Agenda

Metro
600 NE Grand Ave.
Portland, OR 97232-2736

Meeting:	Supportive Housing Services Tri-County Planning Body Meeting
Date:	March 12th, 2025
Time:	4:00pm-6:15pm
Place:	Zoom Webinar, 600 NE Grand Ave, Portland, OR 97232
Purpose:	The Tri-County Planning Body (TCPB) will discuss and vote on a Regional Investment Fund proposal and receive a presentation on the Healthcare Implementation Strategy.

4:00pm **Welcome and Introductions**

- Decision: meeting summary approval

4:10pm **Public Comment**

4:15pm **Conflict of Interest**

4:20pm **Regional Investment Fund Proposal**

- Decision: proposal approval

5:20pm **Coordinated Entry Quarterly Progress Report Update Q&A**

5:30pm **Healthcare Implementation Strategy**

- Presentation
- Questions & Answers
- *Due to time constraints, the decision on plan approval will occur at the April meeting*

6:10pm **Closing and Next steps**

- Next meeting: April 9th, 2025

6:15pm **Adjourn**

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Tri-County Planning Body Meeting Summary

Meeting:	Supportive Housing Services (SHS) Tri-County Planning Body Meeting
Date:	Wednesday, February 12, 2025
Time:	4:00 PM – 6:00 PM
Place:	Metro Council Chambers, 600 NE Grand Ave, Portland, OR 97232 and Zoom Webinar
Purpose:	The Tri-County Planning Body (TCPB) will discuss and vote on the Technical Assistance Regional Implementation Plan.

Member attendees

Co-chair Mercedes Elizalde (she/her), Yoni Kahn (he/him), Nicole Larson (she/her), Yvette Marie Hernandez (she/her), Cameran Murphy (they/them), Cristina Palacios (she/her), Co-chair Steve Rudman (he/him), Mindy Stadtlander (she/her), Sahaan McKelvey (he/him), Monta Knudson (he/him)

Absent members

Eboni Brown (she/her), Zoi Coppiano (she/her)

Elected delegates

Washington County Chair Kathryn Harrington (she/her), Metro Councilor Christine Lewis (she/her), Multnomah County Chair Jessica Vega Pederson (she/her)

Absent delegates

Clackamas County Chair Tootie Smith (she/her)

County staff representatives

Clackamas County – Lauren Decker (she/her), Multnomah County – Cristina Castaño (she/her), Washington County – Nicole Stingh (she/her)

Metro staff

Michael Garcia (he/him), Abby Ahern (she/her), Nui Bezaire (she/her), Cole Merkel (he/him), Liam Frost (he/him), Daisy Nguyen (she/her), Finn Budd (they/them)

Kearns & West facilitators

Ben Duncan (he/him), Ariella Dahlin (she/her)

Note: The meeting was recorded via Zoom; therefore, this meeting summary will remain at a high-level overview. Please review the recording and archived meeting packet for details and presentation slides.

Summary of Meeting Decisions

- The Committee approved the January 8, 2025 meeting summary.
- The Committee approved the Technical Assistance Implementation Plan.

Tri-County Planning Body Meeting Summary

Welcome and Introductions

Ben Duncan, Kearns & West, introduced himself, facilitated introductions, and reviewed the meeting agenda and objectives.

Co-chairs Mercedes Elizalde provided opening remarks and reflected on how the TCPB will need to make strategic choices regarding SHS funding discussions.

Cameran Murphy asked what the process is if an action captured in the meeting summary has not been followed up.

> Ben replied that if there is an edit to the meeting summary, a member is to share that edit before summary approval. He noted that if there is an action item that was accurately captured in the summary but not followed up on, a member should note that for the record after approval.

Decision: Co-chair Elizalde, Yoni Kahn, Nicole Larson, Cameran Murphy, Cristina Palacios, Co-chair Steve Rudman, Monta Knudson, Metro Councilor Christine Lewis, and Sahaan McKelvey approved the January 8, 2025 meeting summary. There were no abstentions or rejections.

Cameran shared that an incomplete action item from the January 8, 2025 meeting summary was for Jake Kirsch from Housing Development Center (HDC) to follow up with more information regarding the Risk Mitigation Program.

> Cristina Castaño, Multnomah County, replied that county staff are meeting with HDC to share that information with the latest Risk Mitigation Fund report in the March meeting packet.

Public Comment

No public comment was received.

Conflict of Interest

Cristina Palacios declared a conflict of interest as Housing Oregon is on Metro's contractor list and could potentially receive future Supportive Housing Services (SHS) funding.

Cameran declared a conflict of interest as Boys and Girls Aid receives SHS funding.

Yoni Kahn declared a conflict of interest as the Northwest Pilot Project receives SHS funding. He noted that he serves on the TCPB to share provider perspectives and does not represent his employer.

Sahaan McKelvey declared a conflict of interest as Self Enhancement Inc (SEI) receives SHS funds. He noted that SHS does not fund his position and that he serves on the TCPB to share provider perspectives.

Yvette Hernandez noted that she works for Home Forward which receives SHS funding, but she participates in the TCPB as a community member.

Monta Knudson declared a conflict of interest as JOIN receives SHS funding.

Tri-County Planning Body Meeting Summary

Technical Assistance Implementation Plan

Presentation

Cole Merkel, Metro, reminded the TCPB that technical assistance and training are two separate goals, and this implementation plan is focused on technical assistance. He noted that the training implementation plan is scheduled to be shared in April.

Cole reviewed the TCPB technical assistance (TA) goal and recommendation language and highlighted the importance of having consistent TA practices across the region and providing menus of TA options for providers to choose from. He shared that the implementation plan included racial equity considerations that center culturally specific providers, noting that "best practices" are often created through a dominant culture lens.

Cole shared that the TA implementation plan also considers understanding the unique TA needs of providers in each county and ensuring jurisdictions are not duplicating TA offerings. He noted that the TA implementation plan accounts for two-way learning between providers and jurisdictions and that the Permanent Supportive Housing (PSH) demonstration project will help define roles and responsibilities for TA between Metro and the counties.

Lauren Decker, Clackamas County, shared that the county is working with four TA providers that SHS providers can access. She noted that four SHS providers, two of which are culturally specific, have opted into the program and have learned about funding sources, contracting requirements, and what additional roles would better support their organizations.

Cristina C., Multnomah County, shared that the county provides TA and support for providers, including assistance for contract renewal and procurement support. She noted that the county partnered with United Way to provide $10 million in capacity-building grants to providers to support workforce recruitment and retention.

Nicole Stingh, Washington County, shared that the county provided grants for organizational assessments, which identified needs around human resources, business services, strategic planning, and policies and procedures. She shared that phase two of the TA program will support the implementation of the capacity-building strategies identified in the assessment.

Cole summarized that each county is consistently leveraging culturally specific provider expertise and creating access to TA. He noted that the counties have different contracting approaches and different TA needs per region. He reviewed Metro's Regional Capacity Team's goals, noting current priorities are TA and training, and shared that the team has developed the first tri-county shared pool of consultants.

Nui Bezaire, Metro, reviewed Metro's Permanent Supportive Housing (PSH) TA demonstration and research project's goals to determine what PSH service standards of practice look like. She shared that the project would support PSH and TA by prioritizing learnings from culturally specific organizations to develop service delivery standards and inform TA programming.

Daisy Nguyen, Metro, reviewed the racial equity considerations for the project. She shared that Metro asked 200 service providers to complete a PSH survey, which received 19 responses. The survey asked what providers their TA needs are, with the top two results being staffing and programming, process, and policies.

Daisy reviewed the TA implementation plan timeline from January to September 2025 and noted that the budget is coming from Metro's administrative funds. She reviewed the implementation plan's metrics, goals, and results, including pairing three culturally specific providers and one dominant culture provider with consultants, with representation from each county.

Tri-County Planning Body Meeting Summary

Clarifying Questions & Answers

- **Question, Yoni**: Will there be another pilot in six months once this one is complete? Does behavioral health play a role in PSH? What is the plan after the discovery phase for the results to be integrated into county systems or Metro's role?
    - **Metro response, Cole**: What comes next is still to be determined. There is potential for the results to be applied to property management, but the results will influence Metro's policy work for PSH.
    - **Metro response, Nui**: This pilot is less prescriptive and more about learning how services are being provided. Any behavioral health learnings will be taken to the next stage of TA, which is still to be determined. The learnings from the discovery phase could lead us to overhaul best practices or could be about integrating certain items.
- **Question, Cameran:** What does culturally specific provider mean? Does the definition include age-specific groups?
    - **Metro response, Daisy**: The project focuses on centering racial equity. The definition describes culturally focused organizations, a majority of their clients are communities of color, and the organization staff, leadership, and board reflect the communities they serve.
    - **Metro response, Cole**: One spot in the project will be reserved for a dominant culture agency, which could include agencies that serve age-specific groups.
- **Comment, Mindy:** If services for high-intensity case management are included in TA, there is an opportunity for Medicaid billing for reimbursement.
    - **Metro response, Cole**: Ruth Adkins from the Metro team will connect with you on that.

Plan Approval Decision

Ben stated that each member would get a chance to share their thoughts about the implementation plan and propose any amendments. After that initial roundtable, a formal vote would occur.

Co-chair Elizalde shared that the implementation plan feels more like a research project and that TA is secondary to the project. She reflected that some PSH parts feel muddled, and the plan should clearly state what is being asked of providers to participate in the project and what benefits providers will receive. She noted that the TA consultant is being paid more than the PSH providers, and how counties currently define PSH and how that would change from this project is missing from the plan.

Cole clarified that the providers would receive six months of legitimate TA.

Co-chair Rudman shared that this is a good effort to solve the issue of PSH.

Cameran agreed with Co-chair Elizalde that it seems that there is not a clear understanding of PSH in the plan and that PSH seems different in each county. They reflected that they hope this project provides clarity on a PSH baseline standard of care.

Nicole L. agreed that there seemed to be tension between the plan being a research project and providing TA. She asked to ensure the objectives are clear for service providers that apply to participate.

Monta had no comment.

Cristina P. reflected that there are funding cuts and asked what continuation would look like for the organizations that participated in the project.

Cole replied that it is a demonstration project that may influence future policy.

Yvette asked if turnover would be tracked for the participating service providers and if there would be a discovery of how organizations are retaining staff. She is interested to know if the TA will produce a decrease in turnover and an increase in quality service.

> Daisy replied that Metro is developing the framework for the TA consultants that includes looking at funding streams and staffing as those two items have a large impact on service delivery.

Sahaan shared that he supports the concept of utilizing the experience of providers to inform PSH practices and that providers will be receiving TA, but that not everything can be done at once. He reflected that future iterations of the project should have a narrower scope, and that county staff would be able to provide TA on how to be a good contractor for them. He noted that it would be helpful to scale up the learnings from the project. He reflected on how "best practices" are "mainstream practices," and that "culturally specific practices" are "best practices." He suggested replacing the language "dominant culture" with "mainstream culture" or "white culture." He agreed with Co-chair Elizalde's comments on honing in on regional priorities, and how to set up TA regionally for SHS priorities or the housing system.

Yoni stated that a lot of good work went into the plan from the first update the TCPB received. He reflected that braided funding is a key question on how organizations are structured and that there is currently an uncertain funding environment at the federal level. He agreed with Mindy's comment about connecting with Medicaid funding.

Mindy stated that the providers selected for the project should be prepared to work through federal funding cuts.

Metro Councilor Lewis shared that this is a priority for Metro Council and while she understood budget and scale constraints, noted that one provider from each county participating in the project is not enough perspective and would hope to add providers in the future.

Washington County Chair Kathryn Harrington appreciated the collaborative TCPB work and Sahaan's comments around language. She reflected that part of the presentation discussed work that was already being done at the counties, and she looks forward to building and sustaining regionalism in the future together. She shared that while this is framed as Metro's work, this is regional work in systems development.

Multnomah County Chair Jessica Vega Pederson shared she appreciated the comments around language and elevating culturally specific work.

Decision: Co-chair Elizalde, Yoni, Nicole L., Yvette, Cameran, Cristina P., Co-chair Rudman, Mindy, Sahaan, Monta, Washington County Chair Harrington, Metro Councilor Lewis, and Multnomah County Chair Vega Pederson unanimously approved the TA Implementation Plan.

Staff Updates

Liam Frost, Metro, stated that the counties are experiencing budget challenges for fiscal year 2026 and that collective action is needed. He shared that the four jurisdictions have been working together to problem solve and a solution has been proposed which includes Regional Investment

Fund (RIF) carryover as a potential source. He reflected that Metro wants stable and effective funding and wants to move solutions fast so that county budgets are not delayed.

Jes Larson, Washington County, reviewed budget forecasts and shortages, and that Washington County is looking at about a 15% reduction. She reflected that all three counties are experiencing this and that real people will be impacted by this including clients and case managers. She shared the jurisdictions are proposing a budget to make sure housing and services are sustained, and that the jurisdictions are working through policy and scenario questions. She stated the proposal looks at using the unallocated carryover RIF before the TCPB developed its goals.

Metro Councilor Lewis shared that stability is the priority along with maintaining and building trust with providers, the public, and the counties. She shared that if the TCPB approves the proposed budget, Metro Council will work to support code or intergovernmental agreement amendments.

Co-chair Elizalde shared that this would be an appropriate consideration and noted that this should not be an excuse for jurisdictions to make hard choices about funding.

Multnomah County Chair Vega Pederson appreciated the multijurisdictional partnership and stated that these funds are needed to transition to the next stage of planning.

Ben stated there would be further discussion at the March meeting and asked TCPB members to send questions to Metro staff via email.

Nicole L. asked if Metro could also share how much RIF funding there is and what has been allocated.

Washington County Chair Harrington asked for the proposal to make it clear that the funds being considered are the carryover RIF from years 1 and 2.

Closing and Next Steps

Ben shared that the next steps are:

- Metro to connect with Mindy regarding the opportunity to integrate Medicaid billing with TA services for high-intensity case management.
- Metro to share current RIF funding allocations.
- TCPB members to share any RIF budget proposal questions with Metro.
- Next meeting: March 12, 2025, from 4:00 – 6:00 pm.

Adjourn

Adjourned at 6:02 p.m.

To: Tri – County Planning Body

From: Clackamas County, Multnomah County, and Washington County staff leadership of Supportive Housing Services

Date: March 5, 2024

RE: One-time use of Regional Investment Funds to support the transition of reduced service delivery capacity

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The Tri-County Planning Body Charter describes the TCPB responsibilities to "review proposals from the counties that outline programmatic strategies and financial investments from within the Regional Investment Fund that advance regional goals, strategies and outcome metrics," and to "provide guidance and recommendations to the Counties on the implementation of strategies to achieve regional goals and outcomes."

This memo outlines a tri-county proposal to mitigate current funding constraints impacting service levels in all three Counties by using reserved Regional Investment Funds (RIF) to protect the goals set forth in the regional program and ensure responsible program implementation. Use of these available and unassigned RIF funds, collected prior to the establishment of the TCPB and the six regional goals, will stabilize County programs with a transition fund that reduces impacts to partner agencies and their participants as County programs downsize.

County staff will bring this proposal forward for your further consideration and consultation at the March 12th, 2025, TCPB meeting.

Background:

In December 2024, Metro released an updated 5-year SHS revenue forecast based on emerging revenue collection trends. The updated 5-year forecast estimates $51.4 million less this program year than previously forecast in November 2023. While implementing partners have always known that the SHS revenue sources are highly volatile, this extreme change in forecasted revenue presented a worst-case scenario for County programs. The scale of reductions necessitates immediate cost saving strategies to prevent overspending in current and future year budgets and plans to reduce program capacity by approximately 15% in the FY 25/26 year, or Program Year 5, base budgets.

After further financial evaluation and consultation with community-based partners over the last few months, it has become clear program reductions at this scale will require transition planning and funds to mitigate the impacts of reductions for partner agencies and their staff, and to ensure no program participants are returned to homelessness due to budget cuts.

In partnership with Metro, and the Financial Review Team, the Counties have prepared for shifts in revenue with Stabilization Reserves. These reserves were established to manage through economic downturns causing multiple years of reduced funding that would put programs and their participants at

risk. These reserve accounts constitute approximately 15% of the total annual program and thanks to unanticipated revenues in the first two program years, are fully funded.

Due to the nature of the current financial constraints resulting from a change in the forecasted tax base rather than an economic downturn, it is our recommendation to not exhaust these reserve accounts. Economic downturns may still lie ahead in our near future, uncertainty that is further exacerbated by looming cuts to federally funded homeless programs. It would be challenging, if not impossible, to refund the Stabilization Reserve accounts as County programs downsize. With County programs are at full capacity, it would take an estimated 5-7 years of stable revenue to refill the Stabilization Reserve accounts if they are fully exhausted.

Therefore, it is proposed that County transition funds be created to mitigate the impacts of program reductions to the newly forecasted reduced SHS revenue base. These transition funds should use a combination of available resources including: all unassigned funds in the County carry forward balances, including RIF reserves, as well as Stabilization Reserves and Contingency Reserves, as needed by each County.

Regional Investment Fund Reserve Proposal:

The SHS program is facing a significant regional challenge as it braces for program reductions resulting from the updated 5-year forecast. Counties are already working to scale back service levels to essential systems of care that can be sustainably maintained with reduced SHS revenue in future years. This regional challenge can be mitigated through regional coordination and the support of unassigned resources carried forward in RIF reserves, from the first two years of the regional SHS program.

At the end of Fiscal Year 23/24, the combined unassigned RIF carryforward balance is $21,976,36. These funds were set aside by the Counties in previous years while the programs were building and the TCPB had not yet been convened or established its regional plan. Today, the six goals are well established, and the implementing partners are assigning costs from the current year RIF budget in alignment with these six goals and the approved strategic plans. However, there is no current plan for using the RIF reserves from previous years. Furthermore, the six regional goal strategic plans, both approved and still under development, indicate sufficient resources in the annual 5% set aside to fully fund the strategic plan budgets; the existing RIF reserves are not necessary to achieve the outcomes of these plans. This proposal holds harmless RIF funds for this fiscal year and future years, ensuring enough resources for the TCPB to continue to advance regionalism and fund implementation plans for all six goals.

The Counties are proposing that the unassigned RIF reserve funds be used to contribute to transition funds to address programmatic expenditures that exceed revenues in FY 24/25 and budget plans for FY 25/26 to mitigate the impacts to provider agencies and their program participants. While each County will tailor their budgets and program reductions plans according to their unique county program needs, using unassigned RIF reserves for transition funds contributes to the regional goals and outcome metrics of advancing equity, creating housing stability, and reducing homelessness.

