Joint Office of Homeless Services

Frequent User System Engagement (FUSE) Pilot

Multnomah County Board Briefing

Today's Agenda

- FUSE Overview
- Background - FUSE 1.0
- FUSE 2.0
  - Team
  - Data
  - Program Design
  - Evaluation
- Challenges and Opportunities
- Alignment
- Q&A

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What is FUSE?

- FUSE is an innovative multi-stakeholder partnership using data to help communities break the cycle of homelessness and crisis among individuals with complex medical and behavioral health challenges by providing targeted PSH. Individuals stuck in this cycle have frequent encounters with emergency departments, jails, shelters, and acute care settings that are often costly and have poor outcomes for people and communities.

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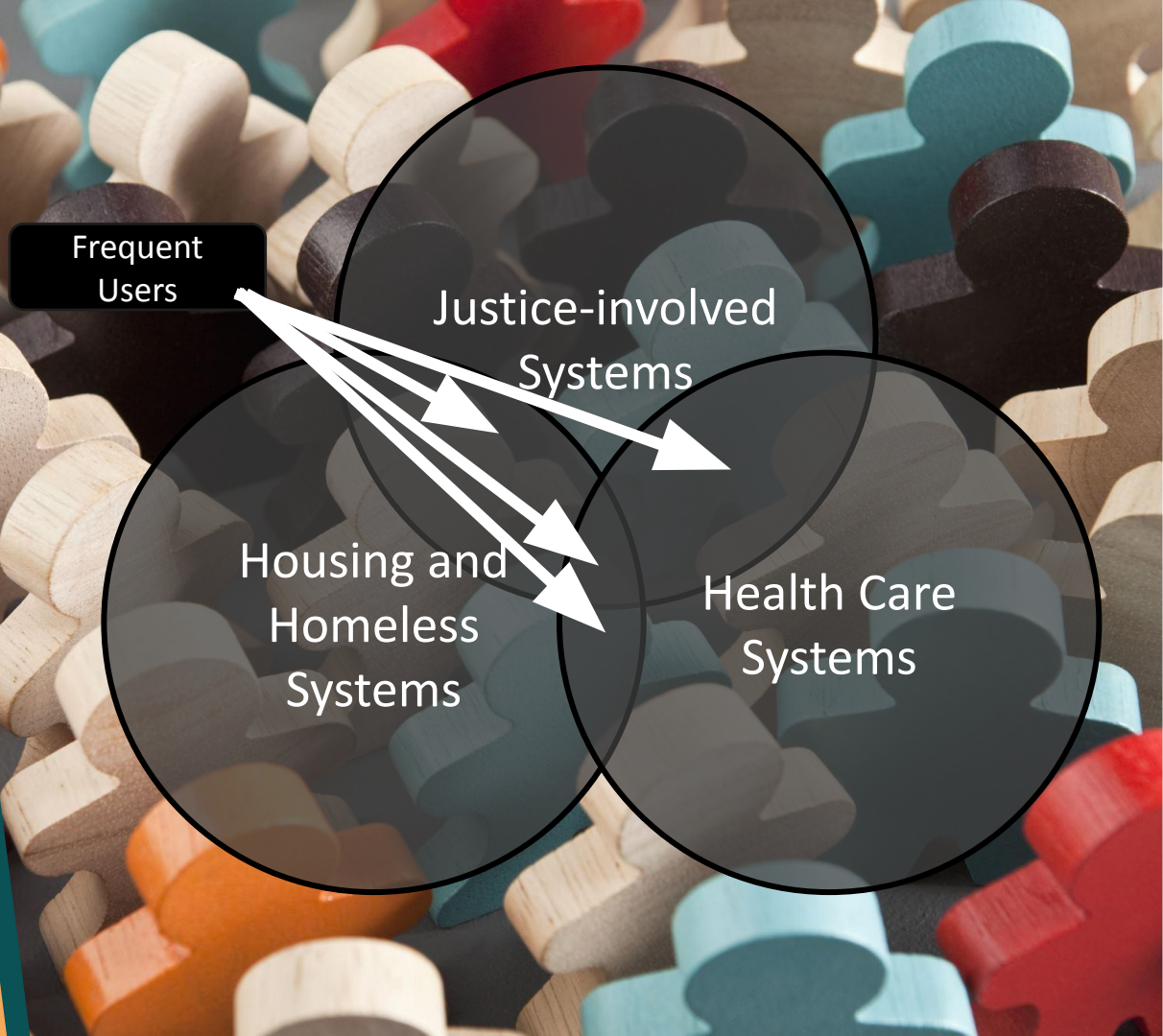
CSH

Who are Frequent Users?

