Patient support: Peer support specialist Lisa Greenfield (left), community outreach coordinator Gary Cobb, and Central City Concern CEO Rachel Solotaroff have seen Portland health systems invest significant sums in affordable housing in the hope of keeping patients stable, housed, and healthy.

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A SERIES ON
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To Improve Outcomes, Health Systems Invest In Affordable Housing

In Portland, Oregon, health care networks are helping expand access to stable housing and supportive services.

BY DAVID TULLER

Lisa Greenfield's father and uncle were heroin addicts. Her dad committed suicide in 2011. She succumbed to substance abuse and for years lived on and around the streets of Portland, Oregon. She became estranged from the family she loved—her mother and the younger siblings she once looked out for. She twice attended rehab programs. Both times, she relapsed immediately after returning to a life without steady shelter.

Finally, three years ago, a third bout of rehab stuck—mainly, she says, after she received a room of her own from Central City Concern (CCC), the social service agency that ran the detox center she attended. "I couldn't believe that I could have my own place, my own key," said Greenfield, now twenty-seven years old, during a meeting one morning in March at the CCC offices in downtown Portland.

Greenfield had dropped out of community college during her homeless period. By the time she got clean, she hadn't held a regular job for years. But after she graduated from a nine-month transitional program at CCC, the organization hired her as a peer support specialist. The job came with access to a long-term studio apartment—something she knew she could never have secured on her own. "Starting at a minimum wage job, no other income coming in, there's no way that I could have afforded any housing here in Portland," she said.

Sporting a mischievous grin and a loose grey hoodie with a Nike swoosh, Greenfield seemed cheerful and optimistic when discussing her current situation—if a bit surprised that things have actually worked out for her. With her life on a healing curve, she has reconciled with her family and has considered pursuing a nursing degree, perhaps even serving ultimately as director of one of CCC's many programs. Greenfield owes any such possibilities, she believes, to her luck in finding a safe landing space. "Without that missing piece—the housing—I just don't think stability and recovery are really obtainable," she said. "Not many people are able to stay clean or maintain a job while being homeless."

Gary Cobb, the agency's community outreach coordinator, attended the meeting with Greenfield and agreed on the critical role of housing in kicking substance abuse. When Cobb left the Coast Guard in 1982, he said, he was already addicted to alcohol, cocaine,

Photographs by Cole Keister

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and heroin. He kept up his carousing for another eighteen years and got clean after moving to Portland in 2000. Cobb has a thicket of salt-and-pepper hair and tattoos on the backs of both hands—angel wings bearing the hand of fate on his right, two roses with a crown on the left. Roses are a well-known symbol of Portland, and the hand tattoos have "significant meaning" for Cobb. "Basically, I feel I've been treated like a prince of sorts since moving to P-Town," said Cobb, using an affectionate local nickname for his adopted city.

Cobb spoke with a gruff acceptance of his own past choices. At fifty-eight, he vividly remembers the challenge of staying sober without anywhere to live. "Oh, man, if you're unhoused, that's a pretty scary place to be. It's easy to go back to using again," he said, his voice steeped with empathy. "'Well, shit, if I'm going to be on the streets, I might as well be loaded,'" he recalled thinking to himself. "It certainly was that way for me."

Like many cities in the US, Portland has long struggled with persistently high rates of homelessness and substance abuse—both also associated with high rates of mental illness and various infectious and chronic diseases. In the years following the 2008 economic collapse, a growing housing crisis caught the attention of Portland's major health care systems, said Pam Mariea-Nason, the executive of the community health division at Providence Health and Services, which has a network of facilities in Oregon and Washington. "We started to see housing emerging as a need in new and more acute ways," she said.

Multiple lines of evidence converged to demonstrate the magnitude of the problem, Mariea-Nason said, with more doctors reporting that patients had lost their homes or apartments, hospitals reporting increases in emergency department usage, and teachers reporting that more students were living from couch to couch. The providers all recognized that the crisis was affecting the health of those they were serving, she added. "Let's say you're a diabetic who is housing and food insecure. Your priority cannot be to manage your diabetes, your priority is to survive," she explained. "No matter how good the medical treatment we provide is, people have to have their basic needs met in order to prioritize their participation in their health care."

Agency chief: Rachel Solotaroff, a physician, ran Central City Concern's medical services before being appointed CEO two years ago.

