HOUSING WITH SERVICES

Executive Summary, October 2016

Institute on Aging, Portland State University

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Acronyms and Abbreviations

CORE	Center for Outcomes Research and Education, Providence Health & Services
DADVS	Department of Aging, Disability and Veteran Services, Multnomah County
ED	Emergency department
HWS	Housing with Services
IP	Inpatient hospitalization
LLC	Limited Liability Corporation
OPMH	Outpatient mental health
PCP	Primary care provider
T1	Time 1 survey (pre-Housing with Services)
T2	Time 2 survey (16 months after HWS started)

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Executive Summary

The evaluation of Housing with Services, LLC (HWS) was designed to assess the implementation process and impacts of a novel program of coordinated health and social services on behalf of over 1,400 residents of 11 affordable housing properties in Portland, Oregon. Affordable housing for older adults and persons with disabilities provides an important financial subsidy for persons with low incomes. However, housing alone is not enough for some residents who lack access to health and social resources, including a primary care provider, preventative health services, mental health services, and food. Housing with Services, LLC was formed by a group of nine non-profit organizations to address social determinants of health, including housing instability, food insecurity, and social isolation among low-income adults living in publicly subsidized housing in Portland, Oregon. The HWS team includes several housing, health, and social service agencies that collaborated to provide and coordinate services. This program aligns with the Oregon Health Authority's triple aim of better health, better care, and lower costs.

The project's launch involved forming a Limited Liability Corporation (LLC) and financial equity contributions from LLC partners: Cedar Sinai Park, CareOregon, Home Forward, REACH Community Development, Asian Health and Service Center (AHSC), Jewish Family and Child Services, Sinai In-Home Care, Cascadia Behavioral Health and LifeWorks NW. The LLC defined a governance and decision-making structure and also addressed risk sharing, intellectual property and liability protections.

Project funders included the LLC partners, a State Innovation Model (SIM) grant to Oregon Department of Human Services and Oregon Health Authority, Meyer Memorial Trust, Family Care (a regional Coordinated Care Organization), Enterprise Community Partners, NeighborWorks and Providence Health Systems. Grants from the Harry and Jeanette Weinberg Foundation and the HEDCO Foundation were used to develop a health and wellness center on the first floor of a centrally located apartment building to house HWS and LLC partner staff and space for social activities and health services.

Low-income older adults and persons with disabilities are at risk of poor health outcomes. Barriers to health and social services, combined with poor health, can lead to housing instability, homelessness, hospitalization and use of other high cost health services. By coordinating access to health and social services, affordable housing residents might have better health outcomes and quality of life, while using fewer expensive health services such as hospitals. HWS coordinated with a variety of non-profit and government agencies, including the Multnomah County Aging, Disability and Veteran's Services, health insurance providers that cover the majority of Medicaid and Medicare Advantage members in Oregon (CareOregon, Family Care, and Providence), and local social and health service agencies.

Affordable Housing Sites

The participating affordable housing properties were designated by HUD for elderly (age 62 or older) and adults with disabilities. A total of 10 properties, home to over 1,400 individuals, were

included in the evaluation (an eleventh property was excluded because of a months-long renovation project). These properties are owned or managed by three agencies: Harsch Property Management, Reach Community Development Corporation, and Home Forward (Portland's Housing Authority).

Housing with Services Program Goals and Implementation

The program goals were developed during a two-year planning process that included input from over 20 non-profit health and social service and housing agencies and state and county government staff as well as residents. In addition, a survey of resident needs and preferences was conducted, and CareOregon and Multnomah County Department of Aging, Disability and Veteran Services reviewed their respective administrative records to learn about characteristics of building residents. These various efforts resulted in the below program goals (Figure 1).

