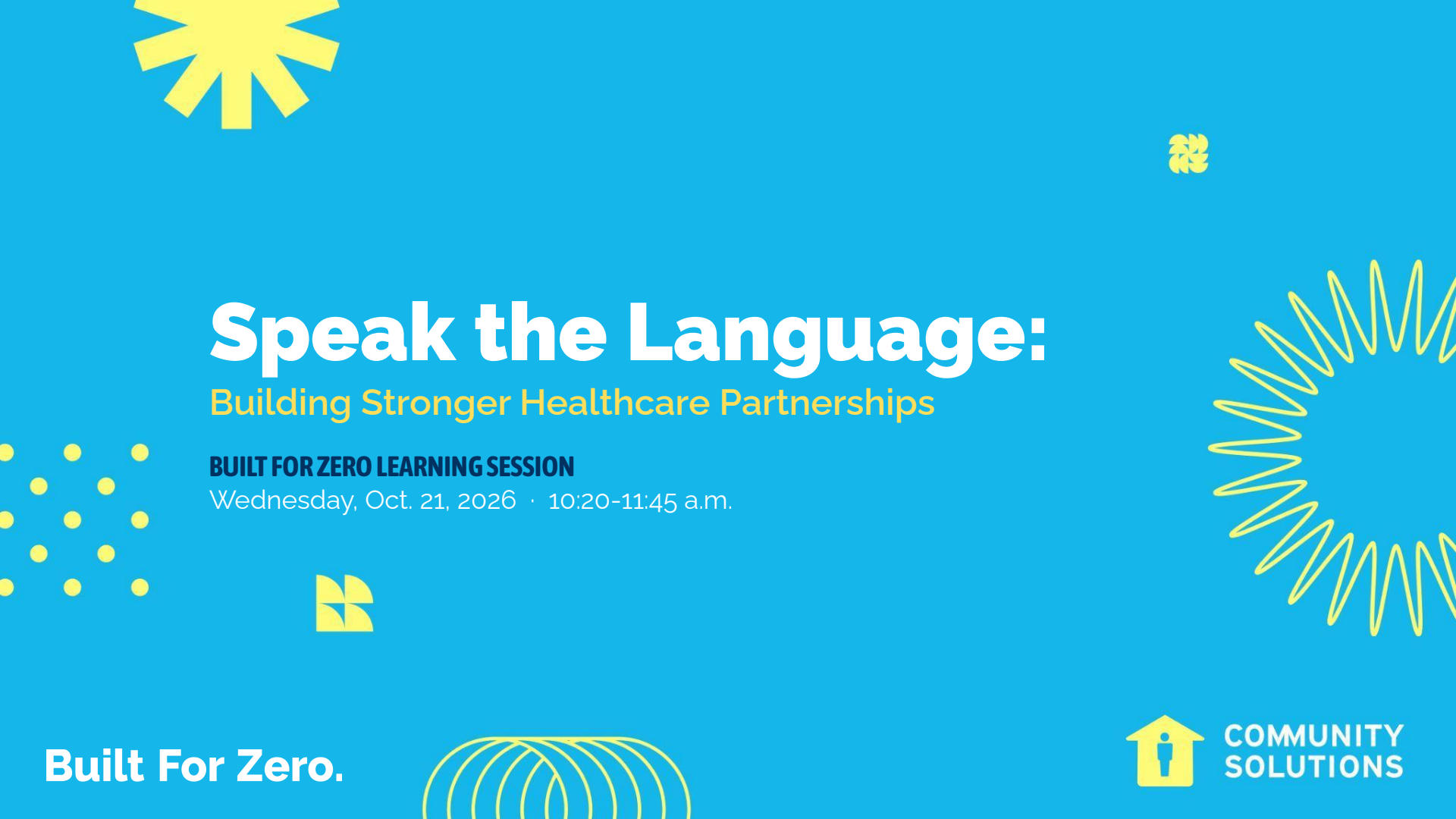




Speak the Language:

Building Stronger Healthcare Partnerships

BUILT FOR ZERO LEARNING SESSION

Wednesday, Oct. 21, 2026 · 10:20-11:45 a.m.

