GOW CoC Meeting
Wednesday, May 25, 2016, 10 AM
Independent Living in Genesee County
113 Main Street, Suite 5, Batavia, NY 14020

GOW Meeting Minutes

In Attendance: Rae Frank (ILGR), Jeremy Reamer (Veterans One-Stop Center), Tricia Williams (FLPPS), Sue Gagne (MHA Genesee/ Orleans), Richard Bennett (Genesee County DSS), Patricia Kurtz (Salvation Army), Kexin Ma (HAWNY), Andrew Dearing (HAWNY), David Daodge (ILGR), Cheryl Thompson (Visions Pathstone), Robin Arnold-Scott (ILGR), Colleen Larson (ILGR), Holli Nenni (Orleans County DSS), Teresa Bales (FLPPS), Karen Anderson (VA)

1.) **Welcome & Introductions**
2.) **CoC Activity Updates**

The larger 5 county CoC has been engaged in discussion around homeless youth, employment/workforce development, and upcoming funding opportunities. This section is an outline/update on discussions happening among the 5 county region:

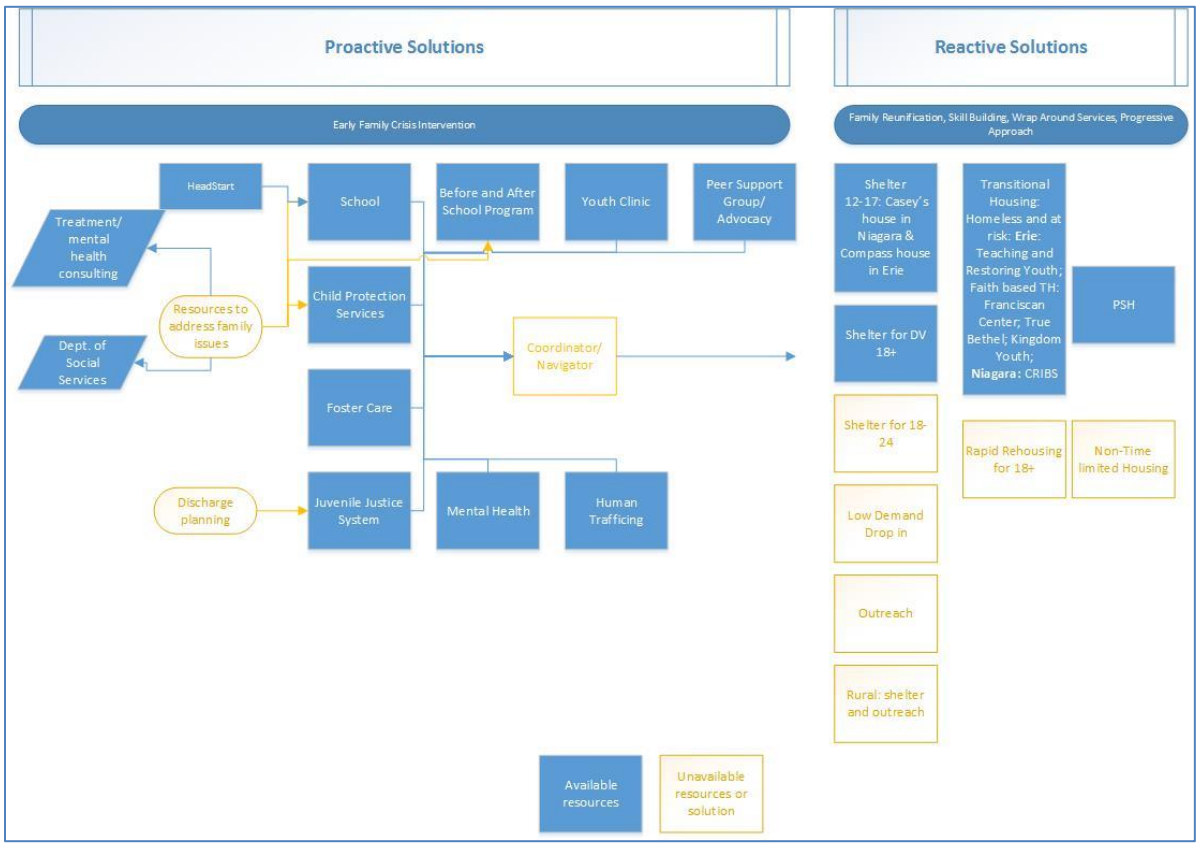
a. **East Hill Foundation Grant**
   i. Reminder that a letter of intent is due to East Hill Foundation Grant by May 31
   ii. http://www.easthillfdn.com/apply/
   iii. Funding can be up to $30,000 and fund supplies and cannot fund entire programs.
   iv. Among current awards is funding for the Ministry of Concern's furniture program.
   v. Salvation Army is planning on applying for kitchen supplies for their main office.