Figure 1. Housing with Services Program Goals

1	Promote optimal use of health and social services by: improving access to health and social services, and reducing health care costs associated with emergency department use and other high-cost health services	**2**	Improve access to long-term supports and services, and delay nursing home admissions
3	Improve housing stability	**4**	Improve resident quality of life
Underlying Goal: Integrate culturally-specific services & programs			

All residents were eligible for HWS-sponsored social events and service coordination. Services began in September 2014 with two HWS program staff and assigned staff from several partner agencies, including CareOregon clinical staff, community health workers from AHSC, and behavioral health staff from two mental health agencies.

Figure 2. Initial Housing with Services Program Components

- Core staff (Program Director, Operations Manager)
- Affordable housing providers and Resident Services Coordinators
- Health and social service provider partners
- Health and Wellness Center
- Resident Advisory Council
- Culturally-specific outreach, education and health navigation
- Behavioral health outreach and intervention

The program staff began by meeting and establishing rapport with residents and identifying those at risk for negative health outcomes or who were eligible for but not receiving health and social services. They helped residents enroll in health plans, access social services, connect with primary care providers

(PCP's) and acquire durable medical equipment. CareOregon staff identified at-risk residents based on referrals from neighbors or building staff who were concerned about a resident's health; referral from a health, housing, or social service agency; an inpatient or emergency department hospital encounter; CareOregon case worker referrals; and through staff follow up with a previously engaged client. Following a referral, clients might receive a visit or phone call from a CareOregon clinician or health navigator to assess the resident's current health status and need for additional support. Following an Emergency Department (ED) visit, the Health Navigator met the client to explain how to connect with a PCP and to assess reasons for the ED visit that could be prevented in the future.

Key Findings

Although HWS was in a developmental process during the first several months of this evaluation, there were several successes, emergent trends and signs of promise associated with key program components. These findings are based on two self-administered surveys completed by over one-third of building residents, analysis of health service claims records during the first 10 months of the program conducted by the Providence Center for Outcomes Research and Evaluation (CORE), and a database maintained by HWS staff that tracked Housing with Services program staff contacts with building residents.

Resident Profile

The residents who live in the participating apartment buildings served by HWS are diverse in terms of age, race, ethnicity, and income, as well as by health and disability status. Residents range in age from 24 to 94, with an average age of 67. Most residents are White and about 8% of residents are Black (based on claims records). Nearly one-quarter (24%) of those who completed two surveys identified as Asian. While all residents have low incomes as a condition of eligibility criteria, 14% of survey respondents said they have no income, and only 25% had incomes over $11,000 per year. The average length of residence was 8 years (median of 5 years), with a range from one month to 33 years.

Analysis of health insurance claims included residents enrolled in Medicaid or dually enrolled in Medicaid and Medicare: 1,395 residents of whom 500 received HWS and were treated as "cases" and the remaining 895 were treated as controls (no HWS contact). Based on claims analysis, residents with HWS contacts were older than those who did not have HWS contacts. For example, among residents who had a HWS contact, 30% were over age 70, and only 5% were under age 45. Women were about 1.3 times more likely to have a HWS contact compared to men. Residents who used HWS were at least 1.5 times more likely to have a mental health condition, and twice as likely to have diabetes, hypertension, and obesity, compared to those with no HWS contacts.

The top five medical diagnoses based on claims were asthma, chronic bronchitis, diabetes, hypertension, and obesity, and the top mental health diagnoses were affective disorder, bipolar disorder, depression, schizophrenia, paranoid state, and psychological disorder. The top 10 diagnoses reported by survey respondents were hypertension, depression, sleep disorder,

anxiety, acid reflux, heart disease, severe dental problems, diabetes, severe vision problems, and post-traumatic stress disorder (PTSD).