Built For Zero.



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What you'll leave with

1

Learn important terminologies and considerations

What is front of mind for health care institutions.

2

Walk through current trends

Medicaid reforms as well as policies and funding tools being adopted by health institutions and public sector

3

Build partnerships that last

Align goals, share risk, and build trust across sectors. Think through practical considerations like billing.



Today's flow

- **Welcome and poll the room** · 5 min
- **Panelist spotlights** · 35 min
- **Moderated discussion** · 20 min
- **Audience Q&A** · 20 min
- **Takeaways and next steps** · 5 min

House People Every Day



House People Every Day



What brought you here?

Raise your hand if you want to...



- Explore opportunities for partnerships for services and case management – where to start
- Build more effective relationships with health payers and institutions
- Understand the nuts and bolts of Medicaid and health funding partnerships
- Hear lessons and practices that could improve existing collaborations



PANELISTS



Jean Field

Director of Policy and
Implementation,
Homebase



Aubrey Patino

Principal, Fractal
Consulting



Ann Oshel

SVP, Community
Innovation and
Impact, Alliance
Health



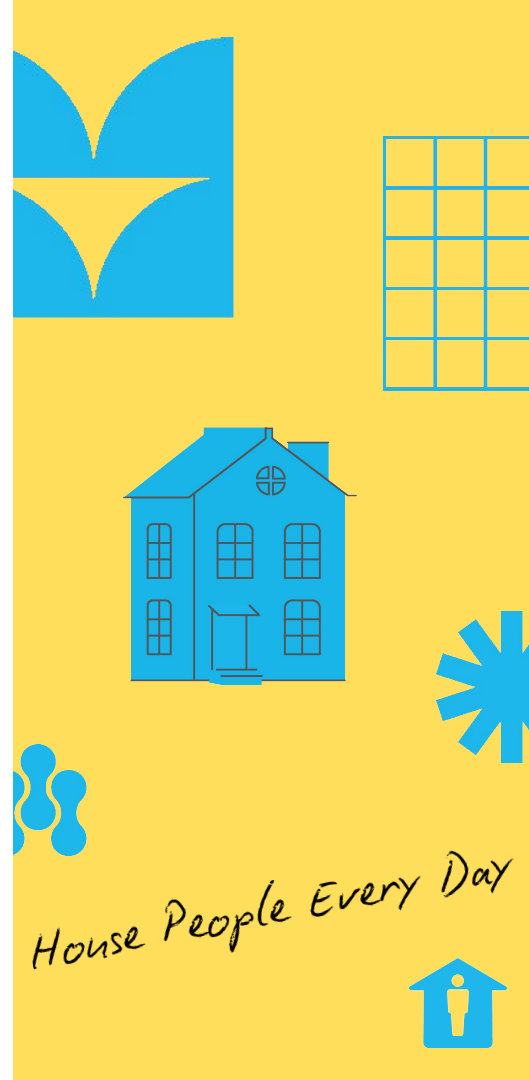
Adam Peterson

Portfolio Manager of
Healthcare and
Homeless Services
Integration, Health
Share of Oregon



Walk in our shoes

- Ending unsheltered homelessness takes every sector at the table
- Partnership starts with knowing what the other side is up against
- Political, financial, and operational realities shape every yes or no
- We haven't figured it all out, and we'll be honest about that