- Periods of institutional involvement and homelessness
- Often lack "chronicity" status
- Siloed service provision allow for frequent use to go undetected
- Community-determined definition and measures



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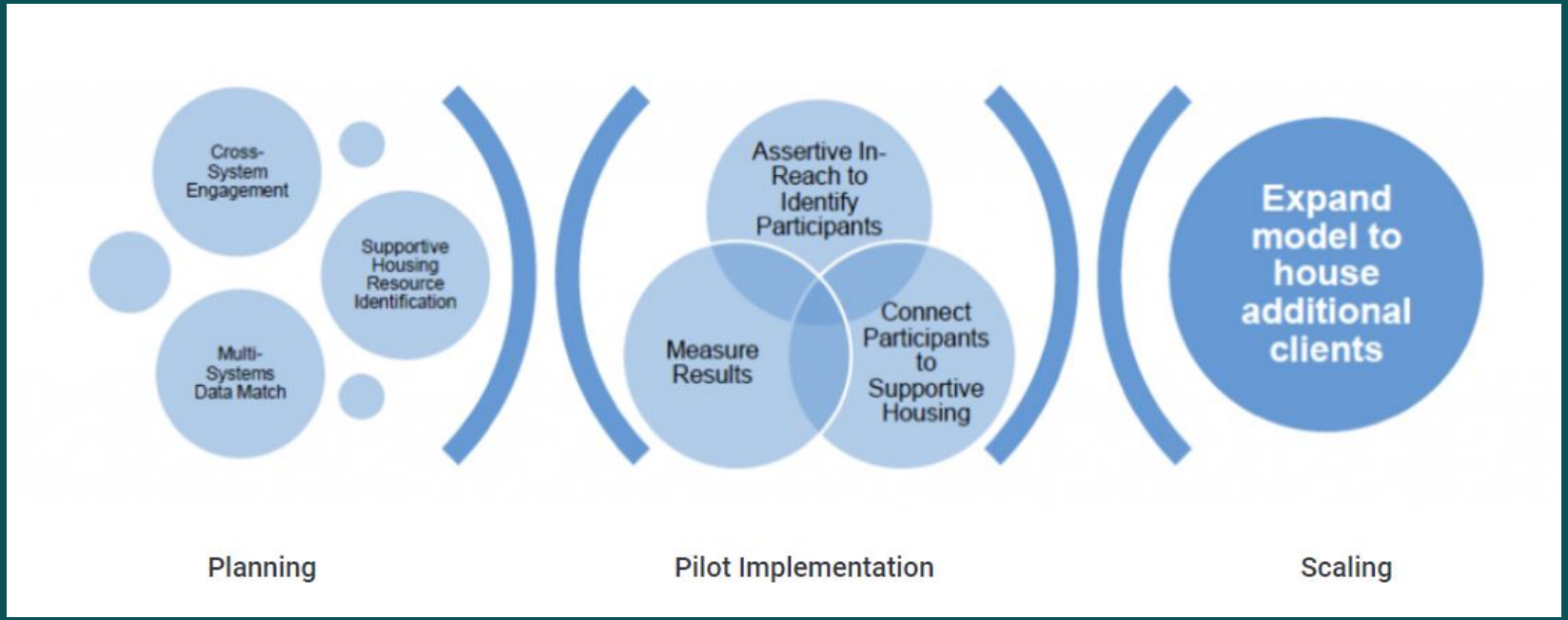
The CSH FUSE Roadmap