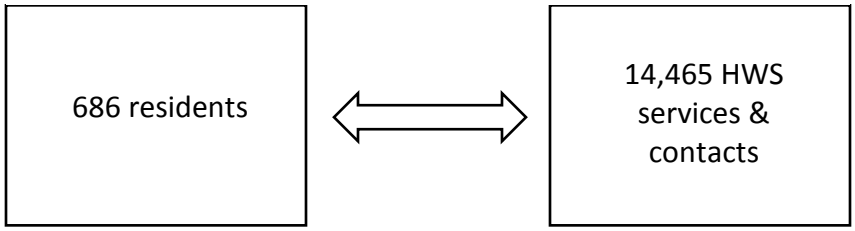
Resident Case Study: Marty

Marty, age 55, moved to his building in 2005. Before that, he had been homeless two years after the loss of a tech job and divorce. He says that his building is in an excellent neighborhood, and he is well-known locally through his volunteerism (>10 organizations). He keeps busy volunteering with FoodRx and coordinating the food pantry in his building. Marty is guided by the value that everyone is accorded a measure of respect.

Marty had significant health problems this year: He woke up with a scratchy throat and couldn't speak. After 3 weeks, he had trouble breathing at night, and the CareOregon Health Navigator advised him to go to Urgent Care rather than wait for an appointment (he didn't have a primary care physician). He was diagnosed with stage 4 pharyngeal cancer, and immediately began a treatment plan that included radiation and chemotherapy. A CareOregon nurse went to medical appointments with him. FoodRX helped with special foods and protein shakes, and Give2Get gave him a Cuisinart. Marty is now cancer-free. However, he had a heart attack, requiring hospitalization to insert a stent. During these illnesses, Marty failed his annual apartment inspection, and the Give2Get Program Manager helped him clean his apartment, enabling him to pass the follow-up inspection. Marty talks of the success of Housing with Services and Give2Get. He has been involved as a volunteer from the beginning, and can't believe how he's been able to use skills to get things done to help others.

Residents' Use of Housing with Services

Figure 3. Count of Residents Using Housing with Services, September 2014 to January 2016



HWS staff and partners used a shared database to track resident services and contacts (Figure 3). Because the number of HWS contacts ranged from 0 to over 300, the analyses compare residents who had 24 or more contacts with HWS (high utilizers) and those with one to 23 contacts (low utilizers), to those with no contacts. Among residents who completed two surveys, 19% were high utilizers, 40% were low, and 41% had no HWS contacts. High utilizers had more contact than low utilizers on advocacy, benefits, case management, information and referral, healthcare services, isolation interventions, mental health, monitoring, outreach, transportation, and various other reasons.

Figure 4. Most and Least Used Housing with Services Services/Contacts

Most frequently used	Least often used
Benefits/insurance access	Legal assistance
Information and referral	Family support
Healthcare services	Lease education
Mental health services	Employment
Isolation intervention	Fair housing
Monitoring services	
Outreach	

Sixteen months after HWS began, residents were surveyed to see if they had attended a HWS event or had heard of HWS services or staff. Over half of survey respondents said they had attended an event or used a service (Table 1).

Table 1. Survey Respondents Use of HWS

Attended a HWS event/used a service	**64%**
Have heard the name HWS	**29%**

Goal 1. Promote optimal use of health and social services

This goal relates to the Oregon Health Authority's aim of promoting better health and care at lower costs. The HWS partners connected residents with primary care providers, preventative health services, outpatient mental health services, and food resources. At the same time, the partners attempted to direct residents to needed medical services provided by hospitals, EDs use, and nursing facilities, while providing alternatives to these medical services when appropriate. Reducing ED use can both improve health and reduce costs for some individuals.

Access to Primary Care Clinic and Preventative Health Services

The resident survey asked whether there was one doctor's office, clinic, or health center the resident usually visited when sick, and whether they had used preventative health services.

Key Findings: Preventative Health Services	• 91% of HWS users reported they had access to a primary care clinic, compared to 81% who did not use HWS ($p < .05$). • 80% of residents got a flu vaccine in 2016 compared to 69% in 2014. Residents who had some HWS contact were more likely to have a flu vaccination. • 89% of residents who had some HWS contact reported more preventative screening (e.g., blood pressure checks, colorectal exam, mammography) compared to 78% residents with no HWS contact.