b. **Rural Outreach & Shelter Development Committee**
   i. Homeless outreach is needed in the GOW that will share resource and stories about where homelessness is being observed and experienced. Major Patti agreed to be a part of this group.
   ii. This committee will take the shape of a monthly conference call.
   iii. There was a sign-in sheet for those interested was at the meeting. If you are interested in participating, contact Andrew <dearing@wnyhomeless.org>

c. **Youth Task Force (5/20)**
   i. Discussed challenges of youth homelessness like lack of address, ID, and substantial paperwork to receive services.
   ii. Discussed common misconceptions about youth receiving Social Security benefits
   iii. Identified the different systems where intervention takes place (school, shelter, juvenile detention,
   iv. HUD has been eluding to a $33 million grant to explore
   v. The Youth Task Force is planning on meeting again in about 2 months to discuss next steps and outline some best practices to be used in the area.
   vi. Kexin discussed the need for a shelter specifically for 18-24 year olds and that we will be releasing a plan to better target youth homelessness on the HAWNY website for review. We also need a low demand drop in center to encourage youth engagement. Also looking for permanent housing option, like no time limit housing models.
   vii. Andrew reminded everyone of the Host Home model that operates like a temporary foster home for youth in a crisis situation. If family reunification

cannot be met then a housing strategy is created for the individual. This is a popular model used in rural areas and is worth further exploring.

viii. Below is an updated version of the Homeless Youth Flowchart developed by this taskforce.



d. CoC Employment Roundtable

i. Roundtable discussion invovled guiding homeless to jobs.
ii. ACE Restoration Society, ILGR, GLOW,
iii. Discussed different client barriers, like transportation, lack of phone, lack of ID, no resources, and broken family ties.
iv. Solutions to barriers were also explored, including ticket to work, mentor programs, tax-incentive for businesses
v. Strong need for collaboration among large employment agencies.

3.) DSRIP Update: Finger Lakes PPS

i. Thank you to Teri Bales, and Tricia Williams for coming and informing the GOW CoC about Medicaid reform and housing initiatives link with healthcare.
ii. Tricia gave us an overview of Medicaid reform happening in NYS
    i. Medicaid reform in NYS is focused on high medical care users by decreasing ER hospital visits by 25% over the course of 5 years. Focused on avoidable hospital visits.
    ii. They are in their 2 year of operations.

iii. Value-based payment system: anyone who bills for Medicaid will be based on quality measures rather than quantity measures.
iv. Homeless individual have been known to use hospitals and ERs as temporary shelter and are less likely to use primary care physicians.
v. Community based organizations come into play by collaborating with local healthcare providers and knowing how to properly triage someone to the appropriate services. (discharge planning)
vi. DSRIP includes 11 projects that aim decreasing avoidable hospital visit
vii. Patient Activation Measure (PAM): one of the projects aimed at connecting the uninsured to coverage and appropriate care.
viii. Other initiatives: behavioral health, transitional housing, health home, crisis intervention, child health, skilled nursing facilities, etc.
ix. Funding came from Gov. Cuomo's MRT (Medicaid redesign team) established in 2011. Has an investment of $7.3 Billion to set up a new process throughout the state.
x. FLPPS has the potential to use $535 Million to establish Medicaid redesign in their area. They have over 600 partner to collaborate with

iii. Teri begins discussing the transitional Supportive Housing Element of DSRIP project.
i. Teri discussed how there is a lack of healthcare providers involved in the discussion with Community Based Organizations.
ii. Transitional Supportive Housing project is about better connecting CBO's with hospitals and **discharge planning**.
iii. A community needs assessment showed that housing in an issue in this region, specifically the lack of shelter placements with the dependence of hotel/motel. Limited discharge options, limited availability, behavioral health issue all contribute to client barriers to housing.
iv. The process starts the hospital by needs identified by social worker and then given care manager to develop the discharge plan.
v. Housing specific organizations to better assess the route to permanent housing.
vi. The idea is that engagement is consistent within 90 days.
vii. Three major roles: hospital/inpatient discharge planning teams, housing organizations, and care management.
viii. Strategies to achieve success:
1. Several submitted proposals to create scattered sites with DSRIP capital funding
2. Only two were funded and there are a 12 month development period

iv. Who are the partners signed up in GOW
i. Wyoming Community Hospital, Medina Hospital, UMMC, Planned Parenthood of Batavia, Pathstone, oak orchard, spectrum, independent living, Wyoming county mental health, Depaul (possibly).
ii. Rae asked if government offices can be involved in DSRIP partnership. They can.
iii. Other partners: companion care of Rochester, epilepsy prelid, Genesee county mental health services, HCR

v. Colleen Larson mentioned the frustration of helping Section 8 clients find housing and how funds from case management could possibly be used for finding housing.