Attachment

County-Held Reserves, September 2024 Financial Report

	Clackamas County	Multnomah County	Washington County	Total
Contingency	$3,682,517	$7,825,348	$5,750,000	$17,257,865
Stabilization Reserves	$14,730,067	$15,650,697	$17,250,000	$47,630,764
Regional Implementation Fund Reserve	$2,817,479	$9,344,552	$9,814,333	$21,976,364
Total County-Held Reserves	$21,230,063	$33,286,856	$32,814,333	$86,864,993

Regional Investment Fund FAQ:

The SHS ordinance requires the counties to contribute 5% of their SHS revenue to a "regional strategy implementation fund" (Section 23.3). The intergovernmental agreements (IGAs) between Metro and the Counties say that the Counties "may use the [RIF] for expenses that are consistent with the 'measurable goals' described in the Metro SHS Work Plan at Section 5.2 until such time as the Tri-County Planning Body has developed new or different regional goals and provided the Parties with the Tri-County Plan detailing these goals."

The Tri-County Planning Body (TCPB) sets regional goals and approves implementation plans for regional goals that are developed by the three counties and Metro. The compilation of that work becomes a regional plan. This plan determines how RIF funds are to be used. Counties have received verbal guidance from Metro that RIF funds can be used for activities that align with a goal if there is not an approved implementation plan.

Each county sets aside 5% of their share of SHS funding towards the RIF. Adding that to the amount raised in previous years, the total amount set aside for the RIF from the beginning of SHS will be about $41.4 million. We forecast that about $10.7 million in RIF funds will be spent in FY23-24, which would leave a balance of about $30.5 million.

County program transition plan summaries

Clackamas County is facing a $10.4M reduction in anticipated SHS revenue in FY 24/25. To mitigate the impact of this reduction to current housing and homeless services, Clackamas County has paused the issuance of RLRA vouchers to contain both current year and long-term costs. In addition, Clackamas plans to use one-time carry over funds including $6M in RIF carryover funds previously planned for a system-wide data improvement.

To mitigate the impacts of the reduced forecast in future years, Clackamas intends to launch a Move Forward initiative, designed to assist households receiving RLRA rent subsidy to increase their incomes and either decrease the amount of rent assistance per household or increase income so that they no

longer need rent subsidy. Clackamas estimates a need for $19M to $22M in one-time funds for the Move Forward Initiative. One-time funds for the Move Forward Initiative would be derived from a combination of carryover funds (approximately $17 million), Regional Investment Fund reserves (up to $2.5 million) and Stabilization Reserves (up to $2 million).

The Move Forward Initiative would also allow Clackamas to gradually ramp down existing service provider capacity by utilizing the staff and organizations that have been providing Housing Navigation programming for the 3-year period of the initiative. Over time, as Move Forward programs increase incomes and create opportunities for households to graduate from RLRA subsidy, Clackamas will be able to begin reissuing RLRA vouchers and serving new households.

Multnomah County is expecting a $57 million shortfall in FY 2025. This is due to a $22 million downward adjustment in the forecast for ongoing funding, a gap in One-Time-Only (OTO) funding caused by under collection from Metro and exceeding our prior year spending target by about $35 million.

Starting on February 20th, the Board of County Commissioners will review budget modifications to maintain FY 2025 services. To address the deficit and preserve services, the County intends to use $7.8M in contingency, $9.3M in RIF reserves, $15.7M in stabilization reserves, and $6.5M in additional State funding for shelter operations from the SHS set-aside funds. The department will continue to identify areas of underspending to address the shortfall. Multnomah County plans to use the RIF reserves in alignment with the six goals approved by the Tri-county Planning Body Council.

Washington County has reduced current service levels in FY 24/25 by ramping down 65 beds of motel-based shelter, and reducing eviction prevention funds, programs funded with one-time funding that has been exhausted. Despite these program reductions, Washington County anticipates current year expenditures to exceed the forecasted revenue by as much as $5 million, dependent on contracted service provider spending rates. Washington County's FY 25/26 budget will reduce current service levels by approximately $15 million in annual operations. However, the draft budget will require approximately $8.3 million in one-time funding to further ramp down program capacity over the next year. These one-time funds will mitigate impacts to service providers and program participants currently enrolled in housing programs with up to 6 months of ramp-down funding for providers to complete services for participants who are near housing program graduation and ensure a smooth transition of caseloads to other providers.

Washington County currently estimates $10 to $14 million for one-time transition funds to cover program costs in FY 24/25 and FY 25/26 that exceed current revenue projections. Washington County intends to use a combination of unassigned carryover funds (approximately $7 million), Regional Investment Fund reserves (up to $9 million) and Stabilization Reservices (up to $2 million) for the transition fund. The need for transition funding will increase if revenue collections are lower than currently forecasted and may be reduced depending on the level of investment Washington County receives for new homeless services funding currently contemplated by the Oregon State Legislature.

Coordinated Entry Progress Report- FY 25, Q2

Goal

The goal of this project is to make Coordinated Entry more accessible, equitable and efficient for staff and clients.

Strategies within this goal include:

1. Regionalize visibility of participant data
2. Align assessment questions
3. Regionalize approaches to prioritization for racial equity
4. Regionalize approach to case conferencing

More information about this plan available at:
https://www.oregonmetro.gov/sites/default/files/2024/11/21/Coordinated-Entry-Regional-Implementation-Plan_0.pdf

Deliverables and Milestones

Regionalize visibility of participant data

- List of potential data visibility changes complete by *October 2025*
- Implement changes to HMIS, relevant RIOs and privacy notices *between August 2026 and February 2027*

Align assessment questions

- Create draft of proposed assessment changes- draft of common assessment questions by *August 2025*
- Once all necessary approvals have been made, implement changes in HMIS, train staff, make necessary changes to reporting *between August 2026 and February 2027*

Regionalize approaches to prioritization for racial equity

- Finalized proposed list of prioritization factors to pilot *by July 2025*
- Updated prioritization policy adopted by counties and full implementation *between December 2026 and June 2027*

Regionalize approach to case conferencing

- Statement of shared purposed for case conferencing, co-created by the three counties, and approved by coordinated entry partners and other interested parties in each county *by June 2025*
- Implementation of strategies *between August 2026 and February 2027*

Status updates

Major accomplishments/milestones in current reporting period Q2 (October 1 2024-Dec 31, 2025) and planned for next reporting period Q3 (Jan 1, 2025- Mar 31, 2025):

Strategy #1: Regionalize visibility of participant data

Q1	
Q2	• CE Regional Implementation Plan approved by TCPB • Confirmed the current data visibility capabilities between counties
Q3	• Draft language to propose changes to the existing visibility policies • Begin discussions with regional HMIS governance boards
Q4	

Strategy #2: Align assessment questions

Q1	
Q2	• CE Regional Implementation Plan approved by TCPB • Gathered detailed data on all existing County assessment questions, including specific information in HMIS and drop-down list options • Map assessment questions so the information is in an actionable format
Q3	• Gather for in-person meeting to make decisions about direction in aligning similar and unique questions currently being asked by counties • Discuss and explore how people needing services may access CE systems across the counties
Q4	

Strategy #3: Regionalize approaches to prioritization for racial equity

Q1	
Q2	• CE Regional Implementation Plan approved by TCPB • Reviewed and analyzed existing racial equity analyses previously conducted by each county • Identified common threads among these analyses
Q3	• Share between counties about existing prioritization strategies • Consider whether to build on aspects of existing prioritization strategies or to begin anew to determining prioritization approach
Q4	

Strategy #4: Regionalize approach to case conferencing

Q1	
Q2	• CE Regional Implementation Plan approved by TCPB
Q3	• Counties share dates for own county case conferencing meetings and sign up for case conferencing meetings in other counties to gather information about what is happening • Counties track questions and learning from observing these meetings
Q4	

Metrics and Outcomes

Strategy #1: Regionalize visibility of participant data: Because this goal is largely in support of the other goals articulated in this plan, the metrics associated with those goals also serve as success measures for this goal. Additionally, due to the effort required to agree upon and implement changes to HMIS in multiple counties, the end date of ***February, 2027,*** *can serve as the primary benchmark for the success of this goal. As the plan develops, additional metrics may be added to support this goal.*

Strategy #2: Align assessment questions

Metric	Goal	Timeline	Data Source	Result
Assessor experience is improved	A goal will be set as part of the CQI action step (#12)	Annual	Future qualitative data source to be identified	FY: n/a
People seeking housing experience is improved	A goal will be set as part of the CQI action step (#12)	Annual	Future qualitative data source to be identified	FY: n/a
Coordinated entry participants experience streamlined connections to service options fitting their needs	A goal will be set as part of the CQI action step (#12)	Quarterly	HMIS data on time between date of initial assessment to referral Future qualitative data source to be identified	Q1: n/a Q2: n/a Q3: Q4:

Comments on Results: *Plan is being implemented to design changes to systems and processes. These changes have not yet been made. Once changes have been made and time has passed with these changes implemented, reporting on metrics will begin. In the meantime, we will continue to develop goals and specifics to these metrics.*

Strategy #3: Regionalize approaches to prioritization for racial equity

Metric	Goal	Timeline	Data Source	Result
Increase in prioritization rate for racial and ethnic groups disproportionately impacted by homelessness a (i.e., referral rate > assessment rate for disadvantaged demographics)	A goal will be set during the third phase of implementation	Quarterly	HMIS data on coordinated entry assessments and referrals disaggregated by race and ethnicity	Q1: n/a Q2: n/a Q3: Q4:
People with lived experience of homelessness support the new prioritization factors and assessment questions	80% of black, indigenous, and other people of color with lived	One-time	Survey at step 12 (closing the feedback loop)	n/a

	experience of homelessness who are surveyed support the new model			

Comments on Results: *Plan is being implemented to design changes to systems and processes. These changes have not yet been made. Once changes have been made and time has passed with these changes implemented, reporting on metrics will begin. In the meantime, we will continue to develop goals and specifics to these metrics.*

Strategy #4: Regionalize approach to case conferencing

Metric	Goal	Timeline	Data Source	Result
Reduced length of time from assessment to match, and match to move-in for those who are case conferenced.	A goal will be set during the Design Meeting proposed in Phase 1, or beginning of Phase 2.	Quarterly	HMIS data related to average length of time in each phase of coordinated entry. By-name list data for those who are case conferenced.	Q1: n/a Q2: n/a Q3: Q4:
Better attendance and more frequent participation in case conferencing by providers.	A goal will be set during Phase 2 of this plan.	Quarterly	Case conferencing attendance tracking mechanisms and/or participant surveys, to be identified during Phase 2 of this plan.	Q1: n/a Q2: n/a Q3: Q4:
Greater provider satisfaction with case conferencing meetings.	A goal will be set during Phase 2 of this plan.	Annual	participant surveys, to be identified during Phase 2 of this plan.	n/a

Comments on results: *Plan is being implemented to design changes to systems and processes. These changes have not yet been made. Once changes have been made and time has passed with these changes implemented, reporting on metrics will begin. In the meantime, we will continue to develop goals and specifics to these metrics.*

Budget- Annual

Item	Budget
Strategy #1: Data Visibility	$200,000
Strategy #2: Assessment Alignment	$50,000
Strategy #3: Prioritization	$200,000
Strategy #4 Case Conferencing	$745,000
Total Budget	**$1,195,000**

Financial report

Although this progress report will be provided on a quarterly basis, financial reporting will be provided on an annual basis for the following reasons:

- There is limited spending on a quarterly basis and actionable changes are difficult to implement on a quarterly basis
- SHS financial reporting includes spending on regional goals, and can be consulted quarterly: https://www.oregonmetro.gov/public-projects/supportive-housing-services/progress
- Annual reporting with narratives for clarification on regional goals is in alignment with financial reporting and narratives for overall SHS reporting
- When TCPB has approved all 6 identified regional goals and their strategies, quarterly financial reporting on all goals will become administratively burdensome
- Broader conversations about funding for regional strategies require resolutions before specifics on regional financial reporting can be defined
- Annual financial reporting was the recommendation from Metro housing finance manager

Spending Narrative

In the future, this section will include a narrative on the specific funding spent to further these strategies within this goal area on an annual basis.

Tri-County Planning Body Healthcare System Alignment Goal

Regional Implementation Strategy

March 2025

Metro

CLACKAMAS COUNTY

Multnomah County

WASHINGTON COUNTY OREGON

health share

Health Share of Oregon

Tri-County Planning Body
Landlord Recruitment Goal

Regional Implementation

Plan – March

2024

If you picnic at Blue Lake or take your kids to the Oregon Zoo, enjoy symphonies at the Schnitz or auto shows at the convention center, put out your trash or drive your car – we've already crossed paths.

So, hello. We're Metro – nice to meet you.

In a metropolitan area as big as Portland, we can do a lot of things better together. Join us to help the region prepare for a happy, healthy future.

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Tri-County Planning Body Healthcare System Alignment Regional Goal and Implementation Strategy Development

After passage of the Supportive Housing Services (SHS) measure in 2020, the Tri-County Planning Body (TCPB) was formed to identify regional goals, approve a regional plan, and approve and monitor financial investments from within the Regional Investment Fund (RIF). With input from Metro, Clackamas County, Multnomah County, and Washington County ("the counties"), the TCPB identified six regional goals to be included in a regional plan; healthcare system alignment was one of those goals.

The TCPB Healthcare Goal states: Greater alignment and long-term partnerships with healthcare systems that meaningfully benefit people experiencing homelessness and the systems that serve them. *Adopted May 10, 2023.*[1]

Along with the goal, the TCPB adopted the following recommendation: "Metro staff convenes and coordinates with counties and key healthcare systems stakeholders to identify opportunities that integrate the Medicaid waiver with the SHS initiative."

With the TCPB goal named, staff from Metro and the counties, along with Health Share of Oregon (HSO) – the primary coordinated care organization serving Oregon Health Plan members in Clackamas, Multnomah, and Washington counties – formed the Healthcare/Housing Systems Alignment Regional Leadership Group (Leadership Group), meeting nine times from November 2023 to February 2025, to discuss shared healthcare system alignment challenges, brainstorm solutions, and develop the strategies within this document. To support the Leadership Group's work, Metro also convened two working groups – a Regional Healthcare System Alignment Implementation planning subgroup of the Leadership Group (the Subgroup) and a Healthcare/Housing Data Integration Workgroup composed of data-focused staff from all three counties, HSO, and the Oregon Health Leadership Council – to focus on strategy development and necessary data-integration efforts to support regional cross-system alignment and coordination. The Data Workgroup met monthly beginning in January 2024 and the Subgroup met at least monthly beginning in March 2024.

To guide regional strategy development, the Leadership Group directed Metro, through its consultant Homebase, to conduct a Landscape Analysis of existing housing/healthcare systems alignment efforts throughout the region to ensure that any proposed regional strategies would build from ongoing work, rather than risk duplication, conflicts, or redundancies. The purpose of the Landscape

[1] Tri-County Planning Body Goal and Recommendation Language, May 10, 2023. https://www.oregonmetro.gov/sites/default/files/2023/10/26/2023-tcpb-goals-and-recommendations-20230510.pdf

Analysis was to identify themes, including common priorities and challenges, and highlight opportunities for regional coordination, scaling, and sustainability of cross-system efforts and systems alignment. The Landscape Analysis (provided as Appendix A) summarized ongoing systems alignment efforts, organized by efforts happening regionally, in multiple counties, and within each individual county. The Landscape Analysis concluded with a section that – based on current efforts – outlined the following primary priority areas across the region:

- Medically enhanced housing models (e.g., medical respite/recuperative care, aging in place programs) as a regional need
- Cross-system care coordination for people experiencing or at risk of homelessness who have complex physical and behavioral health care needs (including, for example, via cross-system case conferencing, coordinated hospital discharge planning)
- Cross-System Data Sharing
- Leveraging Medicaid and other health system resources (e.g., Medicaid 1115 Waiver Implementation, accessing co-located services and supports, flex funds)

Metro and its consultant Homebase then worked with the planning Subgroup to utilize the Landscape Analysis and the identified priority areas as a starting point for developing this implementation strategy.

The first three of those four priority areas ultimately led to the three strategies in this document. Although leveraging Medicaid, including through strategic implementation of Oregon's new health-related social needs (HRSN) benefit through the state's Medicaid 1115 waiver, remains a high priority for all partners, the counties – both individually and in coordination with each other – have invested significant time in planning for implementation of the 1115 waiver benefit, including in partnership with HSO. Given the complexity and breadth of the ongoing work in this area, as well as the narrow scope of the population eligible for the benefit, the counties and HSO did not feel it necessary to include a waiver-specific regional strategy in this implementation strategy at this time. However, the phased approach will allow for continued communication (including insights and lessons learned from initial waiver implementation) and coordination relating to Medicaid throughout 2025. As such, Medicaid-focused regional strategies can be included in the more detailed plans for continued activities and investment that will be implemented beginning in 2026, as appropriate.

It is important to note that the 1115 waiver benefit is just one aspect of potential Medicaid funding and coordination with the housing and homelessness response system. The strategies set forth in this document will seek additional opportunities to leverage Medicaid and other health system funding opportunities wherever possible. The proposed implementation budget for this implementation strategy includes FY 25-26 RIF allocations for staff and other needed capacity to continue and expand efforts to leverage Medicaid (including but not limited to implementation of the 1115 waiver housing benefit) and other health system resources.

The population of focus for this implementation strategy are people who meet the criteria of the Supportive Housing Services program Population A. That is: households with extremely low incomes, one or more disabling conditions, and experiencing or at imminent risk of experiencing long-term or frequent episodes of literal homelessness, and who have physical or behavioral health needs (regardless of whether those needs are currently diagnosed or otherwise known) that are not being fully treated or addressed. However, the system improvements and cross-sector collaborations that will be achieved through these strategies will have a positive impact across all populations served by SHS as well as the workforce striving to meet their needs.

Regional Issue

Homelessness is a complex regional issue that transcends jurisdictional lines, and there is an inextricable, reciprocal link between housing status and health outcomes. Deep siloes between health and housing systems often contribute significantly to barriers for people experiencing and at risk of homelessness to access the critical, and often lifesaving, housing resources and health care services they need. People in need of housing resources and health care treatment often move throughout the region, across county lines, to access assistance. Our housing and homeless response and health care systems must coordinate across the region to facilitate needed referrals and connections to people engaging with multiple systems in multiple counties. A coordinated and regional approach to housing and healthcare systems alignment is central to the work of meaningful systems change and sustainable systems integration needed to improve health and housing outcomes for people across the Metro region.