Overall, residents who had contact with HWS were more likely to use preventative health services.

Access to Outpatient Mental Health (OPMH)

One HWS program goal was to improve residents' access to non-hospital services. Analysis of claims records indicate that residents with at least one HWS contact had higher OPMH use.

Key Findings: OPMH Use	Outpatient mental health use increased among residents with HWS contacts. • The OPMH use rate was 1.0 visits PMPY among HWS contacts compared to .80 visits PMPY for residents with no HWS contacts.

Social and Health Profiles Among Residents with a Mental Health Diagnosis

Nearly half of survey respondents—45%--said they had a mental health diagnosis (e.g., depression, bipolar disorder, schizophrenia). These residents rated their health and overall quality of life lower, reported more problems with mobility, pain, feeling anxious or depressed, and ability to manage self-care and daily activities, compared to residents without a mental health diagnosis. In addition, more residents with a mental health diagnosis were food insecure, reported use of an ED, were hospitalized, called 911, and visited a PCP; compared to residents who did not have a mental health diagnoses.

Key Findings: Mental Health	• Residents with a mental health diagnosis had 32 HWS contacts compared to 20 contacts on average among residents without this diagnosis ($p < .05$). • 91% of residents with a mental health diagnosis reported at least one visit to a primary care clinic compared to 84% of those without this diagnosis ($p < .05$).

On nearly every measure, residents with a mental health diagnosis fared worse, compared to residents who did not report this diagnosis. Future analysis should examine whether HWS outreach improved outcomes for residents with a mental health diagnosis.

Connect with Residents who Have Hospital Use

Information about hospital use was collected from claims records and from the resident surveys.

Key Findings: ED and Hospital Use	HWS successfully engaged with residents whose health needs were greater both before the program was implemented and over time. • Based on claims analyses, in the 6 months before HWS began, both inpatient hospital and ED use were higher among residents who later had HWS contact, compared to those who did not. • Based on claims analyses, ED visits went down slightly among HWS users, from .722 to .711 PMPY (n.s.)

	• HWS staff had more contacts with 256 residents who said they had an ED visit in the prior 6 months. Overall, 45% of residents who had a high level of HWS contacts visited the ED, compared to residents with low (31%) and no HWS contact (20%) ($p < .01$). • HWS staff had more contacts with residents who said they were hospitalized overnight. Overall, 26% of residents with a high level of HWS contacts were hospitalized overnight compared to 13% of residents with low and 12.5% of residents with no HWS contacts ($p < .05$).

These findings make sense given that HWS staff and partners made referrals to hospital care for residents who needed it and because HWS clinicians contacted residents who were discharged from a hospital.

Improve Food Access

Access to food is a social determinant of health. Causes of food insecurity include low income, physical disability, mental illness, and lack of information about food resources.

Key Findings: Food Access	• Food insecurity decreased by 50% among residents with a high level of HWS contact, and by 34% among those with a lower level of contact. • Food insecurity was higher among residents with a mental health diagnosis (40%) compared to those without this diagnosis (19%, $p < .001$). • 27% of residents at high risk of social isolation were food insecure compared to 19% of residents at low risk (approaching significance).

Overall, residents who had HWS contacts reported far less food insecurity compared to residents with no contacts, over time.

Goal 2. Improve Access to Long-term Services and Supports

Access to long-term services and supports (LTSS) such as personal care assistance, housekeeping, and shopping, can support aging in place and delay admission to a nursing facility, residential care, or adult foster home. Oregon Department of Human Services (DHS) uses Medicaid dollars to pay for nursing facilities and LTSS, and has supported LTSS use because consumers prefer to remain in their homes and doing so is less costly than nursing facility services.

Key Finding: LTSS	The number of Medicaid-eligible residents with HWS contacts received long-term services and supports increased during the program period.