In 2016 Providence and five other Portland health care providers made a headline-grabbing announcement that acknowledged the intimate links between housing and health: They revealed plans to invest a collective $21.5 million in the construction of affordable units.[1] Besides Providence, the participants were three other hospital systems (Adventist Heath Portland, Kaiser Permanente Northwest, and Legacy Health); Oregon Health & Science University, which includes a major hospital facility; and CareOregon, a nonprofit health care plan for Medicaid patients. The initiative, called Housing Is Health, involved three buildings with a total of almost 400 living units for people who were homeless or at risk for homelessness. Besides the six large health care organizations, other state and local agencies and groups also contributed funds. CCC owns the buildings and is developing and managing the project.

For Kaiser, based in Oakland, California, the $4 million investment in Housing Is Health is part of a companywide effort to address the housing crisis in regions where its members live. In the Northwest region, Kaiser has also committed another $2.2 million to support traditional health workers and peer support specialists who are helping clients find and maintain stable housing.[2] Last year, in a prepared statement announcing Kaiser's pledge to invest up to $200 million in related endeavors across the country, Bechara Choucair, a Kaiser senior vice president and chief community health officer, highlighted the links between people's well-being and the environments in which they live.

"To improve the health of an entire community we must step beyond the four walls of our hospitals and medical offices to help those most in need," he stated. "We hope this national commitment to impact investing in housing stability will inspire other companies to share the responsibility of this critical issue growing in the United States."[3]

Beyond Health Care

The three buildings in Portland's Housing Is Health project were designed with specific populations in mind. One includes 51 units for families displaced by gentrification. A second has 153 units of permanent housing for people leaving transitional units. The largest building, called the Ed Blackburn Center after the former CCC executive who spearheaded the project, is scheduled to open this summer with 175 units for people in recovery. It will house additional on-site services, such as a primary care health clinic, treatment for substance abuse and mental health issues, and an employment office.

Addressing substance abuse by helping clients stabilize their living situations has long been a key focus of CCC's work: The agency's motto is Homes, Health, Jobs. CCC reports serving more than 14,000 clients annually through an extended network of programs. In 2018 it reported providing temporary and permanent housing in a variety of settings for more than 3,300 people.[4] As its motto also suggests, the organization views employment as another key means of helping clients achieve stable housing and regular health care. CCC provides job training and support but recognizes that working is not a viable option for many of its clients, given their histories and current health status.

Besides the new units from Housing Is Health, CCC controls around 1,700

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others in twenty-four different buildings around the city. Some are short-term transitional apartments for people just out of rehab or right off the streets; some are long-term apartments for individuals or families. Some require sobriety as a condition of acceptance into the building; others are considered "housing first" units, aligned with an approach that prioritizes getting people off the streets even if they are still using or abusing drugs or alcohol. All seek to provide residents with better access to services that can help maximize the potential benefits provided by stable housing.

"You simply can't be attendant to someone's health without housing that is grounded in community, particularly for people who are low income, have trauma, have substance abuse disorders," said Rachel Solotaroff, a physician who ran the agency's medical services before being appointed CEO two years ago. "We can say 'housing' and put someone in an apartment five miles away, where they're disconnected from anyone. If you're in a process of recovery from any number of things, to live in an environment where there is social connectedness is a good thing."

The Housing Is Health initiative, meanwhile, reflects the spirit of a statewide strategy to leverage health care dollars and improve outcomes by focusing on prevention and addressing social needs. This approach is in line with Oregon's long-standing tradition of health care innovation and reform in seeking to expand access. In the early 1990s the state introduced a new version of Medicaid called the Oregon Health Plan. This effort sought to extend Medicaid coverage to all of the state's uninsured residents while introducing an experimental approach to prioritizing the benefits covered. Specifically, through a complex calculus that incorporated data on clinical effectiveness, cost-effectiveness, and societal value, the state created a ranked list of all services and treatments. Then, depending on the annual Medicaid budget, the state established a cutoff point, with the items on the list above the threshold covered by the Oregon Health Plan and those below it not covered.[5]

While the Oregon Health Plan experienced downs and ups and many changes over the succeeding years, the state sen-

Housing Is Health is in line with Oregon's long-standing tradition of health care innovation and reform in seeking to expand access.

ator and emergency department physician who devised it, John Kitzhaber, became a governor with big visions. In 2012 his administration cut an ambitious deal with the federal government. The state committed itself to reducing the growth rate of per capita spending for Medicaid recipients by 2 percentage points, to 3.4 percent a year. In exchange, the state received $1.9 billion in federal funds, which enabled it to expand the Oregon Health Plan.[6]