Building on the impressive systems alignment work already underway in Clackamas, Multnomah, and Washington counties, this implementation strategy enhances these efforts by providing regional coordination support and capacity building, and addressing infrastructure needs identified by the counties, Health Share, and Metro with input from service providers and other partners. The process will involve convening regional meetings, planning, and coordinating efforts to establish shared goals and innovative models for systems improvement. By learning from one another, each county can adapt successful strategies in the way that suits their needs while the region defines and implements supportive infrastructure to ensure sustainable, regional support for continued expansion and improvement of cross-system care coordination and other critical system alignment.

Racial Equity Considerations

Central to the work of the Supportive Housing Services (SHS) Measure is the guiding principle of leading with racial equity and racial justice, with a charge to reduce racial disparities in homeless service outcomes across the region. The counties, HSO, and Metro have committed to addressing the goals outlined by the Tri-County Planning Body (TCPB) while embedding equity in the development and implementation of our work together.

The Healthcare System Alignment strategies in this document center racial equity, focusing on a plan that will result in measurable improvements in equitable access to housing programs. The historical

and contemporary housing and healthcare discrimination and systemic racism toward people who identify as Black, Indigenous and people of color (BIPOC), people with low incomes, immigrants and refugees, the LGBTQ+ community, people with disabilities and other underserved and/or marginalized communities impact people's ability to gain and maintain stable housing and achieve positive health outcomes. These strategies aim to empower individuals and the systems in place to support them with their housing and healthcare goals, expand access to coordinated care and housing resources for historically oppressed communities, and reduce disparities in housing and healthcare access and outcomes among historically marginalized groups.

To this end, the counties, HSO, and Metro have coordinated with health-focused and equity staff with a goal of ensuring all strategies contribute to the reduction of racially disparate outcomes. This included an initial equity lens analysis using the shorthand racial equity lens tool (RELT) developed by Multnomah County.

The shorthand RELT exercise took place on November 21, 2024. The conversation was facilitated by consultants, Homebase, with support from Ruth Adkins (Senior Housing Policy Analyst) and Alexandra Appleton (Equity Manager) with Metro. Representatives from all three counties and HSO participated in the conversation. The RELT shorthand exercise consists of six questions, the first four of which were discussed during the meeting on November 21. Based on this discussion, the group agreed on changes to this proposal, which are listed below and reflected in the relevant strategy sections below:

- Working groups formed and tasked with continued coordination and planning during Phase 1 should be racially and culturally representative of people experiencing or at risk of homelessness across the region. If that is not possible within each working group, it should be collectively achieved when considering working groups established across implementation efforts of all strategies.

- Phase 1 activities should include the involvement of additional partners, including culturally specific health and housing organizations and people with lived expertise and experience of homelessness. Focus groups or other methods to solicit input from people with lived experience of homelessness should aim to include racially and ethnically representative groups.

- Additional Racial Equity Analyses should be conducted during Phase 1, especially with respect to detailed implementation plans developed for Phase 2, and individual strategies or the plan as a whole should be adjusted as needed in response to those analyses.

- Available data relating to program or system access and utilization, as well as the outcomes of any health and housing alignment programs or efforts, should be disaggregated by key demographics and analyzed to inform the development of strategies, implementation plans for Phase 2, and any corresponding performance metrics or progress measures.

- Metrics developed to track progress on this overall plan, as well as the individual strategies, should include racial equity metrics to ensure that the impacts of plan implementation are racially equitable.

In keeping with Metro's commitment to advance racial equity, and the Supportive Housing Services Program's overarching goal to ensure racial justice, data will be disaggregated to evaluate existing and continued disparate impacts for BIPOC communities and other impacted populations. As such, all available data sets will be disaggregated by regionally standardized values and methodology to understand disparate outcomes for people by race, ethnicity, disability status, sexual orientation and gender identity. Where relevant data are not available or comparable across the homeless response and healthcare systems, those gaps will be identified and strategies identified to mitigate or address those gaps.

Notes from the RELT analysis discussion are included as Appendix B. The work group also affirmed that deeper RELT analysis will be performed during the Phase 1 ongoing coordination and evolving implementation planning during 2025. This will include collaboration with Metro, County, and HSO equity teams as well as providers and additional engagement with people directly impacted by the proposed strategies.

The strategies in this proposal also reflect input from people with lived experience of homelessness. Consultants from Homebase facilitated five focus groups (two each in Multnomah and Clackamas counties and one in Washington County) for people with lived experience of homelessness on July 30th-August 1st, 2024. The focus groups covered multiple topics, including accessing healthcare and unaddressed health needs.

Many participants reported negative experiences with hospital systems, including several participants who were discharged to the street or only given cursory referrals, such as resource sheets or recommendations to call 211. Without mention by facilitators of respite and recuperative care as potential solutions, one group of participants suggested that these types of programs would be a valuable addition to the continuum of services available in their county. Notes from the focus groups are included as Appendix C.

The strategies in this proposal – particularly those aimed at supporting post-acute care via medically enhanced housing and shelter models and better cross-system care coordination – aim to address the concerns elevated during the focus groups by facilitating more streamlined and empathetic access to healthcare services and housing, including from and following hospital settings.

Strategy #1: Develop Regional Plan for Medically Enhanced Housing and Shelter Models

Program Description

Vision for Strategy 1

Medically enhanced housing and shelter models are a critical transitional step for people leaving hospitals or institutional healthcare settings and provide a safe, stable and supported environment for ongoing recovery. These models can include medical respite or recuperative care, as well as co-location of physical and behavioral health services and housing models such as Permanent Supportive Housing (PSH), recovery housing, transitional housing, and other programs.

This strategy seeks to align with current state and local efforts to work toward a regional model of support for access to and sustainable funding of post-acute care options for people experiencing homelessness. This would not only directly support long-term partnerships between the homeless response and healthcare systems but also ensure improved access to these critical resources for people experiencing or at risk of homelessness throughout the region.

Building on Existing Efforts

This strategy builds upon the work already happening to support medically enhanced housing and shelter models throughout the region, including: recuperative and respite care programs in each county, Kaiser Permanente's 2023-2025 grant to a cohort of medical respite programs in partnership with National Institute of Medical Respite Care (NIMRC), and coordination by Metro to engage housing and health system partners in conversations regarding service levels and stratification of levels of care in Permanent Supportive Housing (PSH).

Proposed Regional Activities

This strategy will align with and support regional implementation of the statewide recommendations made in November 2024 by the Oregon Joint Task Force on Hospital Discharge Challenges, as well as other systems change work at the state level related to post-acute care including access, funding, and workforce. HSO and its health plan and hospital partners will be deeply engaged in this state-level work; the regional strategy will support and align with that body of work. This strategy also aligns with the State of Oregon Homelessness Response Framework and the Strategic Pillar defined therein on cross system alignment. Additionally, strategies and deliverables identified in this document will coordinate and align with strategies identified in the Portland/Multnomah Homelessness Response Action Plan (HRAP) related to navigating individuals leaving institutional healthcare systems to the appropriate setting for their needs. Learnings from implementation of Oregon's new health-related social needs (HRSN) benefit through the state's Medicaid 1115 waiver will also inform implementation of this strategy.

Timeline, Deliverables, and Milestones

Updates will be shared in the TCPB's monthly progress reports, and more substantial information will be provided quarterly starting in September 2025 to align with current SHS program reporting frequency.

It is anticipated that the items listed in the **Phase 1** chart below will be complete by the **end of 2025, if not sooner,** with interim goals and milestones to complete key planning activities. Deliverables, details, and specific timelines for work beyond the initial implementation phase will be determined during Phase 1. Staff will develop timelines for each deliverable listed below, which will be reported to the committee in the quarterly progress reports.

Metro will be responsible for ensuring the progress of all planning and coordination activities necessary to achieve the Phase 1 deliverables for this strategy, working in close partnership with partners. Metro's intent is to support and enhance existing work led by HSO, other healthcare partners, and/or the counties.

Phase 1 – Coordination and Continued Planning	
Deliverables	**Details**

Crosswalk and plan of engagement with existing efforts to support post-acute care for people experiencing or at risk of homelessness, with an initial focus on medical respite/recuperative care programs and funding streams.	• Convene working group to review recommendations and strategies for supporting medically enhanced housing and shelter models established by:
	  ○ Oregon Joint Task Force on Hospital Discharge Challenges
	  ○ State of Oregon Homelessness Response Framework
	  ○ Portland/Multnomah Homelessness Response Action Plan (HRAP)
	  ○ Any other relevant work underway
	• Establish a workgroup focused on supporting new/emerging medical respite programs in the tri-county region in partnership with health systems and hospitals, while monitoring and engaging in the longer-term work happening at the state level
	• Determine plan of engagement with state and Portland/ Multnomah County HRAP processes to avoid duplication and identify areas where support is needed at the regional level
	• Provide coordination support and facilitate tri-county learning and coordination (including potentially through engaging the National Institute for Medical Respite Care or other consultants) from ongoing medical respite and other medically enhanced housing and shelter pilots and programs in Clackamas, Washington, and Multnomah counties.

	• Coordinate with ongoing efforts to engage housing and health system partners in conversations around service levels and stratification of levels of care in Permanent Supportive Housing (PSH) • Identify any current or emerging opportunities for immediate impact while the longer-term planning continues • Define clear areas for regional alignment, impact, and value add for each of these efforts and initiatives for further action planning • Analyze available data (including data related to post-acute care options in the region and outcomes of existing medically enhanced housing programs) disaggregated by demographics to evaluate existing and continued disparate impacts for BIPOC communities and other impacted populations in order to inform development of strategies and implementation plans for Phase 2 and any corresponding performance metrics or progress measures • Through working group, develop phase 2 regional action plan, including key action items and funding needs that support, enhance, and align with regional implementation of Oregon Joint Task Force on Hospital Discharge Challenges recommendations and HRAP implementation • *Note: Phase 1 activities should include the involvement of additional partners, including culturally specific health and housing organizations and people with lived expertise and experience of homelessness. Working groups should be representative of people experiencing or at risk of homelessness across the region to the fullest extent possible, including people who identify as Black, Indigenous and people of color, people with low incomes, immigrants and refugees, the LGBTQ+ community, people with disabilities and other underserved and/or marginalized communities.*

Details regarding continued work beyond the initial implementation phase will be determined through Phase 1 activities to ensure alignment with implementation of state legislative activity and state-level post-acute care recommendations as well as Portland/Multnomah County HRAP implementation and ongoing work relating to medical respite and other medically enhanced housing and shelter models in Clackamas and Washington counties.

Phase 1 milestones will be refined, and new metrics and milestones **may** be added. Because urgency is warranted when it comes to facilitating improved access to health and housing resources for people experiencing homelessness, staff will work to support all partners involved in this strategy to be able to complete the Phase 1 milestones below within the first half of 2025 if possible. However,

meaningful inclusion of additional partners and other equity considerations, as well as ensuring alignment with ongoing funding and policy changes may warrant the additional time contemplated.

Phase 1 Milestones	**Goal**
Initial work sessions scheduled and medical respite/recuperative care workgroup launched	March 31, 2025
Consultant hired to support/facilitate Strategy #1, if needed *Note: Existing consultant will continue under contract with Metro for ongoing support of the healthcare strategies overall*	May 31, 2025
Crosswalk of existing efforts to support medically enhanced housing and shelter models and opportunities for regional alignment/impact	May 31, 2025
Preliminary outline for Phase 2 strategies and associated FY 25/26 funding and other implementation needs	June 30, 2025
Racial Equity Lens applied to emerging strategies through RELT exercise	June 30, 2025
Progress update: identify any short-term actions, provide roadmap for next 3-6 months	September 30, 2025
Plan draft shared with key partners, additional RELT exercises conducted, as needed	October 17, 2025
Feedback process completed	December 1, 2025
Complete detailed plan for strategies and investments beyond 2025	December 31, 2025

Strategy #2: Establish Regional System for Cross-System Care Coordination

Program Description

Vision for Strategy 2

This strategy seeks to provide regional supports for cross-sector case conferencing and other care coordination efforts happening and in development throughout the region. This will facilitate the improvement, expansion, and sustainability of care coordination between housing and healthcare systems and providers that benefits both systems and people experiencing homelessness who have complex health care needs.

Building on Existing Efforts

Cross-sector case conferencing – a critical aspect of care coordination that involves bringing together health and housing system partners to identify and discuss shared clients and coordinate care to meet their comprehensive needs – is underway in each county in the region, at various points of implementation. The partners involved in each county are working to share information to learn from one another. As successful as this case conferencing has been, the number of people impacted is small relative to the number of people experiencing homelessness in the region, and current case conferencing efforts are focused within each county. Regional infrastructure and support would allow for the successes of ongoing cross-system case conferencing and other cross-system care coordination efforts to be scaled and made sustainable to increase efficiency and impact at the individual, provider, and system levels.

In response to this regional need, over the past year Health Share has developed a proposal for a new Regional Integration Continuum (RIC), which will be a collaboration of Health Share, health system partners, county teams, healthcare and housing/homelessness service providers, and Metro and will include lived experience of homelessness voices as well. The RIC will be convened by Health Share and coordinated by a new Health and Housing Integration team housed at Health Share.

Additionally, the City of Portland/Multnomah County Homelessness Response Action Plan (HRAP) calls for development of a platform to enable service providers to support clients with health care information and services (Action Item 7.2.7). The RIC will align with this HRAP action item and other efforts related to care coordination and health care access.

In addition to the RIC and other health/housing projects underway, each county's health/housing team has requested support from Metro to assist their efforts to better understand and connect to the landscape of local and state resources related to behavioral health and other systems of care.

Proposed Regional Activities

This strategy proposes increased infrastructure to address gaps in data sharing, staffing, resource navigation and communication. A new regional care coordination model will build upon the successes of each county's cross-sector case conferencing to better enable more people who interact with the housing system to access healthcare (including behavioral health) resources throughout the region and vice versa.

Timeline, Deliverables, and Milestones

Updates will be shared in the TCPB's monthly progress reports, and more substantial information will be provided quarterly starting in September 2025 to align with current SHS program reporting frequency.

It is anticipated that the items listed in the **Phase 1** chart below will be complete by the **end of 2025, if not sooner,** with interim goals and milestones to complete key planning activities. Deliverables, details, and specific timelines for work beyond the initial implementation phase will be determined during Phase 1. Staff will work on developing timelines for each deliverable listed below, which will be reported to the committee in the quarterly progress reports.

As lead convener of the RIC, Health Share will be responsible for ensuring the progress of all planning and coordination activities necessary to achieve the Phase 1 deliverables for the RIC, working in close collaboration with Metro, the counties, and other partners.

Metro will be responsible for supporting the behavioral health resource mapping project, working in collaboration with the counties.

Phase 1 – Coordination and Continued Planning	
Deliverables	**Details**
Establish Regional Integration Continuum (RIC) between Health Share, Clackamas County, Multnomah County, Washington County, and identified partners	• Convene regional table around Healthcare and Housing Integration. • Identify area of housing continuum focus for each county • Engage county stakeholders in data sharing agreement, agreeing on language to move forward to legal teams • Create infrastructure for cross-sector case conferencing sustainability in each county, including partner Memorandums of Understanding • Onboard additional homeless service providers and settings in each county beyond initial pilot populations • Identify critical data elements that need to be shared across systems to maximize cross-system case conferencing and

	other care coordination efforts. Consider data elements needed to ensure racial equity of case conference and care coordination implementation. • Analyze available data (including data relating to access to and outcomes of ongoing cross-system care coordination programs), disaggregated by demographics in order to evaluate existing and continued disparate impacts for BIPOC communities and other impacted populations and inform development of strategies and implementation plans beyond 2025 and any corresponding performance metrics or progress measures • Identify training and capacity needs (including in consultation with people with lived experience and expertise of homelessness) to ensure health system frontline staff who will receive referrals of people experiencing homelessness as part of the RIC are able to provide culturally appropriate and trauma-informed care and services. Consider strategies to support pipeline programs for underrepresented professionals in healthcare and housing (e.g., bilingual health navigators) • *Note: Phase 1 activities should include the involvement of additional partners, including culturally specific health and housing organizations and people with lived expertise and experience of homelessness.*
Action plan to improve awareness among housing providers of available behavioral health care and related resources and improve access to those resources by people experiencing or at risk of homelessness	• Review existing county efforts to conduct landscape of behavioral health care and related resources and gaps • Identify and engage additional partners with knowledge of or access to behavioral health care and related resources (including within county departments) • Align on the most critical gaps in access to behavioral health resources – including those that disproportionately impact underserved groups like Black, Indigenous, and other people of color and transgender people and others who identify as part of the LGBTQ community – and the primary causes of those gaps • Explore options to improve housing providers' awareness of existing behavioral health resources and how to access them (e.g., education campaign/trainings; development of resource map, reference sheets, or other materials designed specifically for housing providers)

	• Explore strategies to improve access to behavioral health and related resources for people experiencing or at risk of homelessness (e.g., inclusion of more behavioral health providers/resources into cross-sector case conferencing and/or RIC; development of new workflows or processes for referrals and follow up) • *Note: This may include one or more convenings to bring behavioral and other health care providers together with housing providers to discuss the reasons behind critical behavioral health gaps and strategies to ensure connections to available resources to fill those gaps.*

Details regarding continued work beyond the initial implementation phase will be determined through Phase 1 activities as described above. The planning work group identified potential strategic considerations and action steps for beyond Phase 1, which are included in Appendix D for reference.

Phase 1 milestones will be refined, and new metrics and milestones **may** be added. Because urgency is warranted when it comes to facilitating improved access to health and housing resources for people experiencing homelessness, staff will work to support all partners involved in this strategy to be able to complete the Phase 1 milestones below within the first half of 2025 if possible. However, meaningful inclusion of additional partners and other equity considerations, as well as ensuring alignment with ongoing funding and policy changes may warrant the additional time contemplated.

Phase 1 Milestones for RIC	**Goal**
RIC launched	March 31, 2025
RIC progress report	September 30, 2025
RIC year-end report with plan for 2026, including Racial Equity Analysis	December 31, 2025
Phase 1 Milestones for Behavioral Health-related effort	**Goal**
Convene county partners to review existing efforts and identify next steps	April 30, 2025
Engage additional partners as needed	May 31, 2025
Initial draft action plan complete, including Racial Equity Analysis	July 31, 2025
Interim report: progress update	September 30, 2025

Action plan complete	December 31, 2025

Strategy #3: Build Regional Cross-System Data Sharing Infrastructure

Program Description

Vision for Strategy 3

This strategy seeks to build upon existing data sharing activities occurring in individual counties in order to create a regional data sharing infrastructure that allows the region's healthcare and housing partners to collaborate in new and unprecedented ways. A comprehensive data sharing infrastructure would enable healthcare and housing partners to quickly and easily identify shared clients, facilitate cross-sector interventions, and evaluate the health and housing outcomes of those interventions, all with the aim of improving housing and healthcare outcomes for people experiencing or at risk of homelessness.