vi. Transitional Supportive Housing Projects: Steuben County (Arbor Housing and Development), Ontario County (Lakeview Health Services)
vii. Seeing that FLPPS is the only PPS taking on transitional housing, then there is a high potential for more funding in the future. Once funding is available, there should be a community workshop to develop a project. It probably won't be capital funding but rather program funding, housing vouchers.
viii. The specifics of what additional DSRIP supportive housing funding would involve depends on the RFP, such as the length of voucher/subsidy
ix. Teri is confident that the funding RFP for future transitional supportive housing will be released in 2016.
x. Tricia explains how funding will most likely be distributed regionally with high Medicaid user areas.
xi. Next steps would be encouraging hospitals to interact with CBOs while planning for hospital discharge.

4.) CoC Annual Application (updates and strategy moving forward)

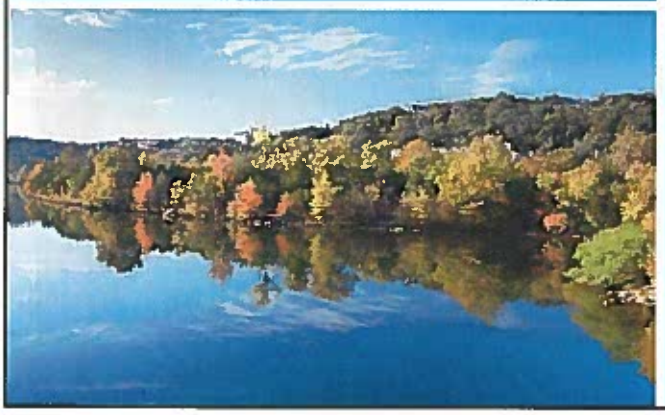
i. Unfortunately ILGR Rapid Re-housing project did not get funded
ii. Overall, our entire CoC did perform well with $10.8 million going to projects in WNY.
iii. Kexin was just de-briefed on CoC application and was told to expect the next CoC application will be released in June and due 7 days after. Everyone is encouraged to be involved in the process in deciding how we will apply and what will get funding.
iv. $67,000 will be available to GOW area for new projects but a total $132,000 is available to GOW as a whole
v. Pathstone is trying to reallocate dollars to RRH but has not been confirmed with Connie. If reallocated, $132,000 will be available to GOW as a joint project. Kexin suggests this being the preferred strategy.
vi. ILGR does not have to lead the joint project and multiple agencies can apply together. Last year ILGR, Community Action, and Salvation Army split responsibilities involved with RRH. Rae doesn't see the application changing much.
vii. Last year our annual renewal demand was $9.2 million with 15% (about $1.2 million) go to tier 2 (unprotected ranking), including existing programs. Our CoC scored 154 out of 203.
viii. Suggested ways to improve our score would to improve HMIS coverage. This would include DSS collaborating. Supposedly, Syracuse DSS does participate in HMIS. HAWNY will connect to Syracuse DSS to discover best practices.
ix. Proving diversion will also improve our score by showing a proven route to housing for client from hospitals, jail, or back into homelessness.
x. Strict ranking process will be applied this year to cut underperforming projects, as well as not preferred HUD programming.
xi. Catholic Charities and Restoration Society are also good resources for agencies that participate in the larger CoC community. They also took an interest in applying.
xii. Kexin mentioned $177 million HCR capital funding to the group to see if anyone is interested in applying. Capital funds will support affordable housing. http://www.nyshcr.org/Funding/OpenWindow/2016/
xiii. **Since the NOFA is supposed to be released in late June, HAWNY will host a conference call for interested GOW member on June 10 at 2PM**

5.) Adjournment – *Next Meeting will be June 22nd from 10AM-11AM at ILGR*

May 25, 2016

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

DSRIP 101 & FLPPS



FLPPS Presenter:

Tricia Williams
Partner Relations for the Western NOCN

Agenda

Meeting Objective: Provide a general understanding of FLPPS, DSRIP, and the 11 projects.

Roadmap for today's discussion:

1. **DSRIP 101**
2. **About FLPPS**
3. **11 Projects**
4. **Q&A**

FLPPS FINGER LAKES PERFORMING PROVIDER SYSTEM

DSRIP 101: Big Picture

Environmental Change Assumptions

- **Legacy of ACA** is delivery system reform and the Triple Aim (improve population health, enhanced health outcomes, reduce costs)
- Financial/market pressures will make **fee for service, fragmented care unsustainable.**
- There will be a **transition to capitated or alternative value-based** payments.
- **Safety Net members/patients will churn** between charity care/sliding fee scale programs, Medicaid, Basic Health Plan, CHIP and Exchange.
- **DSRIP projects will invest significantly** in care delivery transformation and new services for safety net providers and patients/members.
- These **services must become financially sustainable** within a capitated payment arrangement with the state or one or more managed care organizations.

