Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

Lifting up Westchester's (LUW) mission is to restore hope to Westchester County's men, women and children in need, by providing them with food, shelter and support– and lifting them to greater self-sufficiency with dignity and respect. We assist those struggling to overcome the challenges of poverty, homelessness, hunger, health, and education. We work with men, women, and children as they create their own unique path to a more fulfilling, healthy and independent life. Striving to never turn anyone away, we enlist the generosity of a caring community through donations and volunteerism.

LUW has been serving residents of Westchester County for almost 40 years. The county has roughly 975,000 residents, where the median household income is $86,226, far above the New York State's median household income of $60,741 and the national median household income of $55,322. Yet, every year, about 4,750 persons living in Westchester are homeless, an underestimated figure as it does not include the number of families who are homeless but "doubled up" living with friends and family who have taken them in or youth who are couch surfing. In addition to our homelessness challenges, exacerbated by rising home prices and a lack of affordable housing in Westchester, hunger often accompanies those that are homeless or are marginalized by poverty. 1 in 5 Westchester residents, or approximately 200,000 persons, go hungry every year.

In order to combat these statistics, LUW engages in numerous services and programs:

- First: Emergency Services:
  - o we operate the largest soup kitchen in Westchester serving 60 to 100 people every weekday and operate shelters for single adults that house 60 to 80 individuals every night.
  - o Our case managers work with those who come to us in crisis to build relationships, understand their challenges, and develop a plan to build the skills and connect them with the resources they need to remain stably fed and housed.

- Second: Sustainable Permanent Housing:
  - o Not everyone can live independently without some support.
  - o We have over 200 clients with some form of disability living independently in apartments throughout the County where Lifting Up Westchester provides ongoing case management and financial support.
  - o With this additional support, well over 90% of them have remained stably housed for more than 5 years.

- Third: Vocational Training and Employment Opportunities: o
  Employment is a critical part of achieving self-sufficiency
  - o our case managers work with our clients on resumes and job applications, interview skills and job search.
  - o Our Neighbors Home Care Program provides free training for Home Health Aide certification and guarantees all successful trainees employment in our licensed home health agency where we employee over 200 individuals per year.

- Finally: Next Generation Education Opportunities:
  - o these programs seek to break the cycle of poverty by providing homeless and at-risk children with positive role models, enrichment and educational support.
  - o Our after-school mentoring program provides literacy programs, academic tutoring, standardized test prep, STEM education and college prep to hundreds of children where they live and go to school.
  - o Our summer camp allows nearly one hundred children, most of them homeless to have the same opportunity as their housed peers to play, learn new skills and make new friends.
  - o Each of these programs work hand-in-hand to motivate kids to stay in school, improve their grades and go on to college or some other form of post-secondary education.
  - o We are very proud that for the last three years, 100% of our high school seniors have graduated on time… many have gone onto college with the help of scholarships provided by Lifting Up Westchester.

For almost four decades, LUW has provided both the material and emotional support that our clients need to overcome the challenges they are facing. In 2017 alone, LUW assisted 3,445 clients. More importantly, we did so with a focus on creating permanent change in our clients' lives.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

Connecting Health Home Care Managers with Lifting Up Westchester to Serve Homeless Clients Placed in Housing

Our innovation will achieve synergistic amplification of impact by linking and coordinating two existing but distinct public programs-services for homeless persons provided by Lifting Up Westchester (LUW) and Health Home Care Management for Medicaid beneficiaries with multiple chronic conditions.

Homelessness is a grim public health problem with many of its victims living with poor physical, emotional, and mental health - often times with multiple, co-morbid chronic illnesses. Studies have shown that a large proportion of homeless individuals have serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), or complex trauma. As an indigent population, many are unable to find providers and services to get well and stay healthy, thus they remain in a vicious cycle of poor health and destitution. These individuals often have complex medical, behavioral, and social needs that are difficult to coordinate and can complicate their path to a healthier, more fulfilling, independent life. These individuals tend not to be well connected to primary care and often seek medical and mental health services in an Emergency Department setting. The current New York State Delivery System Reform Incentive Payment Program (NYS DSRIP) promotes community-level collaborations as a strategy to address health system reform. DSRIP's goals include: avoiding unnecessary hospitalizations and emergency room visits; helping the uninsured, low and non-utilizing Medicaid beneficiaries obtain insurance and engage with primary care; connecting eligible Medicaid beneficiaries with a Health Home provider and, through the Health Home At-Risk project, to coordinate care and engage patients with complex needs who are not eligible for services under the NYS Health Home program.