Most of the approximately 1,400 residents in the participating buildings are eligible for Medicaid-financed long-term services and supports (LTSS) managed by Multnomah County's Aging, Disability, and Veteran's Services Division (ADVSD). At the start of the HWS program (Fall

2014), 1,163 Medicaid-eligible residents resided in the buildings. Of these 1,163 Medicaid-eligible residents, 219 (18.8%) were receiving LTSS—usually an aide who assists with tasks such as shopping, preparing meals, and personal care (e.g., bathing, dressing). These 219 residents represented 15.6% of all 1,400 residents. As of July 2016, 1,019 Medicaid-eligible residents lived in the participating buildings; the residents receiving Medicaid-financed LTSS represented 21.2% (n=216) of Medicaid clients and 15.4% of all residents.

To assess differences between October 2014 and July 2016, we looked at services received by 276 matched Medicaid-eligible residents who had a HWS contact. Most, 91.7% still lived in the building, 2.9% moved to community-based housing, 2 moved to a nursing facility (.7%), 1 person became homeless (.3%), and the remaining 4% either moved out of the ADVSD system or died. Of these 276 residents, 5.8% moved from being eligible for services to receiving LTSS. Based on these preliminary numbers, it is premature to estimate potential cost savings. However, if HWS delayed nursing facility entry, the cost savings would be significant. Monthly Medicaid based rates in 2016 are $1,405 for residential care, $1,371 for adult foster care, and $8,432 for nursing facility care. In comparison, homecare workers rates are $14.00 per hour.

Goal 3. Improve Housing Stability

HWS staff and partners worked to support aging in place and housing stability by helping residents prepare for and pass annual inspections and reducing the number of evictions. About 13% of survey respondents received a failed inspection notice in the prior year, and 26% needed help to prepare for an annual apartment inspection.

Key Findings: Housing Stability	The HWS program successfully reached residents at risk of housing instability. • HWS staff had more contact with residents who said they needed help to prepare for an inspection: 42% of residents with a higher level of HWS contact said they needed assistance compared to 22% of residents with less HWS contact, and 16% of residents with no HWS contact ($p < .001$). • 24% of residents who had some HWS contact had difficulty passing an inspection compared to 11% of those with no HWS contact ($p < .05$).

During a 17-month period, 24% of 865 residents in 8 buildings permanently moved out of their building. Of these, 32% moved by choice, 28% moved for unknown/other reasons, 27% died, and 14% were either evicted or moved at the management's request or under duress. On average, 8 people moved and three died each month. Only 3.4% of 865 residents were evicted.

On average, 27% of respondents reported needing help to prepare for an annual apartment inspection. The number of respondents who said they needed assistance to pass an apartment inspection did not significantly change over time, and there were no significant changes based on HWS contact level.

Goal 4. Improve Residents' Quality of Life

Improving quality of life can improve overall health. The resident survey included questions about feeling anxious or depressed, mobility impairment, pain, limitations in usual activities and self-care; an assessment of social isolation risk; and use of 911 calls.

Key Findings: Quality of Life	Residents' quality of life differed based on the level of HWS contacts they had. • HWS staff had more contact with residents who said they had mobility impairments. Residents with higher HWS contacts had more mobility impairment (M = 1.70) compared to residents with some HWS contact (M = 1.53) or no contacts (M = 1.46). • HWS staff had more contact with residents who called 911. Overall, 26.5% of residents with high HWS contacts called 911 compared to only 11% of residents who had no HWS contacts ($p < .01$). • HWS staff had more contact with residents who had increased feelings of anxiety or depression during the project period ($p < .001$).

Social Isolation

The HWS partners had several outreach efforts designed to reduce social isolation. People who are socially isolated tend to have worse health outcomes compared to those who have more social connections. One example is the Give2Get program fostered by CareOregon and run by residents. As a peer-based program, residents agree to provide assistance to other residents who request assistance. Between January 2015 and March 2016, 155 residents participated in Give2Get activities. Examples include checking on a resident discharged from the hospital, pet sitting and grooming, driving to the grocery store or pharmacy, and distributing food.