Anticipated Market Changes

Long-term care	Shift to home-based services Shift to community-based services
Physicians	Narrow network Care coordination Payment for outcome
Hospitals	Narrow network Care coordination Payment for outcome Reduced admissions/ED visits Changes to core business model

Why now? We are close to the tipping point and transformation takes time

We are not abandoning FFS. But we are increasingly living in 2 worlds and preparing for greater risk.

DSRIP: A unique opportunity

- The NYS Medicaid Redesign Team (MRT) is redirecting Medicaid funds to projects that radically transform the Medicaid delivery system.
- These projects are part of the Delivery System Reform Incentive Payment (DSRIP) program.
- DSRIP is a chance to get ready for the change that is coming
- DSRIP incentivizes health care and community-based providers to form regional collaborations and implement innovative system transformation.
- DSRIP currently is being implemented in CA, TX, NJ, KS and MA

DSRIP in New York State

- **The overarching objective of DSRIP in NYS is to improve clinical outcomes and reduce avoidable hospital use by 25% over 5 years.**
- A **Value-based payment** model was selected to create:
  - ***Greater Certainty:*** Premium/Capitated payments mean costs are more predictable- stable reduction in per person spend
  - ***Reduced cost:*** A premium model is the state's acknowledgment that they cant control costs themselves
  - ***Shared risk:*** This model shares risk between providers, State, and health plans want to put providers at risk –
    - DSRIP creates opportunity for developing programs to help providers manage that risk.
- **Sustainability** of new delivery system transformation will rely on managed care payment reform.
  - The State is requiring all MCOs to reach a goal of >80% managed care payments be Value-based payments by DSRIP year 5

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Finger Lakes Performing Provider System

Performing Provider Systems (PPS)

- A **performing provider system** is a network of health and behavioral health care providers, social service providers and community-based organizations (CBOs) that have agreed to work together in order to meet predetermined benchmarks and achieve outcomes related to each project to change the health care system in their region using the DSRIP program.
- New York State is divided into ~~25~~ **24 Performing Provider Systems** (PPS) based on geography and regional care delivery.
- The **Finger Lakes Performing Provider System (FLPPS)** has committed to DSRIP implementation across the 13 counties: Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates counties.

To work differently…

DSRIP and the Performing Provider System structure requires us to jointly:

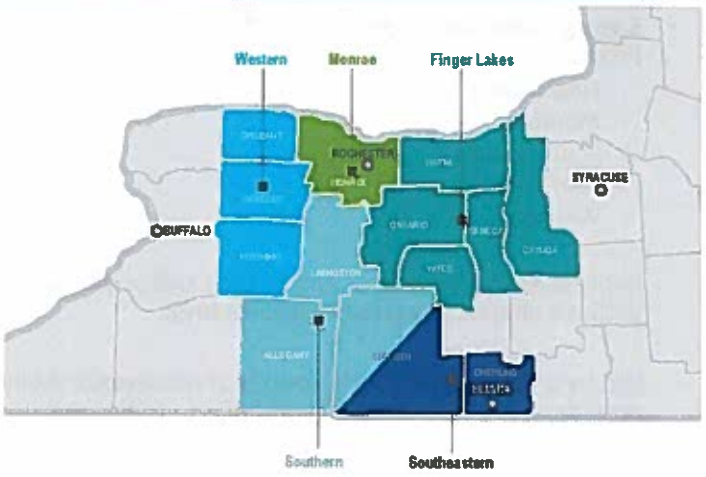
- Develop a clear decision making process
- Build trust in the midst of little information and changing landscape
- Increase accountability and transparency when we barely know ourselves
- Establish common goals and initiatives when we all get paid differently
- Build the foundation of a coordinated and integrated delivery network for Medicaid and uninsured across a 13 county region

FLPPS Principles

- **Focus on the Patient**
  All decisions are weighed against the question – "How will this impact the member/patient's health care needs and cultural and linguistic preferences, enabling provision of the right care, at the right place, at the right time?"
- **Strong Physician and Provider Leadership**
  Physicians and other practitioners have representation and deep engagement in governance and leadership.
- **Accountability, Transparency and Trusting Partnerships**
  Clear and open partnerships with regular, proactive communication to support the design and implementation of truly cost-effective, best practice care delivery.
- **Adaptability**
  Develop the ability to continually transform based on patient needs and environmental changes. Recognize that there is no best, *there is only better.*
- **Capacity & Capability for Managed Care of a Population**
  Develop the ability to manage members/patients across the continuum of care with varying disease states, health care and social needs

Finger Lakes Performing Provider System

- 13 Counties
- 5 Naturally Occurring Care Networks (NOCN)
- 413,289 lives
- 3,000 providers
  Primary care, SNF, Hospice, specialists, Pharmacies etc.
- 600 organizations