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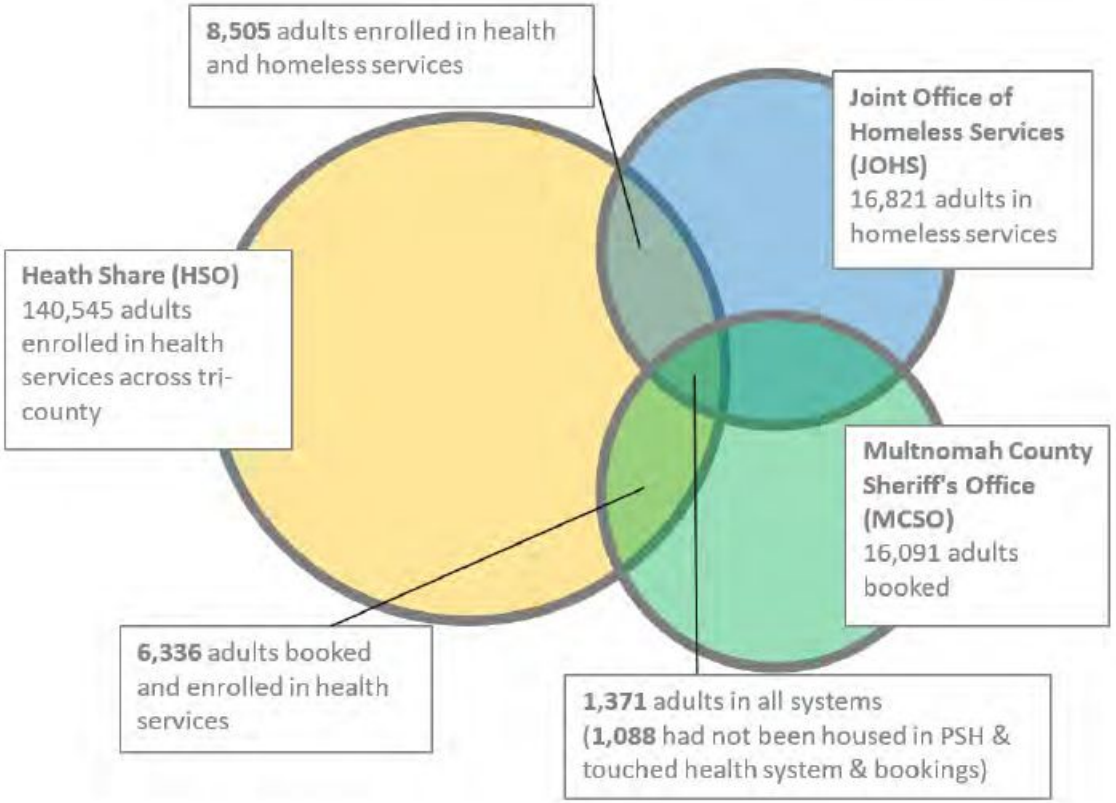
FUSE 1.0

In 2018-2021 cross-system partners shared data across the 3 systems to identify aggregate data about highly impacted people cycling through the systems that would benefit from PSH



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FUSE 1.0

Summary of Impact Analysis

Partners in the FUSE initiative released a report in May of 2021 that included findings from a cross system data analysis, and a set of recommendations for the work moving forward

- Highly impacted people often cycle through and are overrepresented in jails, shelters [and on the streets], hospitals and other crisis services without reaching stabilization
- Lack of coordination of services and connection to housing for individuals who touched multiple systems.
- Need to provide intensive, culturally specific, and individualized services for individuals across systems
- Supportive Housing (SH) reduces adverse system interactions & need for high system utilization particularly for inpatient psych
- SH demonstrates cost saving

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Goals of FUSE 2.0

1. Move forward on the lessons learned from FUSE 1.0
2. Create an updated matched list with expanded data sources and PII
3. Build a multi-stakeholder team for cross-system collaboration
4. Pilot programming by housing 40 individuals in PSH
5. Use FUSE as a catalyst for systems change
6. Engage providers & people with lived experience about service, funding & partnership needs

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FUSE 2.0

Multi-Stakeholder Collaboration to create and maintain cross-system engagement

- Behavioral Health Division
- Corrections Health Division
- Department of Community Justice
- Department of County Human Services
- Health Department
- Health Share of Oregon
- Joint Office of Homeless Services (Planning & Evaluation, Data, PSH, Equity Teams)
- Multnomah County Sheriff's Office
- Corporation for Supportive Housing [CSH] (Technical Assistance Provider)

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FUSE Data

Complete

- Pre-match analysis by Health, Homeless, and Criminal Justice System
- Data Shared between DCJ/MCSO and JOHS
- Executed MOU between Health Share and Multnomah County
- Shared Data with Health Share
- Identified Data Sharing Program suitable for this project and passed through DCA approval process