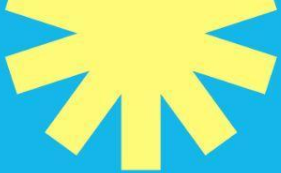
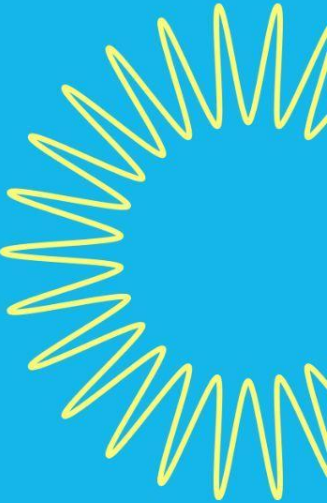


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Panelist spotlights

BACKGROUND AND EXAMPLES · 10-15 MINUTES EACH





Jean Field



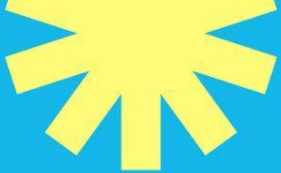
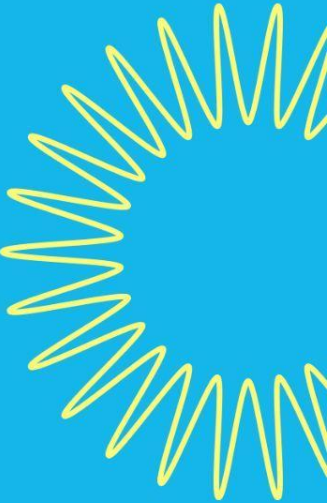
HomeBase

Director of Policy and Implementation,

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Partnerships with healthcare providers

A spotlight on collaboration strategies



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Why Collaborate With Healthcare?

High need: People experiencing homelessness are exposed to many communicable diseases, infections, malnutrition, stress, and exposure - and homelessness makes existing conditions worse

Low access to treatment: People on the streets, in shelter, or unstably housed are often unable to access treatment - even when insured. Even those placed in housing may not receive the supports they need

Shared clients, disconnected systems: Most housing and healthcare systems of care don't adequately communicate about shared treatment or interactions with shared clients

Results:

- Missing information about people's history, needs, whereabouts
- Costly duplication of efforts and failed interventions
- Failure to connect people to needed resources - interventions often depend on where people enter the system



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Who are Healthcare Partners?

- Federally Qualified Health Centers, especially Healthcare for the Homeless programs
- Medicaid Managed Care Plans
- Hospitals
- Behavioral Health Agencies (county and others)
- Street Medicine providers
- Providers using Medicaid and other healthcare funding to serve people experiencing homelessness
- Plus... VA hospitals, other population-specific clinics and providers

Find a Health Center:

<https://findahealthcenter.hrsa.gov/>

Health Care for the Homeless Grantee Directory:

<https://nhchc.org/grantee-directory/>

National Association of Rural Health Clinics: <https://www.narhc.org/>

Find your State Medicaid Agency:

<https://www.medicaid.gov/about-us/where-can-people-get-help-medicaid-chip>

How to Collaborate?

System Level

- **Find your partners**
- **Educate each other:** resources, needs, areas of expertise
- **Share information** on clients, system data, available and needed
- **Plan together** to align services and funding for effective partnership
- **Braid funding for interim and permanent housing** to meet the needs of medically vulnerable people

Better Access to Health Resources and Housing

- **Leverage HMIS and Coordinated Entry and other case conferencing** for health care referrals, followup care, and shared services
- **Coordinate outreach efforts** (ie street medicine, housing navigation)
- **Streamline** eligibility and enrollment assessments, documentation
- **Bring medical, behavioral health supports onsite** to interim, permanent housing

Co-create Housing-Health Resources

- **Support discharge planning** through housing connections (navigators, CE, followup)
- **Provide medical respite, recuperative care** and other post-hospitalization treatment
- **Expand provider capacity** for housing-related Medicaid benefits and services
- **Leverage funding for pilots and best practices** (ie community-based workforce initiatives, co-located care)