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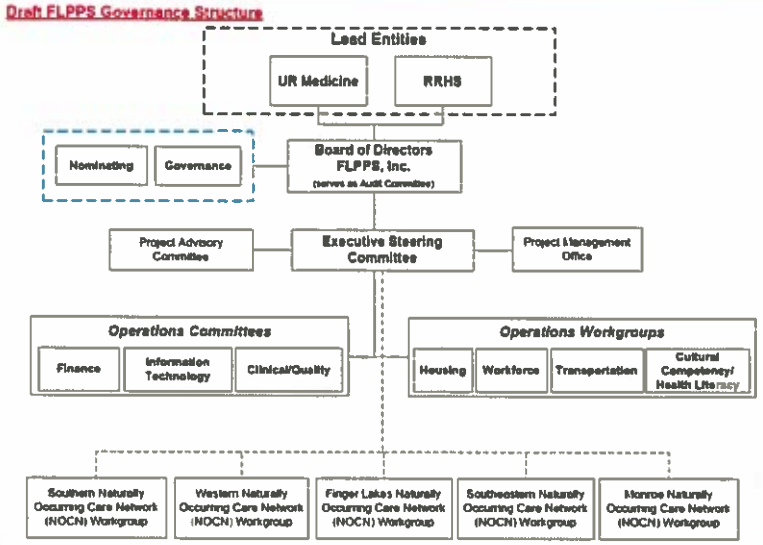
FLPPS Governance Model

Draft FLPPS Governance Structure



FLPPS FINGER LAKES PERFORMING PROVIDER SYSTEM

Naturally Occurring Care Network (NOCN)

- **5 geographic sub-regions ("NOCNs")** of the Finger Lakes Performing Provider System
  - Finger Lakes
  - Monroe
  - Southeastern
  - Southern
  - Western
- Represent the full continuum of care and organizational leadership within a **shared geographic service area.**
- Led by a **participant workgroup** that represents the health care providers, BH/SA Providers and CBOs in their area.
  - Workgroups are responsible for organizing local providers by hosting collaborative dialogue and supporting project implementation.

FLPPS Operational Committees

- There are 7 groups that serve as regional representatives and consultants for the 11 FLPPS DSRIP projects.
- Operational committees develop organizational strategies, policies and procedures, advise project teams, and inform centralized services. Committee members are representative of all care settings and geographic areas.
- 3 operational committees serve as advisory bodies
  - Clinical
  - Finance
  - Information Technology
- 4 workgroups establish protocols
  - Housing
  - Workforce
  - Transportation
  - Cultural Competency/Health Literacy

Clinical Leaders, Subject Matter Experts

- **Clinical Committee** – Co-Chaired by Marc Berliant, MD (UR), Mike Nazar, MD (RRHS)
- In the process of leading a team of clinicians to determine the best way FLPPS can ensure that there's adequate **clinical input** into the development of projects and clinical protocols, and **ensure uniformity in quality of care** across the PPS
- In process:
  - Hire a team of **part time consultants/clinicians** comprised of PCPs, NPs, & Behavioral Health Specialists – clinically based individuals that can sit on project teams
  - Desire is to **identify individuals** from around the region
  - **SMEs will work with Clinical Committee** to understand the quality performance measures we will be "graded" against, "Attachment J"
  - **Work closely with the finance committee** to influence decision making process around funds flow/contracting to make sure that we're including clinical measurements/metrics and incentivizing providers appropriately

FLPPS Project Selection

Project Selection:

- Each PPS, including FLPPS was required to select a minimum of 5 projects from a specified menu of DSRIP projects and domains. (44 Total potential projects)
- The FLPPS Project selection process began with a comprehensive Community Needs Assessment (CNA) conducted by the Finger Lakes Health Systems Agency with widespread community engagement.

FLPPS – 11 Projects

Project Selection:

- These activities helped FLPPS understand the healthcare gaps in our region, which included the need for:
  1) An integrated delivery system to address chronic conditions
  2) Integration between physical and behavioral health care systems
  3) A way to address the social determinants of health and healthcare disparities
  4) Support of women and children
- FLPPS Selected 11 Projects based on these findings.