Key Finding: Social Isolation	Over half—51%—of residents were assessed at risk of social isolation. HWS staff had more contacts—27—with residents at higher risk of social isolation compared to residents at low risk of isolation—23 contacts.

Residents who were at risk of social isolation, based on the number of friends and family they could rely on, fared worse than residents at low risk of social isolation. Specifically:

- 19% of residents at a high risk for social isolation reported being hospitalized compared to 12% of residents at low risk ($p < .05$).
- Residents at high risk of social isolation had a lower quality of life score--58.5—compared to a score of 72.1 for those at low risk of social isolation ($p < .001$).
- 68% of residents at high risk of social isolation had mobility problems, compared to 43% of those at low risk ($p < .01$).
- 58% of residents at high risk of social isolation had problems completing daily activities compared to 45% of residents at low risk ($p < .05$).
- 25% of residents at high risk of social isolation had problems with self-care compared to 13% of those at low risk ($p < .05$).

- 63% of residents at high risk had problems with anxiety or depression compared to 41% of those at low risk ($p < .001$).

Culturally-Specific Services

To directly address health equity, a key project goal was to increase access to health and social services among residents who had limited English proficiency and/or had issues that needed to be addressed with culturally-sensitive services. Twenty-three percent of residents spoke a Southeast Asian language, including Mandarin, Cantonese, Korean, and Vietnamese. Additional languages spoken among residents included Farsi, Russian and Spanish.

Key Findings	Non-Asian language speakers had an average of 30 HWS contacts compared to 14 contacts for Asian language speakers ($p<.001$).

Research Methods

To assess HWS program goals, this evaluation:

1. Assessed the impact of coordinated health and social services on residents' self-reported health, food access, social integration, health service use, quality of life, and building satisfaction. Two resident surveys, the first before services started in September 2014, and the second in February, 2016, were distributed to all residents in 10 apartment buildings. Over one-third of resident participated (544 completed the initial survey; 511 completed the second survey; 272 completed both surveys).
2. Summarized key lessons based on the program implementation process based on interviews with LLC members and various stakeholders, including residents.
3. Assessed the impact of coordinated health and social services on residents' health service use and costs based on insurance claims analysis for the period starting six months prior to the start of services and for the first 12 months of the program. Residents with Medicare Advantage or Medicare fee-for-service plans were excluded due to concerns that they might form a different population from the Medicaid-eligible residents. A total of 1,395 residents fit the exclusion criteria for the evaluation, of which 500 received at least one recorded service from the Housing with Services program. Raw claims data was processed into four utilization types: ED visits, non-obstetric inpatient (IP) stays, OPMH visits, and PCP visits.
4. Summarized the types of contacts that HWS staff and partners had with the building residents based on a database maintained by staff.
5. Summarized access to Medicaid-financed long-term care services based on information provided by the Multnomah County Department of Aging, Disability and Veteran Services.
6. Summarized reasons for move-outs and evictions based on information provided by the housing partners.

Although the study design attempts to account for changes over time, the timeline of deliverables to the funding agency required that some data, including the second resident survey and claims data, had to be collected while the program was still being implemented. Additional details about the research methods, including study limitations, are provided in the full report.

Key Program Lessons

This evaluation provides key findings and lessons regarding program planning and implementation and program impacts on resident health-related outcomes. Based on qualitative interviews with stakeholders and assessment of the various data sources, Table 2 summarizes lessons learned about planning and implementing housing with services for older adults and persons with disabilities.