One of the most important social determinants of health is housing stability. Helping the homeless to find and to keep stable housing is an important intervention to help meet these DSRIP Goals. LUW provides many supportive services to shelter residents to help them find housing, find employment and to connect with primary and behavioral health care services. Shelter residents who are successfully placed in supportive housing continue to receive supportive services from LUW. However, subsets of shelter residents who do not have chronic severe mental health issues are no longer eligible for supportive services from LUW once permanent housing is found. Unfortunately, many of these persons find the transition to independent living overwhelming and recidivism rate is high. Studies have shown that persons who continue to receive supportive coaching and counseling for a transition period after they are placed in permanent housing have a much better chance of successfully maintaining stable housing long term. Many of these shelter residents would be eligible for Health Home services but may not be connected to a Health Home. Others may be enrolled in a Health Home but have not maintained consistent relations with their Health Home care manager. Furthermore, Health Home care managers who come from a Behavioral Health Clinical background may not have experience with the particular issues that are often critical to maintaining stable housing.

Our innovation project will pair one or more Health Home Care Management Agencies with LUW to create a collaborative intervention to ensure that all Shelter Residents who are Eligible for Health Homes are enrolled and connected with Health Home Care Managers. The intervention will facilitate the exchange of experience and best practices such that Health Home Care Managers will learn how to better help clients with housing-specific challenges related to maintaining stable housing and LUW Care Managers will learn from the Health Home experience regarding best practices around chronic condition care management.

Replicating a highly successful integrated health delivery model by placing care managers into primary care practices, WMCHealth PPS, through its Innovation Fund, plans to provide support to allow LUW and a TBD Health Home Care Management Agency (HH-CMA) to expand care management resources to better address the needs of this distinct population. Care Management staff from LUW and HH-CMA will participate in collaborative training, such as the assessment of medical, behavioral, and/or social risk, and best practices for working with homeless individuals with complex health needs to enroll eligible members into Health Homes, as well as identify at-risk members to determine the appropriate supportive services. The care managers will develop care plans and map out the services clients may need to put them on the road to better health. Some of the services may include:

- Connect to health care providers,
- Connect to mental health and substance abuse providers,

• Connect to needed medications,

- Help with housing (finding stable housing, securing security deposits, household items, understanding lease obligations, housekeeping, budgeting etc.)
- Help with social services (food, childcare, benefits, and transportation) and,
- Help with other community programs that can support and assist clients.

Housing is healthcare! This innovative SDH project creates a partnership between housing and health care services that can reduce homelessness while ensuring that these high need individuals can access a range of care and supportive services that promote health and safety, as well as pathways to stability and economic security.

Potential Return on Investment

Currently, there are over 200 individuals live in LUW supportive housing units - 90% of them have been stably housed for more than 5 years, saving the community over $6 million per year! However, not all of our homeless clients are eligible for supportive housing and the ongoing case management services that go with it. With in-house care managers who can help connect all eligible homeless individuals to Health Homes or other support services, savings should increase. Research has shown that providing homeless individuals with stable housing can significantly improve physical health outcomes and reduce their use of social services and emergency rooms. Every permanent exit from homelessness reduces recurring annual hard costs to the community by an average of $45,000 per year (based on national research done by the University of Pennsylvania). The cost of providing public services for a chronically homeless individual is $40,000-$85,000 per year. This includes the cost of policing, criminal justice, detoxification, emergency medical and shelter costs. The cost of housing a homeless individual in a single room or one-bedroom apartment by fully subsidizing their fair market rent and utilities is between $10,000-$25,000, depending on the depth of the subsidy and the geography in question. We strongly believe that if we provide transitional care management services to clients leaving our shelter for their own homes, we can significantly improve their likelihood of remaining stably housed. With the addition of more comprehensive, supportive services, we anticipate that the return to shelter rates will significantly drop. Because Health Home is already a benefit for eligible NY State Medicaid beneficiaries, the cost of sustaining this program will be minimized.