Resources to Fund Project Initiatives

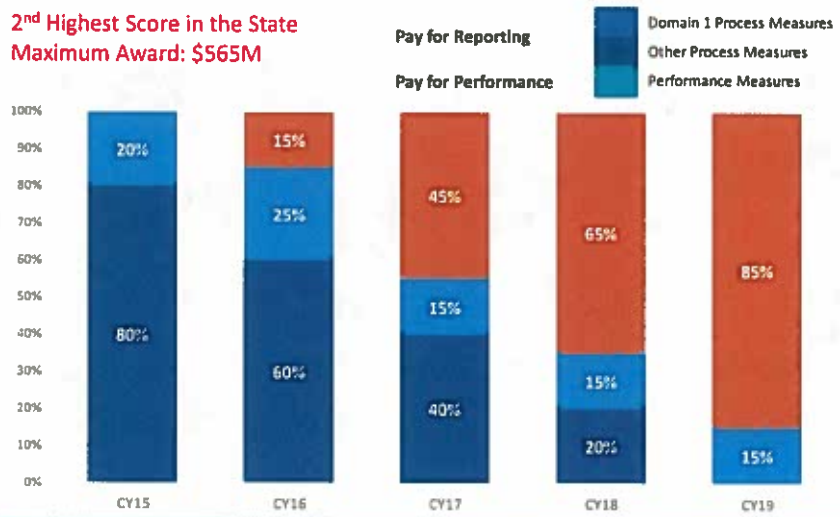
- NYS Medicaid Redesign Team (MRT) is redirecting Medicaid funds to projects that radically transform the Medicaid delivery system.
- New York will invest $7.3 billion of Medicaid savings over the next five years into the transformation of the health care system.
- FLPPS award: Meets Expectations $535million
  Exceeds Expectations $565million

Why is DSRIP Important to regional organizations?

- In 5 years, NYS is planning to be in gain sharing or capitation for all Medicaid eligible patients
- Medicare & Commercial products are also moving in that direction.
- It's not a question of whether change will occur, but when.
- If DSRIP succeeds, will your organization be able to catch up?
- Will the experience help us prepare for the future, regardless of the outcome of this program?
- Do we want to be involved in shaping the payment mechanisms, risks and rewards or do we want to be paid in the future, based on the system someone else developed?
- Benefits to your patients – to be a part of a network and program that invests in better coordination and care for our most vulnerable population

Pay 4 Reporting → Pay 4 Performance

2nd Highest Score in the State
Maximum Award: $565M



Potential Projects

(2.a.i) Integrated Delivery System

(2.b.iii) ED care triage for at-risk populations

(2.b.iv) Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

(2.b.vi) – Transitional supportive housing services

(2.d.i – Project 11) Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations in community-based care

(3.a.i) Integration of behavioral health and primary care

(3.a.ii) Behavioral health community crisis stabilization services

(3.a.v) Behavioral Interventions Paradigm (BIP) in nursing homes

(3.f.i) Increase support for maternal and child health (including high risk pregnancies)

(4.a.iii) Strengthen mental health and substance abuse infrastructure across systems

(4.b.ii) Improve access to high quality chronic disease preventative care and management in both clinical and community settings

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Questions

inpatient Hospital Admission is the first step

• Care Coordinator
• Specialist Housing

Project 2.b.vi Transitional Supportive Housing

Domain 2b: System Transformation Projects/Implementation of Care Coordination and Transitional Care Programs

Problem statement: Homelessness and poor transitions of care are known risk factors for readmissions and increased health care utilization. Mental illness and substance abuse disorder prevalence among the homeless exacerbate these patterns, yet existing transitional and permanent housing programs designed to meet these needs consistently face waitlists and long processing times. Poor coordination between hospitals and community providers perpetuate the ping pong patterns among super utilizers of crisis systems. Hospitals face limited options to discharge patients with housing instability into appropriately supportive environments that will enable them to safely stabilize, rehabilitate and transition back into the community.

Objective: Provide high-risk patients who have difficulty transitioning safely from a hospitalization back into the community with transitional supportive housing based on their need. Develop flexible transitional supportive housing and medical respite sites to prioritize chronic super utilizers and those unable to access the appropriate level of care and support from existing options. Strengthen existing short term and transitional housing sites with coordinated care transition and management through protocols and partnerships between participating hospitals, community housing providers and care management services (including health homes and home care). Improve data sharing and strengthen housing case management services to streamline access to and use of inventories across housing continuum and across agencies.

Core components & Deliverables:

- Develop transitional supportive housing, including medical respite-like options in emergency shelter sites, for high-risk patients to provide short term rehabilitative and recuperative care for patients capable of discharge but facing housing instability, homelessness risk or delays in transition to a long term care program.
- Establish partnerships, policies and procedures to coordinate transition with relevant short and long-term care management that meets patient medical and behavioral health needs and social conditions
    - Connect patients with Health Homes or other community care management solution by engaging/assigning a care manager prior to discharge
    - Identify and prioritize high-risk super users and implement integrated population health management strategies to appropriately meet their medical, behavioral health and social needs
- Partnerships established between FLPPS, community housing/home care service providers, and hospitals, which develop transitional housing and allow for in-hospital transition planning

FLPPS Project Design Elements:

Move the region toward a Housing First approach, which is an evidence-based practice to provide people with housing quickly and then setting up services as needed. Regulatory hurdles, stringent eligibility requirements and insufficient availability of affordable permanent housing in the FLPPS region create barriers to offering high risk super-utilizing patients with immediate housing access, which has be shown to significantly reduce readmissions and Medicaid costs. By partnering with community based housing providers, many of whom also provide a range of care management services for medical and/or behavioral health needs, FLPPS couples Housing First with Supportive housing and aims to apply these concepts in transitional settings (particularly in newly created sites established for the project).