The federal government approved this deal under Medicaid's Section 1115 waiver system, through which states can obtain permission to engage in innovative strategies designed to expand the program's reach. In particular, these waivers have enabled some states to invest in facilitating access to housing, transportation, food, and employment—all of which are known to strongly affect health outcomes. According to a recent examination of such investments in California as well as Oregon, published in the May 2019 issue of *Health Affairs*, Section 1115 efforts in both states benefited greatly from broad support across sectors.[7]

"Within the health care system, growing awareness of the impact of social determinants of health, the backing of senior leaders, and the mission and culture of organizations serving low-income patients all encouraged investment in social interventions," noted the authors of the *Health Affairs* study. "Outside the health care system, the political context, extent of collaboration between health care and community-based organizations, and community attitudes toward social interventions all influenced program implementation."[7(p779)]

In Oregon's case, the 2012 waiver allowed the state to develop a system of regional Medicaid managed care plans called coordinated care organizations, or CCOs. According to the Oregon Health Authority, the state's oversight agency, a CCO is "a network of all types of health care providers (physical health care, addictions and mental health care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid)."[8] Although CCOs are supposed to be managed to meet the needs of local residents, their common goals include expanding access to primary and preventive care and relieving some of the pressure on hospital emergency departments.

Oregon's Medicaid budget is currently around $14 billion, with the Oregon Health Plan covering more than a million lower-income people—about a quarter of the state's residents—through more than a dozen regional CCOs. In the Portland area, Oregon Health Plan members receive coverage through CareOregon, the nonprofit Medicaid health plan that is one of the investors in Housing Is Health. CareOregon also plays a large role in managing the Portland-area CCO, called Health Share of Oregon. Until last year the metropolitan area was also served by a second CCO, FamilyCare, which dissolved amid financial and legal battles with the state. Oregon has been evaluating bids for new CCO contracts and plans to announce the results soon.

Because of Portland's size and the presence of several large providers, the metropolitan area's health care marketplace is more complex than others in the state. Kaiser, Providence, and the other major systems all provide different packages of services to the CCO. That's because when Health Share was launched, none of those organizations wanted to give up their already established presence among the Medicaid population, explained Jeremiah Rigsby, CareOregon's chief of staff. "Health Share is a Frankenstein of various established plans," he said. "We built this hybrid structure that would delegate parts to these other institutions."

Oregon's CCOs have had some success in improving indicators for health care quality and access, among other measures. For example, avoidable emergency department use fell by more than half among beneficiaries in the period 2011–16.[9] In the domain of reproductive health, a 2016 study found that the introduction of the CCOs led to "signifi-

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cant increases in early prenatal care initiation and a reduction in disparities across insurance types."[10]

In 2017 Medicaid renewed and expanded the Section 1115 waiver for the state's program. Under the new waiver, CCOs could count as health related their expenditures on social determinants, such as housing; previously such costs had been labeled as administrative expenses. That accounting shift offered CCOs additional flexibility in decision making related to nontraditional investments. Yet while the state got the waiver, it did not receive the additional $1.25 billion in federal support it had initially requested. Instead, for the past two years Oregon has generated revenue for its Medicaid program through an added tax on health care providers.

Persistent Challenges

According to a count conducted on a single night in 2017, 1,668 people in the Portland area were staying outside or perhaps in a vehicle or tent, 1,752 were in emergency shelters, and another 757 were in transitional housing.[11] Given statistics such as those, as well as the state mandate to invest in social needs, CareOregon considers tracking the housing status of its clients to be central to its responsibilities. Several years ago it hired two housing case managers to take on that role.

On a bright March afternoon, Michael Mellick, one of CareOregon's housing case managers, traveled by light rail from downtown Portland to rendezvous with Joy Harris, one of his dozens of current clients. They had arranged to meet at a new affordable housing complex called Oliver Station Apartments, in the Lents neighborhood half a dozen miles away. Harris, a fifty-eight-year-old Portland native who had been homeless for the past four years, was scheduled to move into one of the studio units.

Mellick, wiry and energetic, spent years in the for-profit housing sector before becoming an affordable housing advocate, eventually joining CareOregon in 2015. After having started his career firmly on the commercial side of the equation, he explained, he switched gears professionally because he wanted to focus more on how housing could be used to stabilize and improve people's health.

Health care organizations confront an ongoing challenge in assessing how far they should go in seeking to address homelessness.

"The barriers to better health are very connected to the barriers to homelessness and vice versa," he said. "[People are] never going to be able to manage their chronic health issues without stable sleep, without stable housing." As an example, he cited the need for people with diabetes to be able to keep their insulin refrigerated—an obvious challenge for someone living on the streets.

