally specific programs to build and sustain partnerships that add access to and increase success in supportive housing.
- Research how to dedicate units for communities of color.
- Ensure systems and programs acknowledge the harmful impacts of institutionalized and structural racism across systems have a compounding effect and work to repair, reduce, and prevent this harm.

State Health Policy Advocacy

- Share the findings of this report with stakeholders involved in:
    - Measure 110, also known as the Drug Addiction Treatment and Recovery Act.
    - Upcoming efforts to seek additional Medicaid authority such as a Waiver or State Plan Amendment that could allow additional services in supportive housing to be funded through the Medicaid, also known as the Oregon Health Plan (OHP).

Closing

From CSH's perspective, the Multnomah County FUSE effort has been one of the most dynamic systems work that CSH has been involved in locally. The ability to create a warehouse of data across the three sectors and pull a variety of analyses is significant. It allowed for a unique way to tell the story of people and systems that has not been conducted in other FUSE efforts. Additionally, the relationships established across the sectors helped build a deeper understanding of the challenges that each face when working with highly impacted people, including communities of color. CSH also appreciates the resources, support, and confidence from the staff at Meyer Memorial Trust to ensure that FUSE continued through challenges and opportunities that systems change and collaborative efforts bring. To learn more about CSH, please visit www.csh.org.

For additional information or questions about this report, please contact Heather Lyons, Director, CSH at heather.lyons@csh.org.