Scalability

In 2017, LUW served 777 unique individuals who are in need of supportive housing. Based on our experience, about 85% of our clients will be eligible for Health Home services or suitable for the Health Home at-risk group. We estimate that about 660 individuals per year will be assessed for these services. The intervention will initially integrate Health Home care managers into the LUW workforce and to provide collaborative training as described above for existing LUW care managers so that all eligible clients are served. Through this program, we intend to demonstrate its success to other potential funders and key stakeholders, including our local government, NYS Health Home program, and private funders to sustain this initiative.

Feasibility

LUW is fully committed to improve the lives of those facing homelessness in Westchester County for almost 40 years, and is the county's most experienced shelter provider. Our Open Arms Men's Shelter and Samaritan House Women's Shelter house a quarter of Westchester's single homeless adult shelter residents. Our staff includes case managers, client care workers and managers working as a team. All residents are personally matched with a caseworker, who works with him or her to develop an individualized program to best meet their needs. Our ultimate goal is to place residents in permanent housing, while moving them toward independent living as quickly as possible.

In 2015, in partnership with the Department of Social Services and four other housing providers, LUW initiated a Permanent Supportive Housing program for 90+ men, women, and families who meet HUD's definition of chronic homelessness. The initiative is assisting these individuals to find apartments throughout Westchester and providing them with rental assistance and case management supports. We have a proven track record of success, and an integration of Health Home care managers into our workforce to provide additional resources to our clients is very feasible and will only enhance our collective workforce strengths to better serve the residents of Westchester County.

Evidence-based support for innovation

According to an Urban Institute's report, approximately ten percent of children living in poverty will experience homelessness in a given year. Furthermore, recidivism rates in Westchester range from 17% after 6 months to over 40% after two years. Many individuals exit and return to homelessness many times during their lives. Homeless individuals struggle with multiple barriers that can make it difficult for them to keep housing- substance abuse, chronic health conditions, criminal backgrounds, lack of work experience and poor life skills. It is not enough to simply place an individual in affordable housing. A multi-faceted approach that includes prolonged care management is essential to ensure long-term success at independent living. Connection to health services through Medicaid, including Health Homes, can meet this need. Evidence-based models, such as Assertive Community Treatment or Housing First, have been proven

effective by connecting people to key housing and other community resources that can help them gain housing and address health care needs.

Relevance to the Medicaid population

According to the Centers for Medicare & Medicaid Services (CMS), expansion under the Affordable Care Act (ACA) significantly increased health coverage for people experiencing homelessness. In NYS, adults with incomes up to 138 percent of the poverty line can enroll in Medicaid regardless of disability, making coverage available for far more people experiencing homelessness and providing them with access to both routine (primary care, mental health services, substance use treatment, supported employment, and transportation to necessary medical appointments) and urgent care. Through this SDH project, our clients, many of whom are Medicaid beneficiaries, will be connected to the much-needed services.

Speed to market

LUW's goal is to implement a multi-faceted shelter exit initiative called Pathways to Self-Sufficiency in an effort to reduce recidivism and create permanent solutions to homelessness. Through the Innovation Fund from WMCHealth PPS, we can immediately implement this SDH project. Learning from the success of WMCHealth PPS' integration of Health Home care managers into primary care practices across the Hudson Valley region, we will expeditiously integrate the HH-CMA care manager into our workforce and adapt our workflows. With clients being connected to Health Homes and other supportive services, we expect to see exceptional and measureable outcomes, where our high need clients can sustain their housing stability and lead fulfilling, productive lives.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	**No**
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Neighborhood and Environment**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**