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Supportive Housing and the New Hampshire DSRIP

Engaging and contracting with your Integrated Delivery Network
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About CSH

Improve the lives of vulnerable people

Maximize public resources

Build strong, healthy communities
What We Do

- Training & Education: Research-backed tools, trainings and knowledge sharing
- Policy Reform: Systems reform, policy collaboration and advocacy
- Lending: Powerful capital funds, specialty loan products and development expertise
- Lines of Business: Custom community planning and cutting-edge innovations
- Consulting & Assistance: Systems reform, policy collaboration and advocacy
Building Strong, Healthy Communities

Locations where CSH has staff stationed

Locations where CSH has helped build strong communities
Today’s Agenda

- Update on Integrated Delivery Networks
- Quality Supportive Housing
- Models that include Supportive Housing - CTI & ICM
- Making Your Case
Background: The New Hampshire DSRIP Program

The Delivery System Reform Incentive Payment Program
DSRIP Goals

- Deliver integrated physical and behavioral health care that better addresses the full range of individuals’ needs
- Expand capacity to address emerging and ongoing behavioral health needs in an appropriate setting
- Reduce gaps in care during transitions across care settings by improving coordination across providers and linking patients with community supports.
- Move fifty percent of Medicaid reimbursement to alternative payment models by the end of the demonstration period

(highlights added by CSH to emphasize delivery system change)
Go to: https://www.dhhs.nh.gov/section-1115-waiver/ to learn about your Region’s Project Plan

**NH DSRIP IDN Project Plans**

- IDN 1 Project Plan: [Narrative](#) | [Supplemental Template](#)
- IDN 2 Project Plan: [Narrative](#) | [Supplemental Template](#)
- IDN 3 Project Plan: [Narrative](#) | [Supplemental Template](#)
- IDN 4 Project Plan: [Narrative](#) | [Supplemental Template](#)
- IDN 5 Project Plan: [Narrative](#) | [Supplemental Template](#)
- IDN 6 Project Plan: [Narrative](#) | [Supplemental Template](#)
- IDN 7 Project Plan: [Narrative](#) | [Supplemental Template](#)

**NH DSRIP Evaluation Design**

- Proposed Evaluation Design: Comments currently under review

**NH DSRIP Overview Slide Deck**
Update on Integrated Delivery Networks

Elissa Margolin, Housing Action New Hampshire
Quality Supportive Housing

DSRIP

Supportive Housing
Connect to Supportive Housing

**Triple Aim Alignment**

**Improving Quality of Care**
- Continuity of care from hospital to community: patients get care they need

**Reducing Costs**
- Reduced readmissions to ER and hospital

**Improving Health Outcomes**
- Stabilizes very fragile individuals through housing and intensive case management services
What is Supportive Housing?

Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity.
What is Supportive Housing?

How do you describe Supportive Housing?

Permanent
Affordable
Independent
Tenant-Centered
Flexible
Voluntary
Supportive Housing is for People Who:

- Are chronically homeless.
- Cycle through institutional and emergency systems and are at risk of long-term homelessness.
- Are being discharged from institutions and systems of care.
- **Without housing**, cannot access and make effective use of treatment and supportive services.
- **Without services**, do not succeed in housing.
Who Lives in Supportive Housing?

Housing

Supportive Services
Supportive Housing is the Foundation for Health

- Safety, Access to Basic Needs
- Tenant Engagement, Independence
- Access to Health Care
### Targeting: Supportive Housing vs. Other Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
</tr>
</thead>
</table>
| Permanent Supportive Housing (PSH) | - Very vulnerable  
|                               | - Chronically homeless                                                     |
| Transitional Housing (TH)     | - Non-disabled, high barrier  
|                               | - Desire structured treatment                                              |
| Rapid Rehousing (RRH)         | - Most homeless families  
|                               | - Newly homeless                                                           |
| Prevention                    | - Targets those at-risk who actually enter system                           |
| Emergency Shelter (ES)        | - Interim housing <30 days while waiting for housing                        |
What is Supportive Housing?

Targeting: Supportive Housing vs. Other Models

Permanent Supportive Housing (PSH)  - Very vulnerable  - Chronically homeless

Affordable & Subsidized Housing  - Low-income  - Prioritization can happen for sub-populations

Market Rate Housing  - Those who can pay market-rate rent without a subsidy
Supportive Housing isn’t Institutional Living

In Supportive Housing residents have...

- 24 hour entry/exit
- Only share units at individual’s choice
- Freedom to furnish and decorate unit
- Control own schedule and activities
- Access to food at any time
- Visitors of own choosing at any time
- Housing is physically accessible
- Unit has private lavatory, shower, kitchen
- Access to transportation
- Broad access to services in the community and opportunities to participate in services
Other Populations Served in Supportive Housing

- Child-welfare involved families
- Criminal justice involved persons
- Frequent or high utilizers of emergency services
- Persons with intellectual and developmental disabilities
- Seniors
- Transition Age Youth
- Veterans
Supportive Housing Models

**Single-site**
Apartment buildings exclusively or primarily housing individuals and/or families who need supportive housing.