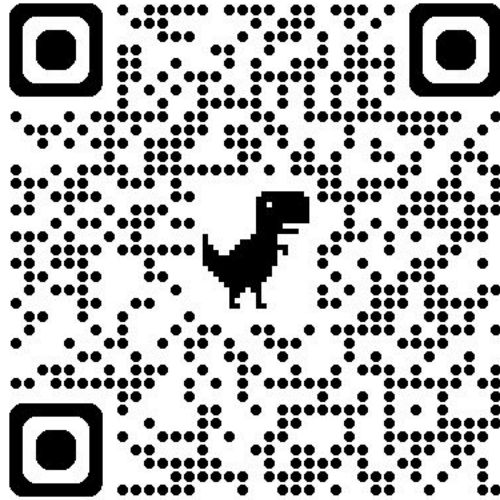


House People Every Day



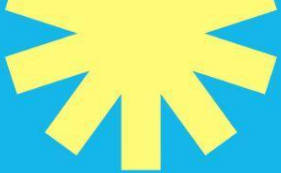
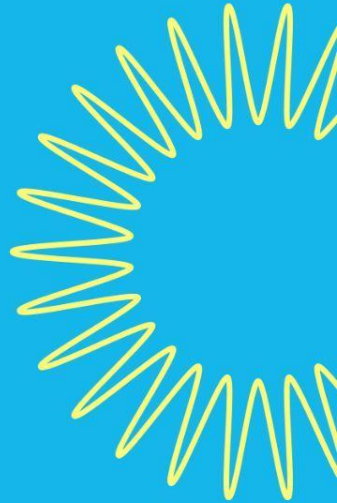
Resources on Partnerships and Practices

Thank you! Homebase hosts resources for homelessness and healthcare providers on its website



House People Every Day





Aubrey Patino

Fractal Consulting
Principal

Built For Zero.



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Provider Readiness

PROVIDER READINESS ASSESSMENT & TECHNICAL ASSISTANCE

01

Governance & Operations

- Understand your WHY
- Leadership & Board alignment
- Accreditation
- Documented P&Ps
- Billing & financial readiness

02

Data, IT & Reporting

- HIPAA-compliant systems
- Dedicated PQI personnel
- Documentation standards

03

Service Provision

- Benefit alignment with services
- Time studies for billable hours
- Qualified staff & training plans
- Quality supervision & oversight

31 STATES WITH CMS APPROVAL FOR HOUSING RELATED SERVICES [CSH]

Michigan Case Study

STEP 01

Provider Level

Assessing provider readiness and offering hands on TA.

STEP 02

Engaging Health Plans

Convening payors, breaking down silos, and supporting providers in case-making to secure contracts.

STEP 03

State-Level Advocacy

Convening state leadership across different agencies, doing data pulls, and leveraging cross-agency expertise.

STEP 04

CCBHC Exploration

Analyzing the capacity of Certified Community Behavioral Health Clinics to integrate housing supports. Partnering with CCBHCs to add housing providers as Designated Collaborating Organizations (DCOs).

EMERGING LESSONS & OPPORTUNITIES

- 1 Rate Setting:** Do rate studies & establish standardized reimbursement rates.
- 2 Systems Coordination:** Create dedicated cross-agency workgroups to resolve barriers.
- 3 Policy Levers:** Encourage state housing finance agencies to leverage benefit in PSH pipeline.
- 4 Benchmarking:** Establish clear benchmarks for provider performance.
- 5 Education:** Engage in statewide education for key stakeholders.
- 6 Local Examples:** Document innovative operational models to support replication.

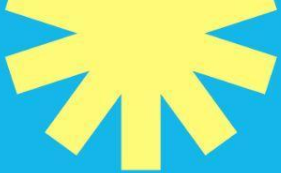
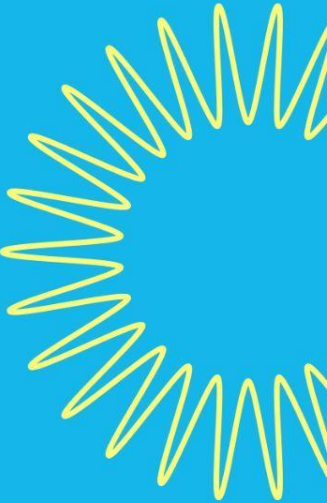
Recommendations to Improve Medicaid Utilization

National & State Analysis

- Evaluate HRS influence on provider revenue, housing stability, and health outcomes.
- Review capacity, billing, reimbursement, referral pathways, and cross-agency coordination.
- Align with HUD & CMS standards.