Table 2. Key Lessons for Program Planning and Implementation

Program Planning	Implementation
Encourage and establish a structure to support partner, service provider and stakeholder involvement, including residents	On-site program staff were critical to support of and connection to outside agencies
Clearly define goals and services, and share with partners	Promote and establish a structure for ongoing communication among partners
Be flexible and adaptable to accommodate changes in revenue, public policy and external political dynamics	Provide staff orientation, training and ongoing opportunities for program feedback
Schedule time to get partner agency commitment	Create and use a shared database to support data collection, reporting, communication and tracking program impact
Agree to share information about residents across agencies within the limitations of resident privacy and HIPAA compliance requirements	Employ an Operations Manager to serve as central communications contact and to provide support/oversight of the care coordination model
Provide strong leadership from a backbone organization and key partners	Employ a mental health clinician with mental health training suited to serve this population
Promote and cultivate organizational commitment from LLC partners through Board support and regular meetings Use Interagency Agreements and MOU's to promote effective services coordination, project understanding and continuous quality improvement.	Create a structure for strong resident involvement in program development, implementation and ongoing oversight.

Executive Summary Conclusion

Portland's HWS grew from a planning group into a coordinated effort among multiple health, social, and housing agencies that resulted in positive improvements in the lives of hundreds of low-income older adults and persons with disabilities during its first 18 months of operation. The program had the most measureable impact on residents with the highest level of unmet

needs, such as those who needed medical care, mental health services, access to benefits for which they were eligible, and food.

As with other service-based interventions, meeting unmet needs can result in increased service use and costs[1]. However, as stated in a recent study of health and housing conducted by CORE[2], health services and subsidized housing have a "blended future." The reasons for coordinating services with housing include improved access to health and social services, a potential for reducing health care costs, promotion of housing stability and improving residents' quality of life. Health care providers are directed by the Affordable Care Act to know where their clients live, including whether they are homeless, at risk of homelessness, or in affordable housing. Housing is unquestionably a social determinant of health that can provide a platform for health and social services.

Housing with Services is an emerging model of community-based care. This is not a licensed health care setting, though some residents receive health services in their apartment. Residents live independently and may choose whether or not to engage in any offered services. Although it was in a developmental stage, the HWS model provides lessons in how housing and health and social service agencies can work collaboratively to coordinate and deliver services to affordable housing residents.

The buildings in this study are designated by HUD for older adults and persons with disabilities. Most of the residents will live in their home for years, or even decades, and many will do so until they die. Many residents need assistance, but housing providers do not provide or coordinate health care or long-term services and supports. This partnership among housing, health, and social service providers provides an example of collective impact that can be adopted by other communities with similar goals of promoting residents' health and the ability to age in place.

Promising directions based on the foundation established by HWS:

1. Project results documented that on-site health navigation and care coordination connected chronically ill and vulnerable residents to health and social services, resulting in improved access to some health and social services, ,especially preventative health services and food resources.
2. Shared coordination of health and services agencies with housing providers that established a foundation for supporting aging in place.
3. Systematic tracking of services and contacts can be used to evaluate program impacts and resident outcomes over time.

[1] Foden-Vencil, C. (2016). Emergency room use stayed high in Oregon Medicaid study. *Lund Report*. https://www.thelundreport.org/content/emergency-room-use-stayed-high-oregon-medicaid-study
[2] Health in Housing (2015). http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/social-determinants-of-health/housing-and-health/

4. Resident involvement in peer-based social services that increased access to food resources and might result in reduced social isolation and improved quality of life.
5. Expanded availability of culturally-specific services, especially for older adults from Southeast Asian countries who do not speak English.
6. Preliminary data indicates that HWS outreach to residents who needed help preparing for an apartment inspection, may have delayed or prevented evictions or move-out notices.

This baseline assessment provides an excellent tool for a future evaluation of HWS. As with other housing with services evaluations (see full report for details), cost savings are not likely to be realized until the third year of the program. Thus, it will be important for the HWS team to continue tracking information about service contacts that can be used in a follow-up evaluation of health so assess outcomes such as housing stability, resident quality of life, use and costs of medical, behavioral, and long-term services and supports, and housing-related costs.