**Integrated/clustered**
Apartment buildings with units set-aside for people who need supportive housing, often called mixed tenancy.

**Scattered-site**
Rent subsidized apartments leased in open market.
Percentage of Supportive Housing Units

- **Single Site**
  - Up to 100% SH

- **Mixed Tenancy**
  - Mix of supportive housing and affordable housing units

- **Scattered Site**
  - As small as one unit in a larger building or a standalone house
Financing as a Three-Legged Stool

- Capital
- Operating
- Services
Services in Supportive Housing

Why are Services Important?

Services make the difference in helping vulnerable persons obtain and sustain housing.

Services help tenants quickly access housing (first) so that they can use it as a platform for health, recovery, and personal growth.
Key Components of Supportive Housing

Why Voluntary Services?

House tenants first - without preconditions

Keep them housed

Form effective service relationships
<table>
<thead>
<tr>
<th>Tenancy Supports</th>
<th>Housing Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach and engagement</td>
<td>Service plan development</td>
</tr>
<tr>
<td>Housing search assistance</td>
<td>Coordination with primary care and health homes</td>
</tr>
<tr>
<td>Collecting documents to apply for housing</td>
<td>Coordination with substance use treatment providers</td>
</tr>
<tr>
<td>Completing housing applications</td>
<td>Coordination with mental health providers</td>
</tr>
<tr>
<td>Subsidy applications and recertifications</td>
<td>Coordination of vision and dental providers</td>
</tr>
<tr>
<td>Advocacy with landlords to rent units</td>
<td>Coordination with hospitals/emergency departments</td>
</tr>
<tr>
<td>Master-lease negotiations</td>
<td>Crisis interventions and Critical Time Intervention</td>
</tr>
<tr>
<td>Acquiring furnishings</td>
<td>Motivational interviewing</td>
</tr>
<tr>
<td>Purchasing cleaning supplies, dishes, linens, etc.</td>
<td>Trauma Informed Care</td>
</tr>
<tr>
<td>Moving assistance if first or second housing situation does not work out</td>
<td>Transportation to appointments</td>
</tr>
<tr>
<td>Tenancy rights and responsibilities education</td>
<td>Entitlement assistance</td>
</tr>
<tr>
<td>Eviction prevention (paying rent on time)</td>
<td>Independent living skills coaching</td>
</tr>
<tr>
<td>Eviction prevention (conflict resolution)</td>
<td>Individual counseling and de-escalation</td>
</tr>
<tr>
<td>Eviction prevention (lease behavior requirements)</td>
<td>Linkages to education, job skills training, and employment</td>
</tr>
<tr>
<td>Eviction prevention (utilities management)</td>
<td>Support groups</td>
</tr>
<tr>
<td>Landlord relationship maintenance</td>
<td>End-of-life planning</td>
</tr>
<tr>
<td>Subsidy provider relationship maintenance</td>
<td>Re-engagement</td>
</tr>
</tbody>
</table>
Key Components of Supportive Housing

Supportive Services

- Health/Mental Health Services
- Child Care
- Community Building Activities
- Independent Living Skills
- Employment Services and Support
- Substance Use Recovery and Support
- Budgeting and Financial Management Support
Uncoordinated Patient Care

Source: Camden Coalition of Healthcare Providers
Coordinated Patient Care
Coordination Models - Supportive Housing in the IDN

- CTI: Critical Time Intervention
- ICM: Integrated Care Management
- TCM: Targeted Case Management
Critical Time Intervention

Core Components of CTI

- Addresses a period of transition
- Time-limited
- Phased approach
- Focused
- Decreasing intensity over time
- Community-based
- No early discharge
- Small caseloads
- Harm reduction approach
- Weekly team supervision
- Regular full caseload review

Source: Center for the Advancement of Critical Time Intervention
https://www.criticaltime.org/cti-model/
Pre-CTI
- Develop a trusting relationship with client.

**Phase 1: Transition**
Provide support & begin to connect client to people and agencies that will assume the primary role of support.
- Make home visits
- Engage in collaborative assessments
- Meet with existing supports
- Introduce client to new supports
- Give support and advice to client and caregivers
Phase 2: Try-Out
Monitor and strengthen support network and client’s skills.
• Observe operation of support network
• Mediate conflicts between client and caregivers
• Help modify network as necessary
• Encourage client to take more responsibility

Phase 3: Transfer of Care
Terminate CTI services with support network safely in place.
• Step back to ensure that supports can function independently
• Develop and begin to set in motion plan for long-term goals
• Hold meeting with client and supports to mark final transfer of care
• Meet with client for last time to review progress made
Integrated Care Teams are an excellent way to engage individuals experiencing homelessness with co-occurring disorders who are less likely to participate in preventive and primary care and more likely to use emergency crisis services.

Integrated Care Teams include health centers providing primary and behavioral health care, supportive housing and homeless service providers, and hospitals. Teams offer intensive case management to participants, which includes care management and housing navigation.
Homeless Service Providers
Role: Provide dedicated care managers, intensive case management and care coordination, immediate temporary housing, and housing navigation and long-term retention. Caseloads remain small at 1:15.