Often patients remain in high-cost acute care settings while available housing is identified, eligibility is verified and payments arranged. These processes can take months, adding unnecessary cost to the health system and burden to the patient. To mitigate these challenges while supporting DSRIP goals, FLPPS proposes a variety of scattered site and congregate living structures across the region to provide a transitional supportive setting that will be utilized by patients capable of transitioning out of acute care but requiring additional time for recovery or processing before movement into long term or permanent housing based on their needs. Combined with strengthened protocols and partnerships for care coordination and management that will better ensure continued patient access to relevant medical and behavioral health services, this project will support the overall goals of reducing costs and decreasing ED utilization and readmission. In the meantime FLPPS will collectively advocate to increase affordable permanent housing.

- Discharge Planning:
  - Hospital and care management staff (health home or home care services) coordinate; care management and housing meet with patient prior to discharge whenever possible
  - Centralized (or regional) housing inventory management and referral processes to streamline access to relevant housing providers
- Transitional = <90 days. Target average length of stay of 30 days for medical respite model.
  - Care Transitions Coach and/or Health Home Care Manager ensures delivery of medical care and behavioral services outlined in patient discharge plan
  - Housing provider provides personal assistance/supervision and support, and housing case management services to identify and arrange long term affordable and adequate housing option
  - Care team assesses medium-long term care and support service needs and ensure those will continue to be accessible by patient after movement out of transitional housing
- Delivery mechanisms for supporting medical and behavioral services will combine the following models:
  - **Built in**, for example via community housing provider staff (e.g. on-site counseling, medication adherence, nutrition/meal support)
  - **Pushed in**, for example via home care service providers or tele-health
  - **Wrap around** via referrals and transportation or accompaniment to partner practitioners and outpatient services for mental, emotional and behavioral health conditions, work training, etc.

90 days → perm housing

Challenges:

- Transitional housing services (room, board, personal assistance, housing case management) are currently not billable to Medicaid
- High risk for bottlenecks due to insufficient affordable permanent and long-term housing (incl Medicaid ALP), particularly for chronic super utilizers or high risk patients with criminal backgrounds
- Potential workforce shortages (health home, home care) for adequate and consistent care management services at appropriate level of intensity; lack of high quality housing case management services
- IT infrastructure: Variable EHR connectivity among care management and housing providers, and lack of HIPAA compliance certification among community providers are significant barriers to coordination
- Complexity of navigating housing options due to lack of coordinated entry and access across siloed agencies and systems that fund various housing and residential service options (HUD, ODTA, HCR, DOH, OMH, OASAS, OPWDD, VA)
- Need for cultural competency: sensitivity to health status/conditions and impact of chronic housing instability