A major problem for many clients, explained Mellick, is a past felony conviction—in some cases, decades in the past. Even when people qualify for subsidized housing, landlords are often unwilling to overlook past criminal offenses. Harris, Mellick's client, was convicted of selling marijuana more than twenty years ago—a factor that has complicated her search for permanent housing. She also experiences chronic and often severe pain from arthritis and fibromyalgia.

Harris said that she has spent the past four years living in her van, where she feels vulnerable to attack. Her American bulldog, Brutus, once bit a man who tried to break in, she said, but the dog died in January. Her voice softened and broke when she spoke of Brutus. On this afternoon, Harris was scheduled to meet with a representative from the landlord's office, discuss the apartment arrangements, and sign documents related to her move.

Harris was looking forward to some basic pleasures. "I feel good. I'll be able to shower and have a bathroom—that will be really nice," she said after the half-hour meeting. "It's been horrible being homeless. I just figured I'd be homeless till the day I died. It will be nice to get a good night's sleep." She allowed herself a small smile.

After being alerted to Harris's situation by a CareOregon social worker, Mellick had been hoping for months to locate suitable housing when the Oliver Station possibility opened up. "It was a first-come, first-served situation," he said. "I helped her with the application paperwork and guided her personally through the process.... [She] basically told me what she needed, and I tried to make it work for her."

Harris was initially denied the apartment because of her past felony, so Mellick helped her navigate the bureaucracy and file an appeal. Once the property management company overturned the earlier decision, he helped secure some basic furniture for Harris at a local nonprofit and identified a housing assistance grant to cover moving costs.

While Harris will now have a place to live, her financial situation reflects the dilemmas confronting Portland's health care and social service agencies as they try to keep people housed. Harris receives $771 a month in federal disability payments. The monthly rent for the new apartment is $505. That obviously leaves very little to buy food and other necessities and pay bills. "It's insane," said Mellick. "And that's considered affordable housing. It's not affordable. But she's excited to have that."

Harris shrugged off any worry about being able to make ends meet. "I'll have enough," she said. "I've gotten used to living on no money."

Mellick's clients struggle with multiple issues, he said, so part of his job is not just to help them find housing but to try to enable them to remain there. He pays follow-up visits, checks that clients are keeping up with rent and other bills, and helps smooth things over when issues arise with landlords or neighbors. But he can't resolve everything.

All Hands On Deck

Despite efforts across the state and city to address the issue of homelessness, making what appears to be progress has been difficult. "It's not any better," said Mariea-Nason of Providence. "We know it certainly has not been solved in the Portland area. I think that we are a long way from seeing this problem solved." And that, she worried, has long-term consequences for the health of the people served by Providence and other providers. "We are in a situation where a lot more people that we're treating and caring for don't have secure places to live, so how are they going to recover?" she said.

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In the last few years, according to Rigsby of CareOregon, many health care organizations have been struggling to find their footing on this issue. "These weren't trails we had walked down until about five years ago," he said. "The role of the health care plan has been fairly undefined. Are we landlords? What's the right middle ground for the health care company in this conversation?"

Rigsby acknowledged that health care organizations confront an ongoing challenge in assessing how far they should go in seeking to address homelessness. The investment in Housing Is Health represented an important statement but cannot be viewed as an easily replicable model for health care organizations, he noted. "We know that that type of investment isn't appropriate all the time," he said. "We don't have enough money to buy a bunch of buildings. We can't support every capital construction project that is needed."

That's why health care organizations are also seeking to combine their investments in affordable housing with interventions involving such areas as food insecurity, unresolved legal problems, and work-related issues. Oregon has highlighted a "focus on social determinants of health and equity" as a key policy goal for CCOs across the state in upcoming years.[12]

Along those lines, Providence has established what it calls the "community resource desk" (CRD) program at six of its facilities. Staffed full time by specialists from local nonprofit social service agencies, the CRDs help Providence clients enroll in health insurance, find the nearest food pantry, prepare themselves for employment, obtain dental care, and deal with utility providers and landlords, as well as providing other forms of assistance. Their on-site presence also means that Providence clinicians or administrators can easily refer patients directly to them for specific needs.

The CRDs and other initiatives, at Providence and elsewhere, can make a difference to individuals and families struggling to remain sheltered, said Mariea-Nason. "We know that for people who are chronically homeless to be able to be successfully housed they need support services," she said. "You can put up units, but you also still need to put supports in place to enable [people] to stay housed." ■

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