Building on Existing Efforts

These efforts aim to enhance cross-sector coordination and build upon existing data sharing efforts already occurring across the region. Each county currently has a data sharing agreement with Health Share to support different initiatives, including case conferencing and Frequent User Systems Engagement (FUSE) efforts. The data sharing agreements and approaches deployed in each county have been critical for individual cross-system efforts. Now that their utility has been tested, they can be used as a foundation for more comprehensive data sharing across the region.

Additionally, the three counties collaboratively launched a new instance of HMIS in the Spring of 2024. While remaining on the same HMIS software, the central administration of the system moved from Portland Housing Bureau to Multnomah County's Department of County Assets (DCA). In the new HMIS, Tri-County partners have improved upon the visibility of data. At the same time, each Continuum of Care is working with DCA on a plan to transition to a new HMIS platform. This transition provides an opportunity to consider how HMIS can better integrate with the healthcare system at the regional level.

This strategy aligns with strategic frameworks and goals around data sharing at the federal, state, and local levels – specifically HUD resources such as the Homelessness and Health Data Sharing Toolkit; Oregon's Strategic Plan for Health Information Technology 2024-2028; the State of Oregon's Homelessness Response Framework, which commits to cross-agency data sharing activities to address homelessness; and City of Portland/Multnomah County Homelessness Response Action Plan (HRAP), which highlights the need to establish data sharing protocols with the City of Portland, Metro, and the State of Oregon.

Proposed Regional Activities

Building on the Healthcare/Housing Data Integration Workgroup which has been meeting monthly since 2024, this strategy involves solidifying regional data sharing implementation and advisory collaboration that can work to apply the successful data sharing approaches in individual counties to the whole region. This includes creating shared legal approaches to data sharing and developing bi-directional data sharing templates that could be adopted across different counties for different data sharing purposes. The workgroup will also articulate the technological infrastructure necessary for real-time data sharing across systems, including the counties' shared HMIS platform. This strategy will provide a regional table for strategic consultation, coordination and problem solving around health/housing data integration, while ensuring alignment with existing data governance bodies and their authority.

Timeline, Deliverables, and Milestones

Updates will be shared in the TCPB's monthly progress reports, and more substantial information will be provided quarterly starting in September 2025 to align with current SHS program reporting frequency.

It is anticipated that the items listed in the **Phase 1** chart below will be complete by the **end of 2025, if not sooner,** with interim goals and milestones to complete key planning activities within the first six months of 2025. Deliverables, details, and specific timelines for work beyond the initial implementation phase will be determined during Phase 1. Staff will work on developing timelines for each deliverable listed below, which will be reported to the committee in the quarterly progress reports.

Metro will be responsible for ensuring the progress of all planning and coordination activities necessary to achieve the Phase 1 deliverables for this strategy.

Phase 1 – Coordination and Continued Planning	
Deliverables	**Details**
Define vision for regional data sharing implementation and advisory team and framework	• Update and maintain ongoing tracker for landscape of existing and related data sharing activities and governance structures at local, regional, and statewide level • Solidify data sharing implementation and advisory workgroup, with members from counties, Continuums of Care, Health Share, Metro and others • Identify short, medium, and long-term goals and purpose for data sharing implementation and advisory team and framework. This discussion should include goals relating to leveraging data-sharing and analysis to monitor performance metrics and outcomes for BIPOC communities and other impacted populations, including identifying and

	addressing data gaps for undocumented individuals and non-traditional subpopulations • Identify any current or emerging opportunities for immediate impact while the longer-term planning continues • Identify regional data sharing priorities that allow for deeper healthcare/housing systems integration across all three counties • Provide support to counties and other partners to clarify use cases, opportunities, and legal considerations related to data sharing • Establish and strengthen partnerships with existing data governance bodies (including tri-county HMIS governance body) and processes that connect to local, regional, and statewide data sharing efforts, such as the tri-county HMIS implementation, PointClickCare or Unite Us • *Note: Phase 1 activities should include the involvement of additional partners, including culturally specific health and housing organizations and people with lived expertise and experience of homelessness. Working groups should be representative of people experiencing or at risk of homelessness across the region to the full extent possible, including people who identify as Black, Indigenous and people of color, people with low incomes, immigrants and refugees, the LGBTQ+ community, people with disabilities and other underserved and/or marginalized communities.*

Details regarding continued work beyond the initial implementation phase will be determined through Phase 1 activities as described above, but will likely focus on two strategic areas: 1) development of regional data sharing approaches; and 2) defining data infrastructure needs for bi-directional, real-time data sharing. The planning work group identified potential action steps for each of these areas, which are included in Appendix D for reference.

Phase 1 metrics and milestones **may** be refined and are subject to adjustment.

Phase 1 Milestones	**Goal**
Create tracking document of activities and initial working list of data sharing goals and use cases for ongoing consideration by regional data sharing workgroup	April 30, 2025

Racial Equity Lens applied to emerging strategies through RELT exercise	June 30, 2025
Interim report: identify any short-term actions, provide roadmap for next 3-6 months	September 30, 2025
Complete charter for the data sharing implementation and advisory team, including top data sharing priorities for the counties, Health Share, and CoCs	October 31, 2025
Complete detailed plan for strategies and investments beyond 2025	December 31, 2025

Planning and Implementation Considerations

In developing the regional plan structure, the TCPB adopted in December 2022 a set of criteria intended for reviewing proposed implementation plans. We have utilized those criteria to summarize below how staff are addressing additional considerations in this regional implementation strategy.

- **Compliance with TCPB Charter**

  The TCPB charter states that the TCPB is responsible for developing and implementing a Tri-County initiative and will be responsible for identifying regional goals, strategies, and outcome metrics related to addressing homelessness in the region. To this end, one of the TCPB's responsibilities is to review proposals that outline programmatic strategies and financial investments from the Regional Investment Fund (RIF) that advance regional goals, strategies, and outcome metrics. This implementation strategy provides the committee with the information necessary to carry out the assigned function outlined in the charter.

- **Feasibility**

  The counties, Health Share, and Metro have determined that this implementation strategy is feasible to fulfill given existing health/housing projects already underway, the requested funding allocation, the proposed technical support provided by qualified consultants, and leveraging the established meeting space and staffing for ongoing healthcare system alignment meetings.

- **Staff capacity**

  The implementation strategy counts on leveraging existing staff capacity and meetings to work together in operationalizing and coordinating the work and ensuring healthcare system alignment work is supported by the RIF. It also considers identifying tasks that should be supported by qualified consultants for strategic support. An important consideration will be

to understand the potential trade-offs in the pace of implementing, given that more pre-work will result in a stronger program while there is an immediate need to address urgent unmet health needs of people within the housing and homeless response continuum.

- **Infrastructure**

  It will take our region time to create an infrastructure that supports meaningful alignment of two robust and complex systems across three separate counties. As new initiatives launch, roles and responsibilities for each county, health system partners, and Metro must be collaboratively identified. This implementation strategy proposes to utilize the expanded capacity of the Metro Housing Department, housing/healthcare system alignment staff within each county, and new housing integration capacity within HSO to lead this work. In addition, cross-system alignment and coordination relies heavily on a well-functioning Coordinated Entry System, Homeless Management Information System (HMIS), and Electronic Health Records (EHR). Coordination between and among healthcare system alignment efforts, regional HMIS efforts, and regional Coordinated Entry efforts will remain vital.

- **Local Implementation Plan (LIP) Alignment**

  Commitments and strategies to improve health services alignment with housing and homelessness programs and to align and leverage other systems of care (including health systems) have been identified as a need in Washington County's LIP (p. 20-21), Multnomah County's LIP (p. 26) and Clackamas County's LIP (p. 29). The counties' LIPs focus on the urgent need to expand access to and coordination of behavioral health care, while also mentioning the need for improved and expanded access to primary and physical care. Although this proposal is not intended to address all facets of or be the primary driver for addressing the state's or region's urgent need for improved access to behavioral health care, the strategies in this proposal will support and align with efforts underway throughout the region and at the state level, for example, through the City of Portland/Multnomah County Homelessness Response Action Plan (HRAP), the state Joint Task Force on Hospital Discharge Challenges, the 2025 state legislative session, and other behavioral health efforts.

- **Unintended Consequences**

  With any systems change come unintended consequences. While the counties and Metro, along with Health Share, have worked hard to identify and mitigate any foreseeable consequences, there will always be some things that are not able to be mitigated or accurately predicted.

  Potential consequences include a general change burden on both housing and healthcare systems and improper data sharing. Program staff, leadership, and service providers in both the housing and healthcare systems all bear some burden in learning and adapting to changes in the system. When sharing data more broadly and/or freely, there is always the increased

chance of a data breach or data being shared improperly. Any data sharing agreement will make all attempts to prevent any breach, and yet it is still a possibility that could come with unintended consequences.

While all partners involved focused heavily and intentionally on mitigating potential duplication, conflicts, or redundancies, it is important to note that these are still potential consequences due to the breadth and depth of the Medicaid Waiver implementation and healthcare system alignment work happening across the region. Using a phased approach in developing each strategy will allow for continued communication and coordination, thereby lowering the risks of duplication and providing time to monitor potential changes in funding and policy that may have an impact on strategic priorities in the housing and healthcare systems.

- **Building on Existing Efforts**

  As highlighted above, there is an incredible amount of work currently underway across the region to support health and housing systems alignment and integration, and this regional effort would not be possible without the work of the counties and their health system partners. Appendix A includes a Regional Housing and Healthcare Systems Alignment Landscape, developed in partnership with Metro, Clackamas County, Washington County, Multnomah County, and HSO, which summarizes those efforts. That Landscape Analysis served as the foundation for this implementation strategy's development, ensuring that regional strategies do not duplicate current work but rather enhance these efforts by identifying opportunities to support continued coordination and fill resource and other gaps in existing work.

Additionally, there is substantial work underway to implement Oregon's new health-related social needs (HRSN) benefit, created through the state's recent Medicaid 1115 waiver. The Leadership Group meetings throughout 2024 included focused discussions about waiver implementation planning, including regional coordination around those planning efforts. While this continuing work to implement the new benefit is not included in this implementation strategy as a standalone activity, the strategies outlined here will be informed by that effort, and will also connect to efforts to identify opportunities to leverage other sources of Medicaid funding in addition to the HRSN benefit. The implementation of these strategies will include facilitating regional conversations and coordinating meetings to ensure continued alignment of health and housing systems coordination across the region.

Phased Approach

Implementation of these strategies is proposed as a phased approach. The initial phase (Phase 1) will accelerate overall coordination and planning across the homeless response, housing, and health care systems to define required investments and programming to fully implement each of the three strategies. Phase 1 is anticipated to be completed during 2025 and includes interim goals and

benchmarks to complete key planning activities, while also allowing flexibility for refinements and adjustments to engage additional partners, monitor policy and funding changes, conduct additional racial equity analyses, and reflect changes in regional needs. The ongoing coordination and planning of Phase 1 will result in the development of more detailed plans for TCPB and other partners to consider and approve for action beyond Phase 1.

During Phase 1, the partners will also identify any immediate or short-term program or system improvements that could bring relief during 2025 to homeless service providers struggling to support participants with unmet healthcare needs. Impacts of these improvements will contribute additional momentum toward longer-term systems change while providing immediate care and support for vulnerable people.

The intention of the phased approach is two-fold: 1) to allow additional time for continued coordination and learnings; and 2) to allow for identification and securing of sufficient, sustainable funding sources to support ongoing regional system alignment work. Phase 1 allows for:

- additional time for continued coordination and learnings from ongoing system alignment work, legislative activity, and emerging policy recommendations – within the region and at the state level – so that the regional collaboration of housing and health care partners can produce a more well-informed detailed plan that is strategically responsive to remaining gaps and emerging priorities; and
- identification and securing of sufficient, sustainable funding sources and development of a collective funding plan to support ongoing system alignment work beyond Phase 1. This includes availability of SHS and RIF as ongoing funding sources as well as identification of additional funding sources through leveraging Medicaid and other health system resources.

The scale and scope of any Phase 2 implementation plan(s) that emerge by the end of 2025 will depend not only on learnings from ongoing work and priorities identified in response, but also on the feasibility of pursuing specific strategies and available funding.

While all parties are fully committed to this work, there is a real, practical need to maintain flexibility given the quickly evolving regional landscape of system alignment work and the changing funding ecosystem (including potential SHS funding level reductions in future years as well as potential health system resources to leverage). The proposed phased approach allows for this crucial flexibility and balances the need to support continued and expanding systems alignment work through immediate action with the need to conduct additional racial equity analyses, bring in additional partners, and develop a plan for continued regional work that will be feasible, impactful, and maximally responsive to current needs.

Budget

As described above, this implementation strategy focuses on an initial phase (Phase 1), which will include defining required investments and programming to fully implement each of the three strategies. The budget included herein relates only to Phase 1 activities, including each county's

existing FY24-25 budget allocation of RIF to support the healthcare regional goal through the end of June 2025, and Metro's investment of its SHS administrative funds toward consultant support plus a seed investment for staffing at Health Share. The counties are also making additional investments in health/housing integration staffing beyond the RIF. Through the course of the Phase 1 activities outlined above, the partners will seek to identify additional funding needed to support continued implementation for the remainder of Phase 1 and beyond.

We anticipate a total of **$1,824,905** in RIF investment for FY25-26 will be needed to support Phase 1 of this implementation strategy.

Updates will be shared in the TCPB's monthly progress reports, and more substantial information, including budget expenditure, will be provided quarterly starting in September 2025 to align with current SHS program reporting frequency.

The counties reserve the right to revise these FY25-26 RIF requests and ability to participate in strategy implementation as the funding landscape changes and counties need to rethink priorities and budgets in response.

Item	FY24-25 RIF (July 1, 2024-June 30, 2025) *For information purposes only; not subject to TCPB approval*	**Proposed FY25-26 RIF (July 1, 2025-June 30, 2026)** ***For TCPB approval***
County Staff and consultants supporting regional healthcare system alignment efforts		
Clackamas Co. health/ housing integration staff	$767,523 [4 FTE, total cost $601,919.27 remaining $165,604.09 available for future use]	**$595,515 [3 FTE]**
Multnomah Co. health/ housing integration staff	$434,183 [2 FTE]	**$459,390 [2 FTE]**
Washington Co. health/ housing integration staff	$675,000 [2.45 FTE across 9 positions]	**$750,000 [3.05 FTE across 9 positions]**
Washington Co. health/ housing consultants	$25,000	**$20,000**
Health/Housing Alignment Programs		
Washington County – pilot LATS medical respite program	$380,000 [$330,000 for pilot; $50,000 for evaluation]	**N/A**
TOTAL RIF INVESTMENT	$2,281,706	**$1,824,905**

In addition to RIF expenditures, we are leveraging Metro administrative funding to support the healthcare system alignment goal as follows:

- Ongoing consultant support as needed to develop and implement the plan and its strategies
- A one-time $400,000 investment to support three (3) Health Share FTE for Regional Healthcare and Homelessness Integration Continuum (RIC) and High Acuity Behavioral Health initiative [Strategy 2 of this plan]

Appendix A: Regional Housing and Healthcare Systems Alignment Landscape

Source: Homebase, "Regional Housing and Healthcare Systems Alignment Landscape," developed January—June 2024 in partnership with Metro, Clackamas County, Multnomah County, Washington County, and Health Share.

This landscape analysis summarizes efforts happening in the Portland Metro tri-county area to support health and housing systems alignment and integration. The following sections detail regional initiatives and efforts, system alignment efforts taking place in two or more counties, and efforts that are specific to each of Clackamas County, Multnomah County, Washington County, and Health Share.

There is much innovation underway, and the landscape is ever evolving. **The information in this summary is current as of June 2024.**

Regional Initiatives and Efforts

The following health and housing system alignment and integration initiatives and efforts have been implemented at the regional level across Multnomah, Clackamas, and Washington counties.

Supportive Housing Services Measure 26-210 / Regional Implementation Fund	In May 2020, voters in Multnomah, Clackamas and Washington counties approved the Metro Supportive Housing Services (SHS) Measure 26-210, which introduced two new taxes that raise about $250 million annually to fund solutions to homelessness. The measure funds services across the region that address chronic and short-term homelessness by providing permanent supportive housing, shelter, outreach, behavioral health services and other supports, while also meeting Metro's requirements for addressing racial disparities.
Multi-Agency Coordinating (MAC) groups / committees	On Jan. 10, 2023, Governor Kotek signed Executive Order 23-02, declaring a state of emergency due to unsheltered homelessness in seven Continuum of Care (CoC) regions across the state, including the Metro region. All state agencies, including Oregon Health Authority (OHA), were directed to prioritize ending homelessness and take all available action to prevent or end homelessness within their authority. Part of the work of MAC groups is to improve engagement with the healthcare system and connect people experiencing unsheltered homelessness to care coordination resources. The state created Multi Agency Coordination (MAC) Groups, which include representatives from multiple sectors – including local homelessness agencies and behavioral health providers – to help respond to unsheltered homelessness in each community. Each CoC region identified in the Executive Order established its own MAC group, including the individual counties in the tri-county region.
Incorporating Health Resources into Coordinated Entry	With the support of Metro, Clackamas, Multnomah, and Washington counties are exploring new ways in which Coordinated Entry can be coordinated and used across the region to help identify, assess, prioritize, and connect people with significant health needs to healthcare resources

	in addition to housing. This includes considering Coordinated Entry as a resource in support of cross-systems data sharing and case conferencing between housing and healthcare partners.
Medicaid Housing Benefit Launch and Implementation Planning	Coordinated Care Organizations (CCOs) Health Share and Trillium, along with systems integration leaders in Clackamas, Multnomah, and Washington counties, are engaged in detailed, practical regional rollout planning for Oregon's Medicaid 1115 Waiver Housing Benefit. This regional planning is supported by each county's internal discussions and planning.

Previous Efforts

Metro 300 Initiative	Launched in 2020, the Metro 300 Initiative partnership was a $5.1 million investment from Kaiser Permanente managed by Health Share in partnership with the three counties to enable unhoused older adults and people with disabilities to access safe, stable housing. Metro 300 and ultimately served 416 individuals, most of whom were transitioned to RLRA or other long-term rent assistance when the initiative ended in 2022. The initiative included a pioneering data-sharing pilot between HMIS in each county with Health Share.

Multi-county Efforts

The following efforts are taking place in two or more of Multnomah, Clackamas, and Washington counties. In some cases, these initiatives look similar in their implementation in each county, while in others the concept is the same or similar but each county's specific implementation differ (as detailed in county-specific sections below).