Implementation

- Bridge implementation gaps with TA.
- Design implementation to support organizations newer to Medicaid.
- Highlight quality of care and quality improvement opportunities.



Ann Oshel

ALLIANCE HEALTH

SVP, Community Innovation and Impact



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Alliance Health

Ann Oshel, SVP Community Innovation and Impact

aoshel@alliancehealthplan.org

Working with your healthcare partner

- We all have the same goal and want the same thing... we just pay for it differently
 - Find the right leverage points
- We are also highly regulated and limited in what we can do AND we need each others expertise and resources
 - Don't give up when it gets hard!
- If we tell you we really don't have to kill you
 - HIPAA is not always a barrier
- You have data we need and we have data you need
 - Together we can tell a complete story

Working with your healthcare partner

- Medicaid operates under “medically necessary services” and clinical coverage policies AND there is still flexibility
 - Ie. Specialized ACT Teams
- Find a champion
 - Learn our acronyms and we will learn yours
- Housing IS Healthcare
 - Create a shared narrative that is mutually reinforcing

Examples of Our Programs and Partnerships

- Wellness Without Walls Street Psychiatry Team (funder)
- Wake@Home Street Medicine
- Street Medicine Pop Up events (funder)
- Clinical Outreach Teams
- \$8 million in capital investments (funder)
- Wake Medical Respite (funder)
- Allocated over 150 Mainstream Vouchers (fund a PHA Liaison)
- \$600,000 in financial assistance (funder)
- Recovery based transitional housing (funder)
- Complex Case Conferencing (Care Review)
- Developed Universal Consent for information sharing



Adam Peterson

HEALTH SHARE OF OREGON

Portfolio Manager of Healthcare and Homeless Services Integration,

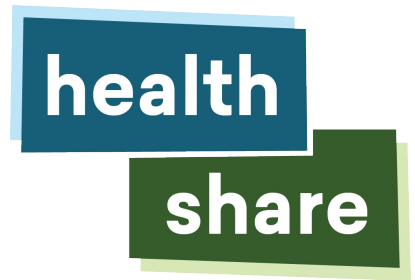
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Health and Housing Connection

Adam Peterson, Portfolio Manager of Healthcare and
Homeless Services Integration
Built for Zero Work Session
October 2026



Health Share of Oregon

Background

Health Share of Oregon is the state's **largest coordinated care organization (CCO)**, with approximately **460,000 members** in the Portland Metro Area.



Health and Housing Partnership Highlights

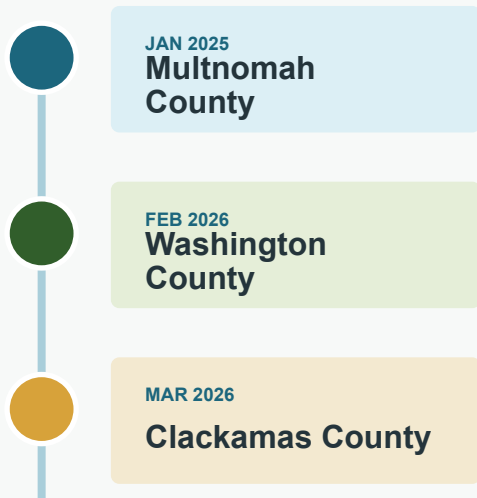


- Data sharing (HMIS and Medicaid claims)
- HR1 – Medicaid continuity planning
- Cross-sector case conferencing
- Health Related Social Needs (HRSN)
- Health and Housing Insights