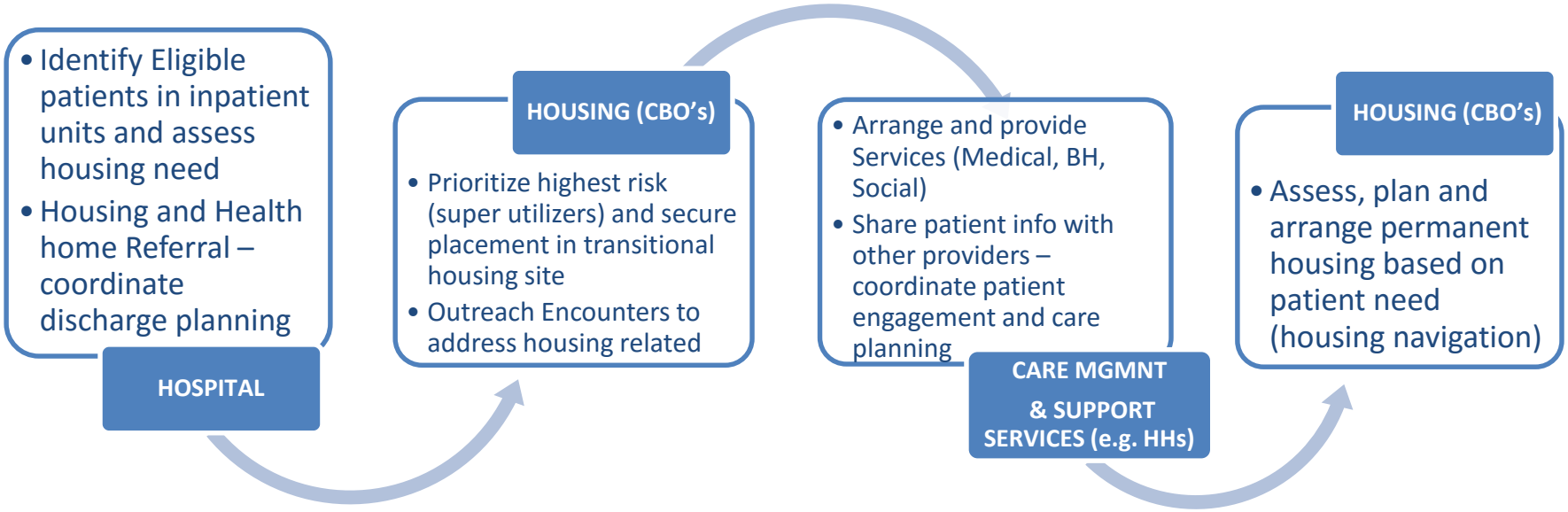
2 capital
Steuben -
Ontario - Lakevi

scattered sites - utilized transitional sites for hospitals
2-months

Housing in FLPPS Region:
Context for DSRIP project selection

- Limited discharge options from hospital for medically complex individuals under 55
- Hospitals have difficulty discharging BH patients safely
  - In western counties, ~4 in 10 homeless patients hospitalized for BH diagnoses are discharged with no change to housing
  - <10% of OMH residential admissions are from Hospitals
- Existing BH (OMH/OASAS) supportive/supported sites have waitlists and are not easily accessed by homeless
  - In 2013 across 11 of FLPPS' counties: 398 homeless individuals (31%) reported mental illness; yet only 91 admissions to OMH Residential Programs (10% of total admissions) were from shelters/DSS
  - 29% of OMH Transitional sites in region have ALOS >2 years
- Behavioral health accounts for 63% of ED visits and increase average length of stay by 2.1 times
  - 59% of FLPPS super utilizers have mental disorders

DSRIP Transitional Supportive Housing Project:
Roles & Requirements per NYS DOH



DSRIP Transitional Supportive Housing Project: FLPPS Vision

PATIENT PROFILE	CURRENT STATE	POTENTIAL FUTURE STATE
Patient admitted: • **Cardiac condition**. • Rural Housing with poor ventilation • Limited Transportation • Limited Family Support Need: • Housing closer to medical resources • Access to public transportation Barriers: • Applying for housing without support • Documentation and application requirements	Either: a. Hospital pays for hotel and sends home care b. Patient remains in hospital. In both scenarios, long term housing situation not likely addressed.	Medical Respite for sub acute care plus access to case management to support long term housing stabilization plan.
Patient admitted: • **COPD exacerbation and co-occurring SMI** • Ambulating short distances independently • Independent w. ADL with set-up from an aide Need: • Housing with some personal assistance and access to BH support services Barriers: • Cost	• Discharge to emergency shelter • Lacks onsite follow up medical or BH support • Likely to readmit	Provide unlicensed DSRIP Transitional Supportive Housing while awaiting entry into Licensed OMH housing via SPOA.

Housing in FLPPS Region:
Challenges to DSRIP Success

- Limited availability of capital funds and CRFP delays to establish new unlicensed sites or enhance existing sites to create options such as Medical Respite
- Inadequate permanent affordable and supportive housing available in region
  - Section 8: ~9,000 families waiting average of 74 month in Monroe and surrounding counties; ~2,500 waitlist in other FLPPS counties
  - Monroe County has 2nd highest rate of homelessness and unmet supportive housing need (1,569 units) among communities outside NYC
- Aging population and aging housing stock mean poor accessibility for seniors and individuals with disabilities

FLPPS Response:
Parallel & Progressive Project Strategies

Short Term

- Place patients in existing non-permanent community sites
- Current state SWOT of provider coordination, transitions of care and housing inventories and housing navigation across systems
- Gather data to profile and prioritize highest risk highest need patients with housing instability that are under-served by existing non-permanent community housing options

Medium Term

- Support providers to create new or enhance existing sites to deliver new models
- Likely options include enhancements to existing emergency shelters for medical respite and new unlicensed transitional supportive sites capable of safely transitioning BH patients with medical needs while awaiting placement into OMH/OASAS/OPWDD residential services or HARP + affordable housing
- Standardize protocols and guidelines for provider coordination and transitions of care

Long Term

- Coordinated inventory management and access – integration across network and with other systems (e.g. HUD, ODTA, DSS, OMH/OASAS/OPWDD leveraging SPOA and HUD Coordinated Access)
- Gather evidence to continue medical respite and flexible unlicensed transitional sites: cost savings, acute service use reduction, health outcome improvement among homeless
- Advocacy and support to increase affordable permanent and supportive housing in region