Although these efforts are not regional in the sense that their implementation is happening at the individual county-level, rather than across counties, their implementation in multiple counties indicates common region-wide priorities and the potential for regionalization of efforts.

Eviction Prevention (to be leveraged for Medicaid housing benefit)	Multnomah, Clackamas, and Washington counties all operate eviction prevention programs that provide resources to people at-risk of experiencing homelessness to help them maintain their housing. All three counties are considering how they can leverage their existing eviction prevention efforts to serve this priority population through Oregon's 1115 Medicaid Waiver. Eviction prevention programs look different across the three counties. For example, Clackamas County's eviction prevention efforts include the provision of mediation resources. Please see the county-specific sections below for more detail.
Cross-System Case Conferencing	Multnomah, Clackamas, and Washington counties have all developed models for cross-systems case conferencing, which are at various points of launch and implementation. As of Spring 2024, Health Share is developing plans for regional support of this model. This includes staff

	support for creating infrastructure around case conferencing, as well as positions specifically supporting healthcare and housing integration. Cross-systems case conferencing involves bringing together health and housing system partners - which may include care coordination organizations (CCOs), Oregon Health Plan (OHP) insurance plans and providers, physical and behavioral health, homeless services, and housing providers, among others - to identify shared clients, coordinate care, and meet their comprehensive needs. Cross-systems case conferencing models can be expanded or replicated to include additional system partners, such as child welfare, criminal legal systems, education system and employment assistance programs.
County-Level Health and Housing Systems Integration Staff	County staff have been hired specifically to carry out responsibilities related to health and housing systems integration. Systems integration-focused staff positions include: Health and Housing System Integration Program Supervisor and Program Planner positions (Clackamas County) and a Lead Health and Housing Sr. Coordinator and a Health and Housing Coordinator (Washington County), and a new position starting mid-June (planned to expand to two positions) that will oversee and manage health and housing work, working with the Coordinated Entry/PSH team (Multnomah County).
Integration of Cross-System Program Staff into Health and Housing Programs	County-funded programs have invested in increased efforts to integrate and embed cross-system program staff into housing and health settings as part of coordinated care models. These efforts include the integration of housing navigators into clinical settings, Behavioral Health Specialists into shelter and housing settings, and housing system liaisons integrated within behavioral health and intensive health setting to conduct housing problem-solving and make connections to housing resources.
Frequent Users of Service Engagement (FUSE) Studies	Both Clackamas and Multnomah counties have conducted Frequent Users of Service Engagement (FUSE) studies. These studies help to identify persons with high utilization of multiple services and systems, including homeless services, healthcare, public safety, and emergency response. The results of FUSE studies can be used develop new strategies and interventions to meet the needs of the highest utilizers of public systems.
Co-Located Housing and Healthcare Services	Multnomah and Washington counties have invested in innovative project models that co-locate shelter and/or housing alongside healthcare services. The type of housing offered in these co-located models is flexible and has included recovery housing, transitional and bridge shelter, and permanent supportive housing. Additionally, a range of health services can be offered on-site, including physical, mental, and behavioral healthcare, prescription medication services, recovery services, recuperative care, and referrals for specialty care. Clackamas County has been able to provide simultaneous access to housing and healthcare services through mobile care and outreach and is interested in exploring physical co-location models.
Permanent Supportive Housing for Health	Clackamas, Multnomah, and Washington counties have increased their focus on permanent supportive housing for persons experiencing significant health vulnerabilities. Populations experiencing

Populations of Focus	homelessness that have been intentionally prioritized for permanent supportive housing within the counties include those facing severe mental health challenges, people living with HIV, seniors / persons aged 65 and older, people with Intellectual and developmental disabilities (*I/DD),* people connected to behavioral health care coordination and intensive care coordination, and people connected to mobile crisis services. Programs also provide robust staffing and supportive services to meet the comprehensive health needs of these populations of focus.
Medical Respite	Clackamas and Washington counties have explored new and expanded medical respite models for people experiencing homelessness. Through a multi-year grant from Kaiser Permanente, Clackamas and Washington counties - along with Central City Concern's long-established Recuperative Care Program and emerging/existing medical respite programs in Marion, Lane, Clark and Cowlitz counties - have formed a NW cohort of medical respite programs. The cohort is convened, and technical assistance provided by the National Institute for Medical Respite Care (NIMRC), an initiative of the National Health Care for the Homeless Council. Key considerations for these medical respite models include offering care through non-congregate shelter settings, facilitating cross-system design and development of comprehensive shelter, housing, and health programming, and developing robust partnerships with health systems to identify sustainable funding streams to maintain and expand medical respite programming after the initial demonstration period ends.

County-Specific Systems Alignment Work

Clackamas County

This section details current and past efforts to support health and housing systems alignment in Clackamas County.

Current Efforts

Eviction Prevention (to be leveraged for Medicaid housing benefit)*[2]	Clackamas County's Eviction Prevention Mediation Program offers mediation services for both housing providers and tenants to reach solutions to conflicts that can prevent eviction. Supportive Housing Services (SHS) funds support case management to assess household that need longer term care or assistance, including access to the homeless services system.
County-Level Health and Housing Systems Integration Staff*	The Health, Housing and Human Services Division of Clackamas County created and hired for a new Health and Housing System Integration Program Supervisor position in late 2023. The Program Supervisor role is dedicated to developing policies and practices to support the

[2]* Indicates a similar effort is occurring in at least one other county, as described in the "Multi-County System Alignment Efforts" section above.

	integration of health services into housing services through methods such as data sharing, IT integration, case coordination, and system connections. A Health and Housing Systems Integration Program Planner supports the Supervisor position in overseeing, planning, developing, and monitoring the ongoing evaluation and coordination of housing and healthcare systems integration, with a particular emphasis on implementing the State of Oregon's Medicaid Section 1115 Demonstration Waiver for Housing Support benefit. Division Directors at Clackamas County continue to invest in positions across Divisions to increase coordination between behavioral health, physical health, and housing activities.
Cross-System Case Conferencing*	Clackamas County has launched cross-system case conferencing, starting with shelter programs. It is engaging a range of health partners, including CareOregon and the county's Behavioral Health Team, along with the voice of peers. Clackamas County developed a Release of Information (ROI) for participating partners, established a workflow, and is using Connect Oregon as a platform for data sharing between housing and health partners. Clackamas County has established a continuous quality improvement process and is gathering data metrics to support the successful implementation and growth over time of the cross-system case conferencing model.
Medical Respite*	Clackamas County is currently planning for the launch of a medical respite pilot program by the end of 2024. Current efforts to plan for this pilot program include development of a scope of work; collaboration with the National Institute for Medical Respite and Kaiser Permanente to explore medical respite models; and connecting with Community-Based Organizations (CBOs) who may be positioned to provide medical respite.

Past Efforts

Frequent Users of Service Engagement (FUSE) Study*	From September 2018 through June 2019, the Regional Research Institute for Human Services and the Toulan School of Urban Studies and Planning at Portland State University conducted a one-time FUSE study. This study analyzed the feasibility of reducing the use of high-cost public services by providing permanent supportive housing to the individuals with the highest utilization of those services. This study focused on service system in Clackamas County, including jails, emergency departments, and emergency response.

Multnomah County

This section details efforts that support health and housing systems integration in Multnomah County.

Eviction Prevention (to be leveraged for	Multnomah County's Rapid Response Eviction Prevention program provides application support, rent payments, and legal support to people

Medicaid housing benefit)*	at risk of losing their housing due to an eviction notice. Persons at risk of losing their housing are identified through 211 and Oregon Law Center and referred to Bienestar for outreach. Bienestar helps contact eligible households and refer them to the Metropolitan Public Defender Community Law for legal support with a focus on intervening before cases reach court. Supports include legal advice, negotiation with landlords, and representation in court.
Frequent Users System Engagement (FUSE) Study and Pilot Program*	The FUSE pilot program is focused on people experiencing chronic homelessness who are the most frequently engaged in the homeless services, criminal justice, and healthcare systems. Between 2018 and 2020, the County participated in an analysis comparing data from three systems, homeless services, healthcare, and public safety to identify individuals who are most frequently engaged. The analysis found that providing these individuals with permanent supportive housing (PSH) had a profoundly positive impact, including reducing criminal justice involvement and crisis healthcare services. The FUSE pilot program draws on the learnings of that analysis through collaboration between the Health Department, the Department of Community Justice, Health Share of Oregon, and the Joint Office of Homeless Services. In the pilot phase, the program will provide up to 40 individuals, who are identified through cross-systems data sharing as high acuity/high risk across the housing, healthcare, and criminal legal systems, with PSH. A housing and healthcare provider will work together to provide navigation and mental health services to the PSH residents housed through the FUSE pilot program.
Cross-System Case Conferencing*	Multnomah County is launching a healthcare case conferencing pilot focused on connecting older clients experiencing homelessness with behavioral health needs to healthcare services.
Co-Located Housing and Healthcare Services*	Central City Concern (CCC) operates the Blackburn Center, which combines an on-site healthcare clinic with affordable housing. Housing consists of 90 single-room occupancy units and 34 studio units. The healthcare clinic offers physical, mental, and behavioral healthcare, an on-site pharmacy, recovery services, and recuperative care.
	Bud Clark Commons is a comprehensive services center that seeks to provide stability to people experiencing homelessness. The project combines a resource center with transitional and supportive housing. The building's first floor is a 90-bed transitional shelter for men. A Day Center occupies the second and third floors, which includes a wellness center that provides basic healthcare and connections to the larger medical community. The Commons' upper floors consist of 130 units of PSH. The operator of the facility's housing component, Home Forward, partners with four community health clinics to administer a vulnerability assessment tool to their clients and screen prospective Commons residents for health needs.
	The Joint Office of Homeless Services (JOHS) has partnered with CCC to support a Medical Mobile Outreach Team Pilot Program. This team offers medication management at different shelters. Behavioral health

	specialists are also able to conduct in-reach and support people residing in shelters.
	The Multnomah County Behavioral Health Division operates 39 shelter beds specific to the ACT and PATH Programs for people experiencing homelessness with behavioral health needs.
Permanent Supportive Housing for Persons with Significant Health Needs*	Cedar Commons is a 60-unit permanent supportive housing project of CCC that serves clients facing severe mental health challenges. Residents have access to a peer support specialist, case manager, certified alcohol and drug counselor (CADC), a qualified mental health professional (QMHP), a full-time property manager and community building assistants who are able to provide comprehensive wraparound services.
	JOHS partners with providers of supportive services in PSH who are focused on specific populations, such as people living with HIV and seniors.
Behavioral Health Recovery Beds	JOHS has partnered with the Multnomah County Behavioral Health Division to explore the development of additional behavioral health recovery beds. Additionally, Multnomah County, the City of Portland, the state of Oregon, and CareOregon are collaborating to help CCC develop recovery beds utilizing bridge funding.
Incorporating Health Resources into Coordinated Entry*	Multnomah County has begun preliminary work to identify ways in which the local Coordinated Entry System can be used to identify and respond to the medical and behavioral health needs of persons experiencing homelessness.

Washington County

This section details efforts that support health and housing systems integration in Washington County.

Eviction Prevention (to be leveraged for Medicaid housing benefit)*	Washington County's Homeless Services Division recently expanded its investments in eviction prevention services in partnership with Community Action Organization and Centro Cultural. Eviction prevention assistance offers eviction prevention funds to help tenants at risk of eviction retain their housing.
Cross-System Case Conferencing*	Washington County conducts case conferencing with Health Share, CareOregon, Kaiser Permanente, and Providence to connect clients experiencing homelessness to healthcare services. Case conferencing takes place twice a month among health and housing partners and is focused on supporting specific shared clients with a self-reported healthcare need in HMIS. This case conferencing process also helps housing system providers to navigate the health and behavioral health systems. The goal of this process is to support collaboration between the county and health systems, including data sharing and coordination of resources/supports.
Permanent Supportive Housing for Persons with	Washington County's Department of Housing Services (DHS) contracted with Sequoia Mental Health to provide on-site services at Heartwood Commons, a permanent supportive housing project that can serve up to 54 households. The county is currently developing a plan to ensure

Significant Health Needs*	Sequoia bills Medicaid for eligible services provided at Heartwood Commons.
	Washington County was awarded a $3 million grant with CareOregon for the development of PSH in Forest Grove. Property has been acquired for this permanent supportive housing project and project design planning is underway.
Medical Respite*	Washington County, Virginia Garcia Memorial Health Center, and Greater Good Northwest (GGNW) non-congregate shelter have partnered to create a Low Acuity Transitional Support (LATS) program. The program serves unhoused individuals who receive medical intervention with low acuity recovery needs in Washington County. Individuals are sheltered at GGNW, given medical support from VGMHC, and connected to housing resources. The mission is to give people a stable, safe environment to recuperate and be put on the path to permanent housing.
	As part of Washington County's initiative to launch medical respite for people experiencing homelessness after hospital discharge, the Homeless Services Division was awarded a $250,000 grant from Kaiser Permanente to launch and sustain the medical respite pilot over its two-year demonstration period. As part of the grant award, the Division will work with the National Institute for Medical Respite Care to build out a funding and billing model to ensure Medicaid and healthcare funding is secured to support the program sustainably and ensure services meet the highest standards in care.
County-Level Health and Housing Systems Integration Staff	Washington County has employed a Health and Housing Integration Program Coordinator (HHS Housing Liaison) position and has developed a position for a Senior Health and Housing Integration Program Coordinator. These positions serve as liaisons between the County Homeless Services Division and Health and Human Services Department to support systems integration and participate in countywide and regional health and housing coordination efforts.
Integration of Cross-System Program Staff into Health and Housing Programs*	Washington County has undertaken a pilot project to embed Housing Liaison positions, employed by community-based organizations, into health and human services programs, including Behavioral Health; Developmental Disabilities; Aging and Veterans Services; the Maternal, Child and Families Program; and Washington County's mental health crisis center, Hawthorn Walk-In Center. Housing liaisons help provide housing navigation services, make referrals to shelter services, access flexible funds to pay move-in costs or assist individuals in rapidly resolving their housing crisis when possible. The program also provides some housing navigation in partnership with service coordinators in developmental disability programs and other services.
Co-Located Housing and Healthcare Services*	Washington County is currently pursuing the acquisition of a hotel site to host different programming opportunities, including recovery housing, bridge shelter, and permanent supportive housing. The site offers five buildings with a total of 140 rooms, which allows for multiple program models to roll out as part of the development of one site, over time. Washington County is exploring opportunities to provide on-site behavioral health and recovery programming. Washington County has a

	Transitional Housing NOFA that will prioritize funding projects that provide recovery and physical health services.

Health Share

This section details current Health Share efforts that support health and housing systems integration.

Housing Benefit Pilot	In 2022, Health Share implemented a demonstration pilot of a supportive housing benefit package for members, with the long-term goal for these housing services to be covered as regular benefits for eligible Oregon Health Plan members. The housing benefit is a collaborative effort with health and housing systems in Clackamas, Multnomah, and Washington counties and community-based housing and homeless service providers. The housing benefit has been administered by Oregon Health Science University in collaboration with Central City Concern. Recent efforts have focused on creating a flexible housing benefit to support eligible Medicaid members at risk of homelessness in eight transition settings (substance use disorder residential, exiting out of Foster Care, transitioning out of corrections, inpatient medical settings, recuperative care programs, acute care rehab, Assertive Community Treatment (ACT) Programs, and inpatient psychiatric settings). The Pilot provides benefits including short-term rental and utility assistance, housing navigation support, move-in support, and accessibility modifications. The pilot program is currently focused on case conferencing to transition clients out of the Housing Benefit Pilot into available county resources. Health Share is working to align these efforts with implementation of the new Health-Related Social Need (HRSN) housing benefit that goes live in late 2024 through Oregon's 1115 Medicaid Waiver.
Capacity Building Funds	Oregon Health Authority (OHA) contracted with Health Share for community capacity building funds, which will be administered through Health Share and other care coordination organizations (CCOs). The funds – $119M in total – are to invest in community partners who will be delivering the HRSN benefits, especially for organizations who are seeking to become contracted Medicaid providers.
Health Share High Risk Behavioral Health initiative	An ecosystem analysis focused on the nexus of substance use disorders, mental illness, and social determinants of health (specifically housing insecurity and homelessness) and how those conditions impact, and are impacted by, the healthcare system. This analysis was conducted through a partnership between Health Share, Central City Concern, Center for Outcomes Research and Evaluation, and CareOregon. In Phase 1 of this project, the Providence Center for Outcomes Research and Education (CORE) analyzed member demographics and utilization patterns for seven cohorts of Health Share members. The project is currently in Phase 2, which involves analyses of cost, geography, anti-psychotic drugs, and more specific sub-population analyses, as well as plans to look at intersections with housing data. This plan involves one-time data sharing and matching between HMIS and Health Share data in

	Multnomah County. Work groups are ongoing for this work. The care model workgroup is looking at current clinical models that best support the care for members falling within the ecosystem. A Care Coordination workgroup is looking at the best way to provide care coordination for ecosystem members. A Risk Model workgroup is looking at different ways to fund the services and supports for these members. All workgroups are slated to end at the end of June, with recommendations being finalized at that time.

Priority Areas and Regional Support

As evidenced by the housing and health systems alignment initiatives and efforts happening across the tri-county region, including those described above, the primary priority focus areas across the region are:

- Medically enhanced housing models (e.g., medical respite/recuperative care, aging in place programs) as a regional need
- Cross-System Care Coordination for people experiencing or at risk of homelessness who have complex physical and behavioral health care needs (including, for example, via cross-system case conferencing, coordinated hospital discharge planning)
- Cross-System Data Sharing
- Leveraging Medicaid and other health system resources (e.g., Medicaid 1115 Waiver Implementation, accessing co-located services and supports, flex funds)

Any regional support for ongoing housing and health systems alignment work should similarly focus on these priority areas, aimed on adding value to existing efforts by providing help to sustain, improve, or expand on those efforts in the form of coordination support, capacity building, infrastructure, or other needs identified by the counties and their health system partners.

Appendix B: Racial Equity Lens Analysis Notes

The three counties, Health Share, and Metro, with facilitation support from consultant Homebase, participated in an initial equity lens analysis on November 21, 2024, using the shorthand version of the racial equity lens tool (RELT) developed by Multnomah County. The RELT shorthand exercise consists of six questions, the first four of which were discussed during the meeting on November 21.