Health Centers and Behavioral Health Providers
Role: Provide integrated primary and behavioral health care. Caseload sizes vary based on intensity of services needed.

Hospitals
Role: Screen and facilitate warm hand-offs to care managers.
Cost Avoidance

**Figure 6: Cost Avoidance**

**Hospital Cost Avoidance**
Pre- and Post- Enrollment
$54,106 average per person per year, n=77

**Net Cost Avoidance:** Amount saved after accounting for 10th Decile Program Costs
$34,306—$39,556

ER Costs Down 67%
Inpatient Costs Down 85%
Total Costs Decreased 79%
Targeted Case Management - subcontract agreements
“…circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

- World Health Organization
Housing Impacts Health

Other Risks

- Obesity, malnourishment, starvation
- Diabetes and other chronic health conditions
- Physical injuries
- Mental illness
- Substance use
- Higher mortality rate
- Early onset health conditions

Barriers to Accessing Healthcare

- Lack of transportation
- Competing priorities
- Lack of ID and/or benefits
- Difficulty navigating the system
Housing Impacts Health

- Communicable Diseases
- Malnutrition
- Harmful Weather
- No Medication Storage
- Violence
Benefits of Stable Housing

- Meets Basic Needs
- Platform for Service Delivery
- Locus of Integrated Health Efforts
- Improves Access to Health Care
- Beyond Crisis Management
Housing-related Activities & Services

1. Individual Housing Transition Services
Services that support an individual’s ability to prepare for and transition to housing.

2. Individual Housing & Tenancy Sustaining Services
Services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy.

3. State-level Housing Related Collaborative Activities
SUPPORTIVE HOUSING IMPROVES HEALTH

Denver study found 50% of tenants improved health status and 43% had improved mental health status.

Seattle study found 30% reduction in alcohol use among chronic alcohol users in Supportive Housing.

Chicago study found 55% survival rate for people living with AIDS in supportive housing compared with 35% of control group, and lower viral loads among housed group.
Impact of Supportive Housing on Health and Healthcare Costs (Average from CSH meta-analysis)

Percent of Crisis Service Usage After One Year of Supportive Housing

<table>
<thead>
<tr>
<th>Service</th>
<th>Baseline (pre-housing)</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter Days</td>
<td>98%</td>
<td>2%</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital Bed Days</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>Ambulance Trips</td>
<td>52%</td>
<td>48%</td>
</tr>
</tbody>
</table>
## Services Funding: what does it cost?

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 FTE Housing Specialist salary</td>
<td>$ A</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>$ B</td>
</tr>
<tr>
<td>Professional fees (supervision)</td>
<td>$ C</td>
</tr>
<tr>
<td>Admin</td>
<td>$ D</td>
</tr>
<tr>
<td>Insurance</td>
<td>$ E</td>
</tr>
<tr>
<td>SH Tenant Operations (move in costs, security deposit, risk mitigation fund)</td>
<td>$ F</td>
</tr>
<tr>
<td>Annual Total for 10 tenants</td>
<td>$ G = A+B+C+D+E</td>
</tr>
<tr>
<td>Yearly Total for 1 tenant</td>
<td>$ G/12</td>
</tr>
<tr>
<td>Per Member Per Month (PMPM) case rate for 1 tenant (12 mo)</td>
<td>$ H</td>
</tr>
</tbody>
</table>
Key Elements to Include in Your Proposal:

- Target Population
- Agency Expertise
- Benefits of Supportive Housing & Social Determinants of Health
- Aligned Outcomes
- Coordination Model
- Budget
Timeline for Proposals
<table>
<thead>
<tr>
<th>Region</th>
<th>Administrative Lead</th>
<th>Contact 1</th>
<th>Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>Mary Hitchcock Memorial Hospital</td>
<td>Dr. Sally Kraft, <a href="mailto:sally.a.kraft@hitchcock.org">sally.a.kraft@hitchcock.org</a></td>
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<tr>
<td>Region 2</td>
<td>Concord Hospital</td>
<td>Peter Evers, <a href="mailto:pevers@riverbendcmhc.org">pevers@riverbendcmhc.org</a></td>
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<td>Region 4</td>
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<tr>
<td>Region 5</td>
<td>Lakes Region Partnership for Public Health</td>
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<td><a href="mailto:Scarita@pphn.org">Scarita@pphn.org</a></td>
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</tr>
<tr>
<td></td>
<td></td>
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<td>Kevin Irwin, Director of Operations, <a href="mailto:kirwin@co.strafford.nh.us">kirwin@co.strafford.nh.us</a></td>
</tr>
<tr>
<td>Region 7</td>
<td>North Country Health Consortium</td>
<td>Nancy Frank, <a href="mailto:nfrank@nchcnh.org">nfrank@nchcnh.org</a></td>
<td>April Allin, <a href="mailto:aallin@nchcnh.org">aallin@nchcnh.org</a></td>
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Technical Assistance & Next Steps

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