Regional Health and Housing Data Partnership

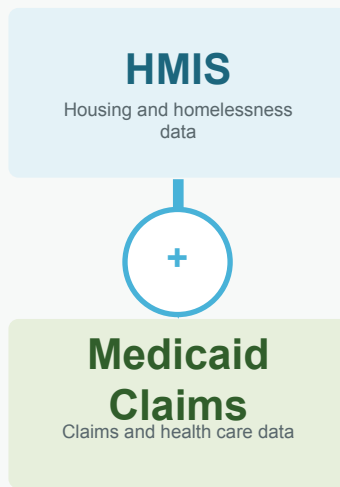
Building a tri-county view of homelessness, housing and health care

DATA-SHARING MILESTONES



Each agreement supports sharing of Homeless Management Information System and Medicaid claims data.

CONNECTED DATA



WHAT THE PARTNERSHIP ENABLES

01

Regional insight

A unified regional view of the intersection between health and housing.

02

Coordinated member care

Stronger connections and greater capacity for collaborative care.

03

Deeper program specific analysis

Infrastructure to analyze health care impacts and housing outcomes for specific housing programs and their residents.

From separate datasets to a shared regional picture

HR1 Homeless System Engagement Work Plan

Objective

Identify matched Health Share members subject to HR1 work requirements and support counties to assist homeless service provider networks reduce coverage disruption

2026

Count Impacted Members

Build an **aggregated** HMIS-matched impact file by county, program type and project/provider type.

Align With County Systems

Use aggregated findings with county homeless response systems to size and shape the cross-sector response.

Equip Provider Network

Share counts and tools; deliver training, education and self-attestation guidance.

2027

By-Name Outreach

January 1, 2027, transmit by-name impacted-member lists for county distribution.

Sustain County Support

Share retention insights and maintain regular by-name and matched-member data feeds.

Health Share Data Deliverables

- 1) One-time aggregated HR1 Impact List showing the number of de-identified members in each homeless program
- 2) Ongoing HR1 By-Name Impact List showing named clients residing in each homeless program
- 3) Monthly HMIS Matched Member Remit File with HR1 Y/N Work Flag and Renewal Date – Shared monthly

Cross-Sector Case Conferencing

A shared approach to connect health care and homeless services

THE CHALLENGE

Fragmented systems slow support

Health care and housing partners have not always had consistent ways to coordinate around shared clients.

Goal

Shift from “my client” and “my resources” to shared responsibility and shared solutions.

HOW IT WORKS

1

Refer

Housing providers identify people with complex, unmet needs.

2

Convene

Health and homeless-services partners meet twice monthly in each county

3

Coordinate

Partners identify connections, clarify roles and build a shared action plan.

WHY IT MATTERS

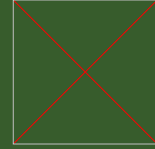
Inclusive access
serves all insurance types, including people without insurance.

Faster connections
Links people to resources efficiently and saves staff time.

Stronger capacity
Builds cross-sector knowledge and health care navigation skills.

Cross Sector Case Conferencing

Client Story - Wrap Services Around Member to Avoid Eviction



- A 56-year-old African American woman residing in permanent supportive housing faces potential eviction linked to challenges related to her substance use.
- Experiencing psychosis and substance use disorder challenges
- Referred for access to culturally responsive care
- In conference, assigned to a **culturally responsive** SUD care coordination program
- Case Manager connected to community based behavioral health outpatient team