Question 1: What is our Goal? (Desired Results)

The following goals were named in response to this question:

- Ensure that unhoused people are not discharged from hospitals to the streets and have equitable access to the appropriate level of care to meet their needs.
- Provision of culturally and linguistically appropriate services; services that are trauma-informed and person-centered.
- Develop pathways for housing providers to be able to connect their participants to their OHP benefits and health care, using trauma-informed and patient-centered processes.
- Reduce duplication of efforts. Alleviate the burden on the health systems that results from lacking resources to address patients' housing needs and the burden on the homelessness system that results from lacking resources to address individuals' health care needs.

Consensus was reached around the following primary goals:

- TCPB Goal: Greater alignment and long-term partnerships with healthcare systems that meaningfully benefit people experiencing homelessness and the systems that serve them.
- Improve coordination between housing/homeless assistance and health care systems to reduce the likelihood that complex health care needs lead to or prolong the experience of homelessness and to improve equitable access to health care resources for people experiencing or at risk of homelessness (including recently housed people) in the region.
- Ensure continued health and housing system alignment efforts and strategies reduce racial disparities in both access to health care and housing resources and in health and housing outcomes.

Question 2: What do we know? (Data, History)

The following information and questions were raised in response to this question:

- People experiencing homelessness in the three counties are disproportionately people who identify as Black, Indigenous, or other people of color, and it is critical that we provide services to assist with meeting health care needs.
- People of color have experienced systemic barriers, racism, and all kinds of harm from the healthcare system. Even well-designed or well-intentioned system improvement efforts may not fully meet their needs or mitigate these failings.

- Lack of diversity (race/gender) of healthcare staff and decision-making tables has and continues to lead to a workforce that does not fully understand or consider the unique needs of different populations.
- Multnomah County has data from FUSE (Frequent User System Engagement) program, which includes information from healthcare, housing, and criminal legal systems.
- Case conferencing has shown meaningful disproportionality and not having the right providers in the room is a barrier.
- Recommendation on qualitative data would be really helpful; often expensive and overlooked. Connecting with Lived Experience Advisory Group could be a good option.
- Health Share is close to finalizing an enhanced data sharing agreement with Multnomah County, which could be a template for other counties and the possibilities for sharing large scale data are exciting.
- There are limitations around data collection on the homeless services side. We collect a lot of data about who enters the system, but we don't know who is not entering the system. Demographic data is optional and self-report, but most people do provide the information. Shelters are the programs where we see higher rates of lacking that information.
- Washington County does a racial equity analysis twice a year to compare who is and is not being served in programs. This analysis compares homeless system data to poverty data and overall county population numbers. However, there are limitations in that the ways we collect demographic data aren't the same as the comparison data sets.
- One barrier to understanding equity data/outcomes is the lack of data on subgroups (e.g. within Asian/Asian American population); we are starting to have mechanisms to collect subgroup data but nothing to compare it to.
- Demographic data from the Medicaid Waiver pilot would be valuable as an addendum to our data, to see who is at risk and not engaging.
- Undocumented people are often wary of data being shared, so we must take special care to ensure access while making sure people are aware of the risks of engaging with systems and providing personal information.
- Did the Health Share behavioral health ecosystem study have results disaggregated by race. If so, is that information available?

Question 3: Who should we connect with? (Stakeholders)

The following were named during the discussion around this question:

- Community based organizations (CBOs)
- Health care partners, including:
    - Additional Medicaid CCOs and providers beyond HSO: Trillium, HSO members organizations, and organizations serving Open Card members
    - Community Health Workers
    - Safety net clinics
- Participants of case conferencing and respite program participants
- Additional people with lived expertise/experience (including through focus groups)

- Leaders and parties with influence to be able to model and apply equitable practices in the work
- Culturally specific health and housing organizations
    - There's a need, and some efforts being made, for culturally specific services – to make sure there's robust building out of culturally specific resources/networks with organizations that are known to people. Many are tied to established housing or social service organizations. Examples: Urban League has CHWs; Native American Youth and Family Center (NAYA); lots of culturally specific Long-Term Services and Supports (LTSS) programs and providers; organizations that work with people without legal status
    - In the context of system coordination, there are many culturally specific organizations that, even if not health care agencies, can still play a significant role in planning/implementation of connecting folks to health resources in addition to housing and other social services.
    - Organizations/networks that serve transgender people
- We need additional provider opportunities for engagement, both in terms of ways to engage and also to open it up to additional providers, including those beyond "the usual."
- Community Partner Outreach Program (CPOP) and Healthier Oregon outreach staff

In review, a County equity manager suggested Mental Health & Addiction Association of Oregon (MHAOO), a peer-led organization, and noted that culturally specific mental health and substance use treatment providers should also be identified as parties to connect with.

Question 4: Who will be impacted? (Race, Geography, LGBTQIA)

The following groups and discussion points were raised in response to this question:

- Individuals experiencing homelessness who are transitioned back to 'double up' or 'tripled up' living compared to those offered stable housing and care
- Undocumented people/people without legal status
- People who have not accessed Oregon Health Plan or are underinsured
- We know people have less access to health systems, including because of lack of connections or previous negative experiences. It's one thing to say we want to serve (proportionately) as many Black, Indigenous and other people of color in respite as white people, but it's not enough to make sure people are getting through our doors. We might need to go upstream and downstream. For example: work with health plans to say we are holding an extra bed for a subpopulation that has historically not had access or, for case conferencing, it's probably not enough to connect people who have historically not had access to the health system with a bunch of new resources – we might need to follow along to make sure they're meaningfully using them.
- People who are not already accessing hospitals, which are disproportionately people of color, are less likely to benefit from respite/medically enhanced hospital models if referrals come

only from hospitals. Similarly, people who are not already connected to systems are not going to be case conferenced.

- People with Open Card coverage often have a harder time connecting to health resources. That group is disproportionately Native American/Indigenous people because Open Card coverage allows for use of tribal health services.
- People who are very decompensated in Mental Health or Substance Use are less likely to access voluntary services, which are health care and homeless services are.
- If hospitals are unable or unwilling to provide care for transgender people, that could increase existing health/housing disparities. Could also lead to increased advocacy and pushback which may complicate healthcare/housing policy and efforts. *In review, a County equity manager suggested this item warrants further discussion.*
- We need to be mindful of capacity when we think about access limitations. And we might not be providing services in culturally responsive ways, which creates additional barriers for certain groups.
- With respect to the Medicaid waiver programs, housing locations that don't use leases (e.g., sober housing) aren't supported in the same way, so those types of policy rules will impact who is served and how.
- Everyone should be impacted, but we need to consider specific equity measures. For instance, how do we ensure racially equitable access to respite/case conferencing? How do we track data to verify access?

In review, a County equity manager shared the following considerations and ideas for the plan:

- *Expand Data Equity:*
    - *Develop a framework to address data collection gaps for undocumented individuals and non-traditional subpopulations.*
    - *Highlighting existing disparities through disaggregated data.*
    - *Focus on underrepresented groups like Black, Indigenous, and People of Color (BIPOC) in homelessness.*
    - *Partner with academic institutions or local organizations to create dynamic, community-specific data dashboards.*
- *Incorporate Workforce Equity:*
    - *Support pipeline programs for underrepresented professionals in healthcare and housing (e.g., bilingual health navigators).*
    - *Support staff of color to access employment opportunities.*
- *Enhance Community Health Partnerships:*
    - *Build relationships with non-traditional partners, such as faith-based organizations, immersion schools, culturally specific groups, and advocacy groups.*
- *Funding Advocacy:*
    - *Advocate for dedicated funding streams to support culturally specific programs and equity initiatives.*
    - *Explore partnerships with humanitarian organizations to provide funding for innovative equity-focused solutions. Flexible funding that that allows for a variety of equity initiatives with little or no limitations.*

Appendix C: Lived Experience Focus Group Notes

The strategies in this proposal also reflect input from people with lived experience and expertise of homelessness. Consultants from Homebase facilitated five focus groups (two each in Multnomah and Clackamas counties and one in Washington County) for people with lived experience of homelessness on July 30th-August 1st, 2024. There were 55 participants across the five sessions. The focus groups covered multiple topics, including accessing healthcare and unaddressed health needs. A summary of responses across the five groups follows.

Regarding experiences accessing healthcare services while experiencing homelessness:

- Many participants reported negative experiences with hospital systems, including several participants who were discharged to the street, or only given cursory referrals, such as resource sheets or recommendations to call 211.
- Many participants also reported being treated poorly by hospital staff and discriminated against due to perceptions of homelessness.
- There was also some discussion of flex funds, with some participants being connected to those easily, and others not being made aware of the resource.
- The Providence Health system was regarded as the most helpful and compassionate local health system.

Regarding participants' unaddressed health needs:

- A few participants reporting forgoing necessary procedures due to poor experiences with the health system, or inability to dedicate the necessary time to recovery (due to lack of housing, or inability to take time off work).
- Many participants noted mental illness as a factor that makes it difficult to access services, leading to delays in care.
- Without mention by facilitators of respite and recuperative care as potential options, one group of participants suggested that these types of programs would be a valuable addition to the continuum of services available in their county.

The strategies in this proposal – particularly those aimed at supporting post-acute care via medically enhanced housing and shelter models and better cross-system care coordination – aim to address the concerns elevated during the focus groups by facilitating more streamlined and empathetic access to healthcare services and housing, including from and following hospital settings.

Appendix D: Strategic Considerations and Potential Action Steps for Work Beyond Phase 1

Strategy #1: Detailed Plan Implementation	
Strategic Considerations	**Potential Action Steps**
Regional funding strategy to support expansion, creation and sustainability of medically enhanced housing and shelter models	• Building on and in alignment with progress made at the state level to develop post-acute care access, identify local, state, and federal funding options to support the delivery of services that are traditionally provided on an outpatient basis in medically enhanced housing and shelter models (e.g., respite/recuperative care, housing programs with behavioral health care services including PSH+). • Identify opportunities to support efforts by the state and OHA to identify options to fund medical respite, including potential State Plan Amendment, new 1115 waiver modeled on other states, or other mechanism. • Enhance regional data collection and analysis of the specifics of the need for medically enhanced housing and shelter models to support requests for increased investment in medically enhanced housing and shelter models. • Facilitate a regional conversation on strategically leveraging Medicaid and other sustainable funding sources to expand medically enhanced housing and shelter models.
Regional model for standardized access to medically enhanced housing and shelter models	• Facilitate conversations around Coordinated Access as a means of prioritizing access to medically enhanced housing and shelter models (e.g., PSH / PSH+) for persons experiencing homelessness. • Align with existing work to engage housing and health system partners in discussions around PSH service levels/stratification to help identify health and housing factors that can be used to prioritize access to medically enhanced housing and shelter models operating outside of Coordinated Access for persons stepping down/ transitioning out of healthcare institutional settings and other primary and behavioral healthcare settings. Develop a risk stratification model for identifying, assessing and connecting people at-risk of and experiencing homelessness to medically enhanced

	housing and shelter models, utilizing health and housing risk factors identified by both health and housing system partners. Launch a pilot program for use of the risk stratification model in healthcare settings for patients at-risk of and experiencing homelessness. • Engage with Portland/Multnomah HRAP efforts to coordinate and align medically enhanced housing and shelter models regionally with hospital and homelessness response systems.
Regional coordination and sharing of best practices for medically enhanced housing and shelter models	• Collect information from existing medically enhanced housing programs in Clackamas, Multnomah, and Washington counties to identify best practices and models of operation that can be replicated or expanded. • Explore national best practices for medically enhanced housing and shelter models. • Convene a regional medical respite / recuperative care network focused on regional coordination and information of sharing across programs. • Establish a regular meeting and/or online forum to allow for ongoing coordination and sharing of best practices among partners working in medically enhanced housing and shelter models across the region.

Potential Phase 2 Milestones & Metrics

Potential milestones could include:

- Monthly meetings with work group to review ongoing efforts/recommendations/strategies on medically enhanced housing and shelter models, in alignment with state and HRAP.
- Quarterly coordination meetings with Metro on housing and health care engagement efforts around service levels and stratification of levels of care in Permanent Supportive Housing (PSH).

Potential metrics could include:

- Fewer people are discharged from hospitals to homelessness/unsheltered settings

- Increase in number or percentage of people experiencing homelessness accessing medical respite programs

Strategy #2: Detailed Plan Implementation	
Strategic Considerations	**Potential Action Steps**
Regional support structure for sustainability and expansion of cross-system case conferencing.	• Stand up support structure defined during Phase 1 • Provide staffing, training/education, and other infrastructure support (including regional healthcare/housing data-sharing infrastructure) in alignment with defined needs.
Multi-sector shared funding model for regional cross-system care coordination pilot that expands upon successes of cross-system case conferencing happening in all three counties.	• Define funding need to continue pilot implementation for 3 years (including for staffing, healthcare/housing data-sharing infrastructure, and monitoring and evaluation). • Identify and prioritize potential healthcare, housing, and other funding sources to meet the defined need. • Secure necessary approvals for individual sources and overall strategic funding plan.
Long-term sustainability plan for regional cross-system care coordination	• Identify key outcomes from cross-system case conferencing and other care coordination efforts and define remaining or expected funding needs/gaps for ongoing continuation. • Confirm availability of existing funding sources and identify additional potential funding sources (including Medicaid waivers or state plan amendments, if appropriate). • Outline options for braided funding structure to permanently sustain regional cross-system care coordination.
Data-sharing plan to support regional cross-system care coordination infrastructure, in alignment with Strategy 3.	• Define gaps in existing healthcare/housing data-sharing agreements and infrastructure, in alignment with Strategy 3. • Explore information exchange options (with a preference for existing tools/infrastructure) that allow partners and providers from various systems to access, review, update and share information on client housing and healthcare plans.
Training and capacity building plan to support regional cross-system care coordination efforts.	• Implement prioritized training and capacity needs identified during Phase 1. • Determine additional funding and staffing needs to evaluate continued needs and deliver ongoing needed training and capacity building.

Potential Phase 2 Milestones & Metrics

Potential milestones could include:

- Staffing secured to serve as regional cross-system case conference communications/ coordination lead
- Quarterly exchange of cross-system case conferencing challenges, successes, and opportunities
- Annual identification of case conference best practices for scaled implementation
- Regional care coordination pilot to facilitate cross-system care coordination for providers and healthcare and homeless system navigation support fully staffed and funded.
- Pilot liaisons have access to Electronic Health Record and Homeless Management Information System data
- Training curriculum developed for health system frontline staff who receive referrals from homeless response system.

Potential metrics could include:

- Increase in number or percentages or subpopulations of people experiencing homelessness who are regularly discussed during cross-system case conferences
- Increase in referrals from housing system to health care and vice versa (including for specifically identified resources or services)

Strategy #3: Implementation and Technology Scoping	
Strategic Considerations	**Potential Action Steps**
Development of regional data sharing approaches	• Develop shared legal approach and templates for data sharing priorities defined during Phase 1, including opportunities for shared legal education. • Initiate and execute data sharing agreements identified as being needed during Phase 1 with appropriate legal and privacy teams. • Recommend best practices for data matching between healthcare and housing data sources and tracking outcomes for healthcare/housing interventions.

	• Engage people with lived experience of homelessness around proposed data sharing approach and uses of personal information. • Recommend system enhancements and new infrastructure adjustments, in coordination with local Continuums of Care.
Scope data infrastructure needs for bi-directional, real-time data sharing	• Partner with HMIS development teams to ensure CoCs' new HMIS platform has integration options with health care data systems like EHRs, HIEs, etc. • Scope additional data sharing infrastructure that aligns with priorities of regional data implementation and advisory team. Align the effort with HUD's Homelessness and Health Data Sharing Toolkit continuum. Use scoping to inform additional procurement approaches and resource allocation needs.

Potential Milestones

- Data sharing templates developed for specific priorities that can be used by all counties and partners for top data sharing priorities
- Data sharing agreements executed for top data sharing priorities
- Data match conducted across counties and Health Share that allows partners to know which individuals are served by both systems and the health care and housing status of those individuals
- Request for Proposal (RFP) or Request for Information (RFI) released for data infrastructure technology needs

METRO SUPPORTIVE HOUSING SERVICES TRI-COUNTY PLANNING BODY

Monthly progress report | March 2025

The goal of this report is to keep the TCPB, the Supportive Housing Services Regional Oversight Committee, Metro Council and other stakeholders informed about ongoing regional coordination progress. A more detailed report will be provided as part of the SHS Regional Annual Report, following submission of annual progress reports by Clackamas, Multnomah, and Washington Counties.