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FUSE Data

In Progress

- Health Share developing script to complete the match
- Multco IT developing script/working on program to match criminal justice and homeless data
- Identifying "benchmark thresholds" for matched list in alignment with the Philadelphia Hi-Five method

Next Steps

- Final full matched list between all three system - likely to be much higher than 160 and will need to work on prioritization/additional eligibility criteria in alignment with FUSE and SHS goals
- Equity analysis of the matched list to ensure data match is not replicating systemic inequities

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Future FUSE Data Analyses

With the data garnered from the FUSE data match we will be able to:

- Identify adults who have interaction between homeless system, health care system, and criminal justice system for eligibility for FUSE pilot PSH
- Understand the population who are identified as frequent users
- Set further "high utilization" indicators to derive lists of people intended to be served with FUSE
- Identify trends between homeless services, sheriff's office bookings data, and healthcare data
- Conduct a racial equity analysis of this population
- Other health outcome analyses conducted by Health Share

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FUSE Programming

- FUSE NOFA introduced a new funding model of match-making providers
- Providers were scored by a panel of diverse stakeholders on their program design, experience, ability to serve the FUSE population, past partnership experience, & ensuring racial equity in programming
- Top applicants were then interviewed by CSH, who provided a final funding recommendation to the project team

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FUSE Programming

Program Design and Defining Elements:

- Regional Long Term Rent Assistance (RLRA) Vouchers
- Outreach and Housing Navigation
- Tenancy Support Services
- Behavioral Health and/or Substance Use Treatment Services which include in-house support and connections to intensive services as needed
- Multi-provider collaboration and partnerships with health systems and medicaid
- Connection to community and mainstream resources

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FUSE Programming

Next Steps

- Contract finalization
- Collaborative Budget finalization
- MOU between providers and JOHS
- In-person FUSE orientation with providers & community partners
- In-reach, Outreach, and Lease Up

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Evaluation

Measures Inventory

In addition to standard performance measures that JOHS providers are evaluated by, the FUSE project team is currently designing a measures inventory for key FUSE performance measures, their connection to success, and their business logic.

- Includes quantitative and qualitative measures and regular feedback from people with Lived Experience and current participants
- Examining both the participant outcomes and experience as well as provider experience in program design, referral patterns, service use/provision, etc.
- E.g. Returns to homelessness, retention rates for BIPOC participants, post-enrollment jail bookings, in-patient psych stays, & ED visits

Category	Measure	Connection to Success	Business Logic (if applicable)	Data Elements	Data Source	Access?
Housing	ex. Length of stay in housing	Increases in lengths of stay is indicative of housing stability. We want the program to support and sustain people in permanent housing long-term.	Comparing the date difference from housing move-in date with either the report period end date or program exit date, whichever comes first.	Project Start Date Project End Date	HMIS HMIS	Yes Yes

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Challenges & Opportunities

Data Sharing

- Our systems are not designed to talk to each other - getting them to a place to talk to each other in a meaningful, bi-directional way e.g. challenges with HIPAA, challenges with HMIS capabilities. Designing systems differently to effectively talk to each other takes significant problem solving and strategic investment.
- The final data sharing agreement executed with Health Share provides the framework for much larger and more regular data sharing between the county and Health Share.
- This data sharing agreement can also serve as a regional template for addressing social determinants of health.

Challenges & Opportunities

New Funding Model

- Providers noted they would prefer more say in the service delivery model including what elements of the service delivery model they are able to apply for, and support from JOHS in forming relationships with other CBOs who could fill in service gaps
- Offered a new model of NOFA application which resulted in a longer process
- Learned a best practice: interviewing top candidates for NOFA's to learn more about what they can offer and their experience

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Opportunities & Alignment

FUSE Contributions to current and future systems alignment work

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Integrating Healthcare & Justice Information with Housing Data for Future Programming and Prioritization

Medically Vulnerable Populations

Focus population from HMA

Behavioral Health and Housing

Evolving Coordinated Entry

- Combining multiple system data to augment prioritization process
- Combined with Built for Zero, new ways to identify and prioritize services beyond PSH

Medicaid Waiver

Identifying shared populations, Data sharing for client service coordination and braided funding


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