Case Conference Outcome

She maintained housing thanks to additional supports

Cross Sector Case Conferencing: Early Reach and Outcomes

Participant results, six months before and after case conferencing

366

MEMBERS
ENGAGED

493

CASE CONFERENCE EVENTS

Outpatient SUD Treatment: Events per 1,000 member months

Pre case conference	Post case conference	Difference
688.82	1,181.70	492.88

6 months pre and post case conference



Inpatient Medical: Events per 1,000 member months

Pre case conference	Post case conference	Difference
59.58	31.54	-28.04

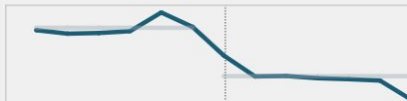
6 months pre and post case conference



ED Visits: Events per 1,000 member months

Pre case conference	Post case conference	Difference
375.75	195.38	-180.38

6 months pre and post case conference



Events per 1,000 member months

**EARLY
SIGNAL**

Lower emergency and inpatient use, with greater connection to outpatient SUD treatment.

Pre/post trends only. No comparison group; results do not establish causality.

Program and claims data updated 10/14/2026

Health Related Social Needs (HRSN) Benefit

- State Medicaid agencies are exploring covering HRSN through 1115 waivers
 - 18 states have social determinants of health waivers (as of 10/15/26)
- Oregon's 1115 waiver launched in 2024 and includes:
 - Climate
 - Housing
 - Nutrition supports
- Elements
 - Includes CBOs contracted to deliver approved benefits.
 - Unite Us – technology platform connecting health care and social service providers
- Unclear future of HRSN nationally
- Lots of learning of role of Medicaid in partnership with housing sector



Housing and Health Care Opportunities



- Combined data sets creates opportunity for shared populations of focus between health and housing systems
- Better alignment of resources creates opportunity for optimized service matching
- Cross-sector partnership removes barriers for member coordination
- Bottom line: healthcare and homeless systems integration leads to better member outcomes in both health and housing

Moderated discussion

FIRESIDE CHAT • 20 MINUTES



Your questions

AUDIENCE Q&A · 15 MINUTES



- How could this work in your community?
- Which partner is missing from your table?
- Where do your partnerships get stuck?





One action to take tomorrow

ROUND ROBIN

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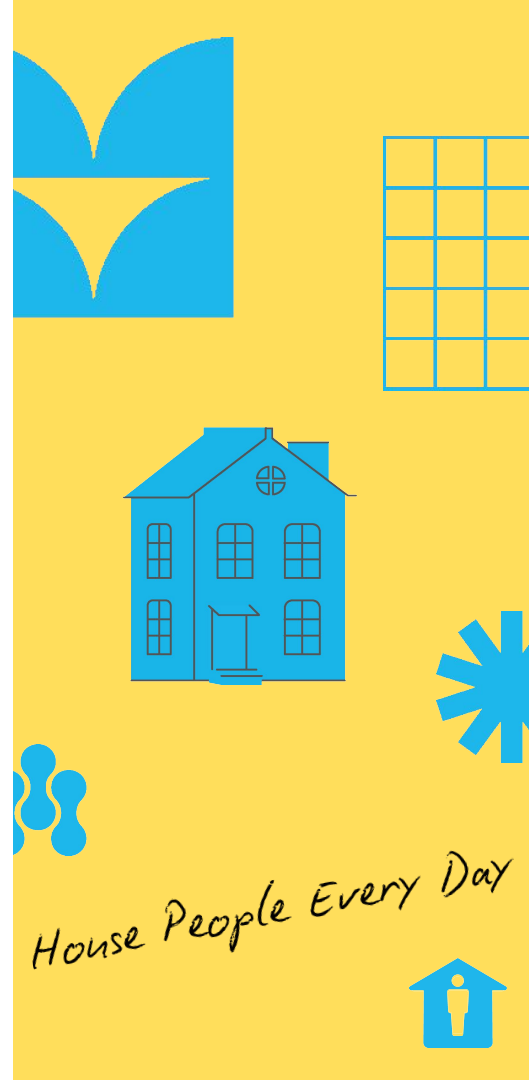


Session Feedback

Please scan the QR code to complete the feedback survey.



<https://survey.alchemer.com/s3/9042138/2026-BFZ-Learning-Session-Workshop-Session-Feedback>



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Thank you