Tri-County Planning Body regional goals*

Goal	***Implementation Strategies Status***	***Progress***
Regional Landlord Recruitment	*Implementation Strategies approved by TCPB (03/13/2024)* *Implementation strategies (4 of 5) underway. Strategy 3 (24/7 Hotline to launch in December)* *Next Quarterly Report in June 2025*	*As part of the Plan's Strategy #1: Communication and education plan, Metro have created a webpage on Metro's website with information on county landlord financial incentives and Metro is working on procuring a consultant. Metro is working with Focus Strategies, a consultant, on Strategy #2: Align financial incentives and Strategy #5: Investigate needs for property management. Multnomah County continues to make progress on Strategy # 3: tracking and access to unit inventory, as they pilot using Housing Connector. Clackamas County has not yet begun work on Strategy #4: prioritize quality problem-solving services, and they plan to launch a hotline for landlords in December, 2025. All counties and Metro meet monthly to update each other on progress, share ideas, and problem-solve.*
Coordinated Entry	*Implementation Strategies approved by TCPB (10/09/2024)* *Implementation strategies (4 of 4) underway.* *Next Quarterly Report in March 2025*	*Work on the four strategies outlined in the CERIP has begun, and counties and Metro collaborate across all strategies. For Strategy #1: Regionalize visibility of participant data, conversations with regional HMIS administration have begun. For Strategy #2: align assessment questions, counties have provided detailed information on existing questions and consistencies and differences have been mapped. For Strategy #3: Regionalize approaches to prioritization for racial equity, counties are learning about each other's approaches and*

		considering options. For Strategy #4: regionalize approach to case conferencing, county CE staff are observing each other's case conferencing meetings and will bring learnings to a shared discussion. All counties and Metro meet monthly to work through the steps of the implementation plan, share ideas, and problem-solve.
Healthcare system alignment	*Implementation Strategies to be approved by TCPB in March/April 2025* *Implementation strategies under development* *First Quarterly Report in September 2025*	*The regional planning workgroup (Health Share, counties, and Metro, with support from Homebase) has finalized the implementation strategy with a focus on regional opportunities to support, supplement, and advance existing health and housing system alignment initiatives. The strategy presentation is on the March TCPB agenda, allowing flexibility as needed to continue the presentation and/or vote on the strategy in April, depending on time needed for other agenda topics. The team provided an update to the SHS OC in February and will present the regional strategy for OC approval following approval by the TCPB. The regional strategy will describe next steps for implementation and ongoing collaborative work by the counties, Health Share, and provider partners, with quarterly progress updates to TCPB to begin in September 2025.*
Training	*Implementation Strategies will be presented at April TCPB meeting*	*Metro and the counties continue to collaborate on the training goal and are looking forward to bringing the TCPB the training implementation strategy in April.* *Immediate trainings being offered: Work is happening now to advance trainings throughout the region. In early January, Metro's Regional Capacity Team launched a pilot project to assess the effectiveness, value and regional scalability of the on-demand trainings available through National Alliance to End*

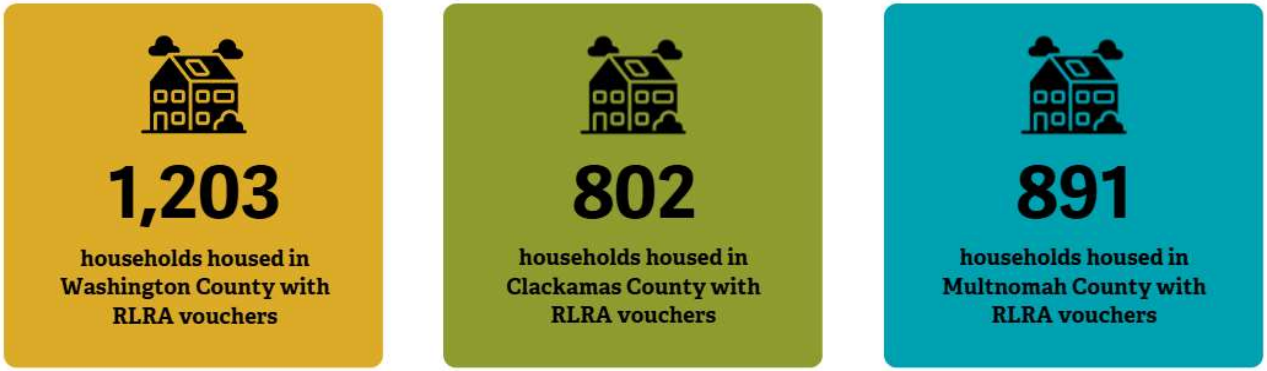
		Homelessness and Corporation for Supportive Housing. In total, two staff at 15 agencies are taking seven training courses and share their feedback to inform future implementation for Metro and the counties. The pilot report, which will include findings and recommendations, should be released in summer 2025. *Research toward longer term strategy: Metro's Regional Capacity Team is also building on the research paper shared with the TCPB last fall with additional research into regulated training hub models, workforce boards and more. We plan to have a final version of that paper ready with our next TCPB presentation in April, along with the results of the service provider outreach the team conducted in fall 2024*
Technical Assistance	*Implementation Strategies approved by TCPB (2/12/2025)* *Counties TA RIF requests under development*	*The Technical Assistance Implementation Strategy was approved by the TCPB on 2/12/2025. Metro staff will continue to work with the counties to gather counties' TA RIF requests ahead of April TCPB meeting.* *The Permanent Supportive Housing Technical Assistance Demonstration and Research project, which aims to identify opportunities for regionalizing technical assistance and learn best practices in PSH delivery from culturally specific providers, continues to move forward with the goal of pairing PSH service providers and consultants to begin to begin their technical assistance work in April.* *Proposals for RFP 4406, which will form the basis of technical assistance providers, are being reviewed. The Letter of Inquiry (LOI) application process to identify the PSH providers who will participate in this project launched January 20 and closes in*

		early March. Metro staff hosted two LOI application process informational sessions with providers. Staff from three counties and Metro will be reviewing the LOI applications with the goal of identifying four service providers to participate—ideally, at least one from each county.
Employee Recruitment and Retention (ERR)	*Implementation Strategies scheduled to be presented at May TCPB meeting* *Implementation strategies under development* *First Quarterly Report TBD depending on timing for strategy approval*	*We are meeting monthly with a tri-county workgroup to draft a regional strategy, reviewing concepts discussed in the June/July 2024 progress updates and exploring opportunities to work toward a livable wage standard as well as to develop regional approaches to contract policies and to track progress toward livable wages. The ERR strategy is currently scheduled to come to TCPB in May 2025.*

**A full description of regional goals and recommendations is included in Attachment 1.*

Existing REGIONAL PROGRAMS AND COORDINATION EFFORTS

****Households housed through the RLRA program as of September 30, 2024:***



The data comes from the SHS quarterly reports, which includes disaggregated data (by race and ethnicity, disability status and gender identity) and can be accessed here: https://www.oregonmetro.gov/public-projects/supportive-housing-services/progress

**As of 8/15/2024, Metro has updated the way numbers are reported on our SHS dashboards. Beginning at the end of Year 3, Metro has shifted to reporting the number of households served with SHS resources. We are no longer reporting the number of people served, as several people can be members of the same household which has been served with SHS resources. Please note: This will cause the number on the dashboard to appear smaller, even though SHS service levels have only continued to increase.*

Risk Mitigation Program: *All RLRA landlords are provided access to a regional risk mitigation program that covers costs incurred by participating landlords related to unit repair, legal action, and limited uncollected rents that are the responsibility of the tenant and in excess of any deposit as part of the RLRA Regional Landlord Guarantee.*

The following information is derived from the counties' FY2022-2023 annual reports

Landlord Liaison and Risk Mitigation Program: *In January 2023, Metro and tri-county program staff began meeting monthly to coordinate Landlord Liaison and Risk Mitigation Program education activities. Together, staff shared existing engagement tools and identified innovative methodologies for expanding unit availability across the region. Training for existing landlords is coordinated regionally and staff continues to coordinate to identify strategies for expanding unit availability.*

Regional Point-in-Time Count: *In January 2023, the counties conducted the first-ever fully combined regional Point-in-Time Count. This tri-county coordinated effort included creating a shared methodology and analysis, a centralized command structure, and unified logistics around the recruitment and deployment of volunteers. As a result of the combined Count, analyses include regional trends in unsheltered homelessness, sheltered homelessness, and system improvements made possible by regional investments in SHS.*
An initial summary of the 2023 Point-in-Time Count data can be found in this May 2023 press release from Multnomah County: https://www.multco.us/multnomah-county/news/news-release-chronic-homelessness-number-falls-across-tri-county-region-2023.

Regional Request for Program Qualifications: *This program year also included a Regional Request for Programmatic Qualifications to procure new and diverse organizations as partners for service provision. Tri-county partners worked to ensure broad engagement and technical assistance to support the full participation of new and emerging organizations, especially culturally specific service providers. 60 applications were qualified to create a broad network of 167 tri-county pre-qualified service providers with diverse expertise and geographic representation.*

Homeless Management Information System (HMIS) Regional Implementation: *Starting in 2023, an updated Privacy Notice & Policy created a more trauma-informed and person-centered approach to obtaining participant consent for data sharing while maintaining a high level of data privacy. Next steps included moving toward regional visibility and more comprehensive integration of each of the counties' HMIS systems.*

TRI-COUNTY PLANNING BODY GOAL AND RECOMMENDATION LANGUAGE

May 10th, 2023

COORDINATED ENTRY

Goal: Coordinated Entry is more accessible, equitable and efficient for staff and clients.

Recommendations: Map the unique challenges and successes of each of the three Coordinated Entry Systems.

Assess opportunities to create connectivity among the three Coordinated Entry Systems to improve equitable access and work towards regionalizing some tools within Coordinated Entry.

Explore opportunities for co-enrollment with other systems.

REGIONAL LANDLORD RECRUITMENT

Goal: Increase the availability of readily accessible and appropriate housing units for service providers.

Recommendations: Contract with a qualified consultant to identify areas where regionalization can support existing and future county efforts and submit recommendations.

Develop a regional communications campaign to recruit new landlords, including specific outreach and engagement to culturally specific media and BIPOC community groups.

HEALTHCARE SYSTEM ALIGNMENT

Goal: Greater alignment and long-term partnerships with healthcare systems that meaningfully benefit people experiencing homelessness and the systems that serve them.

Recommendations: Metro staff convenes and coordinates with counties and key healthcare systems stakeholders to identify opportunities that integrate the Medicaid waiver with the Supportive Housing Services initiative. Bring draft proposal with next steps and timeline to committee within 6 months.

TRAINING

Goal: Service providers have access to the knowledge and skills required to operate at a high level of program functionality; the need of culturally specific providers will be prioritized through all program design.

Recommendation: Counties and Metro coordinate and support regional training that meets the diverse needs of individual direct service staff, with sensitivity to the needs of BIPOC agencies.

TECHNICAL ASSISTANCE

Goal: Organizations have access to the technical assistance required to operate at a high level of organization functionality; the need of culturally specific providers will be prioritized through all program design.

Recommendation: Counties and Metro coordinate and support regional technical assistance and investments in capacity building especially among culturally specific providers.

EMPLOYEE RECRUITMENT AND RETENTION

Goal: County contracts for SHS funded agencies and providers will establish standards throughout the region to achieve livable wages for direct service staff.

Recommendations: Map current wage and benefit conditions.

Draft a housing-worker wage framework that provides guidance to Counties and SHS-funded agencies and providers and includes contracting evaluation and alignment.

Consider ways to allow for differential pay for lived experience, bilingual employees, and culturally specific organizations.

Consider ways to address challenges faced by organizations with multiple funding streams.

Assess reasonable scale of outcomes and case load as it relates to compensation.

Within each Supportive Housing Services (SHS)-funded agency, monitor the distribution of pay from lowest to highest paid staff to ensure improvements in pay equity.

Supportive Housing Services Oversight Committee Meeting Summary

Meeting:	Supportive Housing Services (SHS) Oversight Committee Meeting
Date:	January 13, 2025
Time:	9:30 a.m. to 12:00 p.m.
Place:	Virtual meeting (Zoom)
Purpose:	Vote on housing funding memo to Metro Council on behalf of the SHS Oversight Committee, discuss proposed recommendations for annual regional report, receive a housing funding update.

Member attendees

Co-Chair Dr. Mandrill Taylor (he/him), Co-chair Mike Savara (he/him), Peter Rosenblatt (he/him), Kai Laing (he/him), Cara Hash (she/her), Felicita Monteblanco (she/her), Dan Fowler (he/him), Jeremiah Rigsby (he/him), Jenny Lee (she/her)

Absent members

Carter MacNichol (he/him), Mitch Chilcott (he/him) Dr. James (Jim) Bane (he/him), Margarita Solis Ruiz (she/her)

Elected delegates

Washington County Chair Kathryn Harrington (she/her), Metro Councilor Christine Lewis (she/her)

Absent elected delegates

Multnomah County Chair Jessica Vega Pederson (she/her)

Metro staff

Patricia Rojas (she/her), Yesenia Delgado (she/her), Breanna Hudson (she/her), Yvette Perez-Chavez (she/her)

Kearns & West facilitator

Josh Mahar (he/him)

Note: The meeting was recorded via Zoom; therefore, this meeting summary will remain at a high-level overview. Please review the recording and archived meeting packet for details and presentation slides.

Summary of Meeting Decisions

- The Committee unanimously approved sending the Housing Funding Memo to Metro Council.
- The Committee unanimously approved the December 2 and 9 meeting summaries.

Welcome and Introductions

Co-chairs Dr. Madrill Taylor and Mike Savara provided opening remarks and reflected on the purpose of building a functioning service system.

Josh Mahar, Kearns & West Facilitator, facilitated introductions between Committee members and reviewed the meeting agenda and objectives. He noted that once enough members joined to reach

quorum, the Committee would vote on approving the housing funding memo written by the Co-chairs and the two December meeting summaries.

Conflict of Interest Declaration

Peter Rosenblatt declared that he works at Northwest Housing Alternatives, which receives SHS funding.

Kai Laing declared a potential conflict of interest as he works at Self Enhancement Inc., which receives SHS dollars.

Dan Fowler declared he is Chair of the Homeless Solutions Coalition of Clackamas County, which receives SHS funding.

Public Comment

Javonnie Shearn, Up and Over, provided public comment and shared statements from those who received services in Clackamas County. She stated it would be a tragedy for SHS funds to be reduced.

Recommendations

Yesenia Delgado, Metro, reviewed the FY 24-25 Annual Regional Report process and shared that Kris Smock, Kristina Smock Consulting, will support the Committee in drafting the regional report and transmittal letter. She shared that this discussion would help provide direction for Kris to draft the transmittal letter to discuss at the next meeting.

Committee members had the following questions and comments:

- **Question, Peter**: Last year's recommendation dashboard had many still in red and yellow. Are we adding to last year's recommendations? At what point are there too many recommendations? It is difficult to conceptualize this process while knowing Metro will move forward with a ballot measure that would change everything. This seems like an academic exercise.
    - **Metro response, Yesenia**: Last year's recommendations that were not accomplished will continue to move forward. Some of them fall under the Tri-County Planning Body's work. There will be some overlap between this year's and last year's recommendations. At this point, we do not know if any changes are happening, so it is important that this group continues to do the work to improve accountability.
- **Comment, Felicita Monteblanco**: I agree with Peter, there is tension and frustration. The way I am approaching this is that we still have a job to do and that our work and the ballot measure are two parallel paths.
- **Comment, Metro Councilor Christine Lewis**: No decision has been made. There is an opportunity to reform the measure. Metro Council shares frustrations with the recommendations still in red and yellow, which is proof that accountability and oversight need to be improved.

Co-chairs Taylor and Savara reviewed the draft recommendation topics which are regional priorities, oversight and accountability, jurisdictional partnerships and decision making, data integrity and evaluation, and provider partnerships. Draft language for each topic area can be found in the archived meeting packet on pages 48-52.

Committee members had the following questions and comments:

Regional priorities

- **Comment, Peter**: I like how this is worded. The overarching priority for next year needs to be around data. I am not sure if there is a willingness or ability for the jurisdictions to come to an agreement on data reporting. Consistent data across jurisdictional lines is needed to make data-driven decisions.
- **Comment, Co-chair Savara**: The country is at a key inflection point on how to address homelessness. These priorities will help jurisdictions make decisions from data and humane perspectives. There needs to be a conversation between providers and county partners. We need practices that align with the values of the SHS measure, not practices that are quick and easy. We have to prioritize approaches as there are not enough resources to do everything. I look forward to hearing from county leaders on this.
- **Comment, Dan**: I agree with Co-chair Savara. I have questions about what convening that conversation looks like and who is involved. I believe that key nonprofit providers and/or the people they are serving should be included. A bottom-up approach seems important for this critical work.
- **Comment, Kai**: It feels like we are addressing issues that are not formalized yet. We need to focus on the results of the report and address those results. We need to hear from the jurisdictions on their difficulties and priorities and ensure accountability rather than making and forcing decisions.
- **Comment, Felicita:** I agree with Dan's comments and want to elevate that providers are a part of that conversation.

Oversight and accountability

- **Comment, Peter**: The word "empowered" resonates as the key theme for this one. This language clarifies the role as oversight rather than advisory. Clackamas County never implemented its oversight committee for SHS and there is no accountability. Why was Multnomah County placed on a performance improvement plan for not spending money and Clackamas County was not for its failure to implement its oversight committee? Power is money; at some point, it seems that funding should be taken away for not implementing pieces. The contractual relationship needs to be evaluated.
    - **Response, Metro Councilor Lewis:** The relationship you are describing does not exist, which is one component of reform. As long as counties spend funds on allowed items, there is no accountability to certain components under the current intergovernmental agreements (IGAs).
    - **Metro response, Patricia Rojas**: Currently the IGAs charge Metro with oversight and accountability functions. Several functions are best practices, but there are questions for mechanisms to ensure local structures like the LIPs. The reason Multnomah County was placed on a performance improvement plan is that the IGAs require corrective action plans if there are material deviations from spend-down plans.
    - **Response, Washington County Chair Kathryn Harrington**: There are provisions in the IGAs for elected officials to get together for accountability. There will not be another IGA around SHS from the board I serve on with these gross generalizations.

Elected bodies must be treated as partners. We have come together to do something that no other multi-county jurisdiction has done before.

- **Comment, Felicita**: I resonate with "oversight" and "empower." I appreciate "funder best practices" as a critical piece of the work.
- **Comment, Dan**: Perhaps a specific oversight question can be, "Have you implemented your local advisory committee and other parts of your local implementation plan (LIP)?" to measure accountability and success.
- **Comment, Kai**: I suggest including "with service providers and partners" in the language to provide human-centered feedback beyond just data.

Jurisdictional partnerships and decision making

- **Comment, Peter:** I do not speak for the Clackamas County Board of Commissioners, but I do attend their meetings, and I feel that this would resonate with them. It speaks to the desire for clarification on process, decision-making, and what input means. I felt that lack of clarity as a provider and as a member of this committee.
- **Comment, Dan:** This is a hot topic and boils down to attitude. Counties have been doing social services work for years and are experts. Metro sees itself as the funder, but the funder is the taxpayers. The lack of trust and respect between the jurisdictions needs to be resolved.

Data integrity and evaluation

- **Comment, Washington County Chair Harrington**: I try not to respond to work in this Committee, however, I get frustrated with status updates and progress reports from Metro staff to Committee members. The draft data-sharing agreements in 2023 were put on pause, but during the second half of 2024, I pushed my staff to learn more about it. I got an update on Friday that there is just one last sticking point from county staff around data quality. I share this Committee's frustration and intend to follow up on this. I hope before the regional report is released, this will be resolved. Thank you for advancing this need.
- **Comment, Peter**: This is the key goal and I would list this recommendation first. It is hard to make decisions without this information. Counties need to be able to count Populations A and B in the same way. This issue connects to empowerment.
    - Multiple Committee members agreed that this is a priority and should be listed first.
- **Comment, Metro Councilor Lewis**: This is key. Metro has operated in good faith and has given concessions. I do not want folks disparaging Metro's team on this.
- **Comment, Co-chair Taylor**: Integrity is needed for trust. There is a lot of hard work to do. The intent is to not put down anyone's efforts and ensure this remains a priority and value. This connects to the underlying issue of trust.

Provider partnerships

- **Comment, Felicita**: This is critical and important work.
- **Comment, Peter**: Multi-year contracts are important and are not exclusive to pilot projects. Multi-year contracts should include cost of living increases. This is hard to reconcile with the ballot measure and living wages could increase costs of services, while the ballot could decrease the amount of funds available.
- **Comment, Co-chair Savara**: I suggest changing the last bullet to "building on promising practices to expand" and striking pilot projects.
    - Committee members agreed to this edit.

Josh asked the Committee if anything was missing or if there were any last reflections.

- **Comment, Cara**: The last two categories resonated a lot. Data integrity and partnership are consistent themes.
- **Comment, Peter**: Timelines and due dates are important and should be realistic and express urgency. How do we integrate last year's recommendations? Perhaps we can merge the recommendations to have a singular plan to work from.
- **Comment, Felicita**: I want to note there are things that we have recommended that are not done and I do not want to lose them.

Kris Smock, Kristina Smock Consulting, thanked the Committee for the discussion and confirmed she would incorporate the input into the next draft.

Yesenia confirmed that last year's recommendations will still move forward and supported Peter's suggestion of one singular comprehensive plan.

Co-chair Savara stated that a work plan and timeline for the recommendations would be helpful to receive from Metro staff. He reflected that the Committee does not have visibility on how some recommendations are moved forward. He thanked the Committee for their input.

Co-chair Taylor stated that when reviewing recommendations to form a comprehensive plan, it could be helpful to think about barriers to implementation to see if there is something systemic occurring that the Committee is not thinking about.

SHSOC Housing Funding Memo

Co-chairs Savara and Taylor reviewed the Housing Funding Memo to send to Metro Council on behalf of the Committee.

Dan noted that once the Committee knows the full recommendations of the ballot, they may have further comments.

Decision: The Committee unanimously approved sending the memo to Council.

Decision: The Committee unanimously approved the December 2 and 9 meeting summaries.

Housing Funding Updates

Metro Council President Lynn Peterson thanked the Committee for their work and shared that Council is preparing to consider a ballot measure and an accompanying ordinance. The ordinance will go to staff with specific deadlines. She shared that Council has heard from many voices and the Stakeholder Advisory Table and reflected that a difficult decision needs to be made when facing funding cliffs and public skepticism. She thanked the Committee for sharing the memo with Council and that she read the draft in the meeting packet.

She reflected on the group's discussion on themes of limited oversight authority, unclear decision making pathways, and barriers to data sharing and reporting. She stated that the measure would establish a more empowered Housing and Homelessness Policy Advisory Committee (HHPAC), allow for a negotiation of the IGAs, adopt outcome-based performance management practices, and support evidence based decision making.

Committee members had the following questions and comments:

- **Question, Co-chair Taylor**: I appreciate your attendance and responding in real time to the memo. Elected officials are included in the HHPAC. When was that proposed and how do you envision their role complementing that of experts and providers?
    - **Response, Metro President Peterson**: Elected officials are where recommendations end up and they have the authority to implement. The structure will help regionalize programs and foster collaboration. Some groups have advocated for no elected officials, but they are trusted by the voters.
- **Comment, Peter**: Advisory and oversight are two separate roles. It seems that affordable housing has shifted from an allowable use to a mandated activity, why? Could a county not allocate funds to affordable housing and only allocate to SHS? It seems that voters would be voting on something where the details would be decided after the election. How many units of affordable housing would be built? How would PSH services be in place?
    - **Response, Metro President Peterson**: The affordable housing component you are speaking to was part of an allocation model to show how allocations can be made to provide stability for counties. The draft ordinance has HHPAC providing a recommendation to Council of an allocation formula that works for all counties and to define what they are trying to achieve on affordable housing. The allocation model work will move at the speed of trust if the ballot is passed. The ballot measure focuses on the extension, personal income tax reduction, and making affordable housing an eligible use. Each county's allocation will be a part of the regional action plan which has to be approved by Council.
- **Comment, Dan**: Can you speak more about the personal income tax reduction? Typically, counties have been the social service providers, and I support the idea of accountability and removing the city program. Providers have built out programs and hired staff, and they are now scared and worried about the change. Can there be a transition period over two to three years to give providers time to adapt to funding changes?
    - **Response, Metro President Peterson**: There will be a transition period. The personal income tax rate would include a 20-year extension with a 25% personal income tax rate. The Portland Metro Chamber and Here Together Coalition have agreed to an upfront 10% cut which would increase to 15% in 2031. There are still questions as to how, when, and who receives the tax cut. The SHS measure should not be the only funding in this region, and state funding will need to be considered.
- **Comment, Felicita**: I appreciate Dan's comments on each county's uniqueness and look forward to having conversations with cities to get their perspective. When can we read the ballot measure? We have stated that we want to invest in culturally specific providers and I am worried about them not having the resources they need and having to have conversations on program or staff cuts.
    - **Response, Metro President Peterson**: The Metropolitan Mayors' Consortium (MMC) has asked Metro for funding to not go through the counties as each county treats cities differently. Cities are using their general fund to support housing services and they are looking for support. The ordinance directs HHPAC to figure out what a city program could look like and if that should be incorporated into LIPs. The tax is volatile and cuts are already happening. We want to budget in a way that provides stability for providers. There is work to do in the ordinance and with pay equity issues between the three counties.
- **Comment, Co-chair Savara**: The State wants to be a partner in this work. Service providers need to be supported. It is hard to provide support if the expectation is for them to cut programs, lay off staff, and decrease their scope of work. The Stakeholder Advisory Table wants to see that balance.

- **Response, Metro President Peterson**: There are larger societal issues, including a healthy economy. Some signs indicated that the economy may be going in the wrong direction, and we need to make progress and commit to solving these issues. Long-term stability could worsen if we do not make a change.

Next Steps

Yesenia stated that feedback on the draft report would be due on January 14 and the Committee will meet again on January 27, 9:30am-12:00pm.

President Peterson shared next steps for Council include sharing the draft ballot and ordinance language before the Thursday work session. January 23 there will be the first reading of the language with public testimony, which will likely lead to amendments.

Adjourn

The meeting adjourned at 12:10 pm.

Supportive Housing Services Oversight Committee Meeting Summary

Meeting:	Supportive Housing Services (SHS) Oversight Committee Meeting
Date:	January 27, 2025
Time:	9:30 a.m. to 12:00 p.m.
Place:	Virtual meeting (Zoom)
Purpose:	Receive Metro tax collection and disbursement update, receive FY24 admin costs update, receive FY24 technical regional report status update, review FY24 transmittal letter, review FY24 recommendations.

Member attendees

Dr. James (Jim) Bane (he/him), Co-chair Mike Savara (he/him), Peter Rosenblatt (he/him), Kai Laing (he/him), Cara Hash (she/her), Felicita Monteblanco (she/her), Dan Fowler (he/him), Jeremiah Rigsby (he/him), Jenny Lee (she/her)

Absent members

Co-Chair Dr. Mandrill Taylor (he/him), Carter MacNichol (he/him), Mitch Chilcott (he/him), Margarita Solis Ruiz (she/her)

Elected delegates

Washington County Chair Kathryn Harrington (she/her), Metro Councilor Christine Lewis (she/her)

Absent elected delegates

Multnomah County Chair Jessica Vega Pederson (she/her)

Metro staff

Yesenia Delgado (she/her), Breanna Hudson (she/her), Yvette Perez-Chavez (she/her), Valeria McWilliams (she/her)

Kearns & West facilitator

Josh Mahar (he/him)

Note: The meeting was recorded via Zoom; therefore, this meeting summary will remain at a high-level overview. Please review the recording and archived meeting packet for details and presentation slides.

Summary of Meeting Decisions

- The committee did not take any formal votes during this meeting.

Welcome and Introductions

Co-chair Mike Savara provided opening remarks and reflected on the 2025 Portland Tri-County Point in Time Count as an important moment for the housing and homeless system, where surveys and data will be collected about where people experiencing homelessness slept on the night of January 22nd.

Josh Mahar, Kearns & West Facilitator, facilitated introductions between Committee members and reviewed the meeting agenda and objectives.

Supportive Housing Services Oversight Committee Meeting Summary

Conflict of Interest Declaration

Peter Rosenblatt declared that he works at Northwest Housing Alternatives, which receives SHS funding.

Dan Fowler declared he is Chair of the Homeless Solutions Coalition of Clackamas County, which receives SHS funding.

Jenny Lee declared she works at Coalition of Communities of Color, which received SHS funding.

Public Comment

No public comment was received.

Metro Finance Update

Jane Marie Ford, Metro, provided a Metro finance update on monthly tax disbursement. She provided a high-level overview of the full memo in the meeting packet.

Committee members had the following questions and comments:

- **Question, Dr. Jim Bane:** I have hard time understanding the line-graph data, is there another way this data could be displayed?
    - **Comment, Peter:** I agree.
        - **Metro response, Jane:** Yes, I can do that. We are currently testing a new month-to-month graph. We can share an online clickable graph so folks can see the data differently.

Yesenia Delgado, Metro, provided information on administrative rates and what Metro is seeing. Currently, Metro does not have a mechanism to collect rates from service providers, but they do from counties. Jane shared an analysis on this, and Yesenia asked what information the Committee needs to have the conversation around administrative and service rates.

Committee members had the following questions and comments:

- **Comment, Peter**: I appreciate seeing this, and I am confused. There is a difference between administrative rates, what we put in the contract, and what the true cost of that work is. I think we could explore these differences, and I suspect we would find significant gaps in what's contracted versus what's overhead rates.
- **Comment, Felicita Monteblanco**: Thank you for this. This data is really critical to the non-profit sustainability conversation. I hope there is an opportunity to create a floor, to have an automatic percentage that the counties can provide, and then create opportunity for providers to have negotiations.
- **Question, Co-chair Savara**: It is difficult to understand county contracting processes. I suggest we have a future topic around county contracting with specific county staff here to discuss this. What is informing their planning and thinking around budgeting for their needs?
    - **Metro response, Yesenia**: On the administrative side of things, I think this a good first step toward that conversation. It is helpful to hear this and we will follow up with our county partners to see what additional information we can get. We are

scheduling workplan and budget presentations later this spring and into the summer.

- **Question, Dan:** If 10% is the contracted rate versus an actual rate, do you give your actual rates as a non-profit? It would be nice to know what the difference is.
    - **Peter response:** Not many funders want to know the true and accurate cost of your services. The true and accurate costs of programming is unknown to counties. They only know what they are asking for.
- **Comment, Mike:** I want to know if we are keeping rates at 10%, at that maximum limit. If we are under 15%, we need to understand the reason. We should be matching the federal government's posture on this.

Jane Marie shared that she would be happy to answer any follow up questions via email.

FY24 Technical Report Update

Kris Smock, Kristina Smock Consulting, reviewed the drafted FY24-25 Annual Report. She shared that the report is intended to provide a comprehensive summary and analysis. The revised draft that the committee received in the meeting packet the meeting packet incorporated feedback from the committee. To address committee comments, Kris added additional framing and contextual information throughout the Report and Transmittal Letter. She will incorporate the final fiscal update into the report. The final Technical Report and final revised Transmittal Letter will be in the February SHS Meeting Packet for the committee's final review and approval.

Committee members had the following questions and comments:

- **Comment, Felicita:** I request that we receive redlined documents so we can follow the changes made between meetings.
    - **Kris' response:** Yes, we can do that.
- **Comment, Dan:** I would like to see us incorporate a clear picture of tax collection data.
    - **Kris response:** We can try to include a link to the updated dashboard for the most clear and up-to-date data capture.

FY24 Transmittal Letter Review

Introductory Section

Kris started by going over the introductory section of the Transmittal Letter, which includes a brief introduction, the role of the measure and committee, the purpose of the report, and framing around the status of SHS as Metro moves into the second part of implementation.

Committee members had the following questions and comments:

- **Comment, Peter:** It is important to note that the report covers a certain timespan, but we are sending it out in a different timespan. Shortly into the new timespan, Clackamas County Regional Long Term Rent Assistance (RLRA) hit its cap and because of possible budget challenges, they are pulling back. We may want to indicate, with an asterisk or footnote, the changes and the caps that may have happened after the timespan of this report.
    - **Kris response:** You are getting at a challenge Metro faces each year with this report. We aim to present a comprehensive body of information. We could add some language noting this is focusing on a particular data set, and that data may have

changed when we give presentations about the report. I will try and add more clarifying language about what we saw through the end of the fiscal year.

- **Comment, Dan:** We have to keep in mind that not everyone will get a presentation, so that clarifying language in the report will be helpful.
- **Comment, Dr. Bane:** I appreciate the highlighted sentence. It is reflective of what I see in the report, and the times are changing.

Key Highlights Section

Kris reviewed the key highlights section, which serves as an executive summary of the key content of the report.

Committee members had the following questions and comments:

- **Question, Peter:** I suggest adding a high-level introductory sentence on what projects the committee is working on. I am also confused on RLRA and the overlap with permanent supportive housing (PSH). Is all RLRA, PSH and vice versa?
    - **Kris response:** I can add more information on RLRA program policies and who it serves. RLRA is a tool to provide long term rent assistance and commonly used as a key component of PSH. One of the challenges referenced in the transmittal letter and recommendations are around needing to do work for greater alignment on PSH definitions.
    - **Metro response, Yesenia:** Kris spoke eloquently about this. They are not interchangeable, there are differences. In Summer 2024, the Metro PSH lead joined an SHS meeting to give a presentation, and we could link that meeting in the final report so folks can review that final presentation.

Challenges Section

Kris reviewed the challenges section, which focuses on four broad topic areas: growing need, competing priorities, financial oversight, and regional evaluation.

Committee members had the following questions and comments:

- **Comment, Peter:** Clackamas County has not had an LIP since April of 2022. Any additional indication would be incorrect. I think Washington County was the only county to create a multi-year expansive LIP, so maybe it can be written as a kudos to Washington County.
    - **Kris response:** There was general agreement among this group to keep the report focus at the regional level and not call out specific counties in the transmittal letter. But I will make sure the language is accurate.
- **Comment, Dr. Bane:** Related to the "growing need" section, I think that is an unrepresented challenge and is of extreme importance. The need is outpacing the resources. We need to know who this need is coming from. Who are the people coming into the system and what do they need? It would help to clarify who is coming into the system, and the data from the coordinated entry program could give us an up-to-date snapshot of who is coming in, where they are coming in, and what they need.
    - **Kris' response:** That is a good point. We can look at the data and flush this section out a little bit.
- **Comment, Peter:** There may be some confusion in Clackamas County about this. Clackamas County former Board of Commissioners has different talking points than what this report

shows, this report is not how we have been talking about the data. Clackamas might need to see a call out of the region-specific data.
    - **Kris' response:** I can talk about the range.

Kris indicated she would be providing an updated version, either redlined or highlighted by revised sections. Josh reminded the group to send any additional edits to Kris as soon as possible.

FY24 Recommendations Development

Kris provided a broad overview of the edits to the recommendations that were made after the committee's discussion in the January 13th meeting. Josh indicated that there would be a temperature check on these recommendations with the group following Kris' overview. Yvette displayed the drafted recommendations.

Committee members had the following questions and comments:

- **Comment, Peter:** As we look at the new priorities, I would like to see more sequences. I also want to see that providers want to be at the decision-making table. We want to be thought partners and help create the system and be a part of that accountability. It could expand in the provider partnership section, or in the oversight section. Metro, Counties, and providers need to be working together.

Josh called for a temperature check, asking members to share a thumbs up for full approval, a thumb sideways for approval but with some additional suggestions, and a thumbs down if they had concerns with approving the recommendations. A majority of the group indicated via thumbs up that the draft shared today incorporates the committee's thoughts and recommendations and that they would be comfortable approving the recommendations. Some group members indicated via thumbs sideways that they were comfortable with the recommendation but also had ideas for additional improvement. No members shared a thumbs down.

Josh facilitated discussion around final suggested improvements.

- **Comment, Co-chair Savara:** This generally captures our recommendations. There are a few recommendations where I do not think we have solidified a solution. I want to hear from other folks.
- **Comment, Peter:** I shared my thoughts moments ago.
- **Comment, Dr. Bane:** I appreciate and generally like the recommendations. I missed the last meeting, and have not seen a meeting summary, so I am not really sure I understand everyone's thoughts and how these recommendations came to light. I want to review the last meeting summary.
    - **Josh response:** I know that meeting summary is working it's way through internal approval and we will make sure you receive it and aim for a quicker turnaround on those.
- **Comment, Kai Laing:** It is good to see the group's additional suggestions for refinement, and this is good as written.
- **Comment, Jeremiah Rigsby:** I agree with a lot of the things folks are saying around providers. I care about jurisdictional partnerships and decision-making space. I am concerned about the swirl around Metro and the counties' roles and am wondering what our role is as we think about oversight bodies moving forward.

- **Comment, Felicita:** I want to give major kudos to Kris for this work. The only thing that stood out to me was some of the language on page 8 and 9 of the letter around oversight and accountability and jurisdictional partnerships. I wrote out my suggested changes in the chat:
    - Page 9 suggested rephrasing: *The oversight committee recommends that collaborative efforts to shape the processes and requirements of the SHS measure are consistently used. The Committee requests that a framework for decision-making be agreed upon by the Counties and Metro with a process that ensures the Oversight Committee itself can enact decisional authority on key topics relating to the oversight of the SHS funds*.
    - Page 8 suggested rephrasing: *The SHS Oversight Committee through Metro staff should be empowered to conduct core oversight functions in alignment with funder best practices. This includes performance monitoring, evaluation, and compliance activities on a regular basis.*
        - **Kris Response:** I would like to hear from committee members if they are comfortable with these recommended changes.
- **Comment, Co-chair Savara:** I fully support the recommended changes here. For the first one, I love the idea of creating a framework that Metro would work with the counties on. That framework should encompass how decisions on funding are made and bring clarity to who makes budget decisions or why they are made. There have been times when that has not been clear. I like that this elevates the committee's role of meaningful oversight.
- **Comment, Peter:** I agree with what Mike beautifully said.
- **Comment, Dan:** I am wrestling with this tension, but where does it exist? The funding and oversight of this measure is from the top down and region-wide, while the delivery is bottom up. It comes from the nonprofits and the counties. Policy is better with cooperation and consensus decision-making. We have to decide things collaboratively. I support the language Felicita put forward. I really like the language in the oversight and accountability section.
- **Comment, Cara Hash:** I have no additional thoughts. Felicita's additional language captures that piece.
- **Comment, Jenny:** I echo that. Thank you, Felicita, and thank you Kris for your work on this.

Josh asked folks to indicate their support for Felicita's proposed updates, and there was full agreement among committee members to incorporate Felicita's recommended language. Josh noted that the group will officially vote on these in the next meeting.

Next Steps

Yesenia stated that feedback on the draft report would be incorporated into the next version, with the hope of voting on the draft at the February 10th meeting. All additional feedback or questions should be sent to Kris as soon as possible. Yesenia will reach out to members not in attendance to bring them up to speed. Depending on the vote on February 10th, we will begin to work on the presentations to counties and Metro Council. The Metro Council presentation is scheduled for March 4th, Multnomah County on March 18th, and Washington County on April 1st. We are still working on scheduling Clackamas County.

Adjourn

The meeting adjourned at 11:23am.