Trust
Alaska Mental Health Trust Authority

3745 Community Park Loop, Suite 200
Anchorage, AK 99508
Tel 907.269.7960
www.mhtrust.org

MEETING AGENDA

Meeting: Program & Planning Committee
Date: August 26, 2021
Time: 10:45 AM
Location: online via webinar and teleconference
Teleconference: (844) 740-1264 / Meeting Number: 2459 130 1475 # / Attendee Number: #
https://alaskamentalhealthtrust.org/
Trustees: Verné Boerner (Chair), Rhonda Boyles, Chris Cooke, Kevin Fimon, Brent Fisher, Anita Halterman, John Sturgeon

Thursday, August 26, 2021

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Future Meeting Dates

Full Board of Trustee / Program & Planning / Resource Management / Audit & Risk / Finance

(Updated – August 2021)

• Full Board of Trustee	August 25-26, 2021	(Wed, Thu) – Anchorage
• Audit & Risk Committee	October 20, 2021	(Wed)
• Finance Committee	October 20, 2021	(Wed)
• Resource Mgt Committee	October 20, 2021	(Wed)
• Program & Planning Committee	October 21, 2021	(Thu)
• Full Board of Trustee	November 17-18, 2021	(Wed, Thu) – Anchorage
• Audit & Risk Committee	January 5, **2022**	(Wed)
• Finance Committee	January 5, **2022**	(Wed)
• Resource Mgt Committee	January 5, **2022**	(Wed)
• Program & Planning Committee	January 6, **2022**	(Thu)
• Full Board of Trustee	January 26-27, **2022**	(Wed, Thu) – Juneau
• Audit & Risk Committee	April 20, **2022**	(Wed)
• Finance Committee	April 20, **2022**	(Wed)
• Resource Mgt Committee	April 20, **2022**	(Wed)
• Program & Planning Committee	April 21, **2022**	(Thu)
• Full Board of Trustee	May 25, **2022**	(Wed) – TBD
• Audit & Risk Committee	July 26, **2022**	(Tue)
• Finance Committee	July 26, **2022**	(Tue)
• Resource Mgt Committee	July 26, **2022**	(Tue)
• Program & Planning Committee	July 27-28, **2022**	(Wed, Thu)
• Full Board of Trustee	August 24-25, **2022**	(Wed, Thu) – Anchorage

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Future Meeting Dates

Statutory Advisory Boards

(Updated – July 2021)

Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
AMHB: http://dhss.alaska.gov/amhb/Pages/default.aspx
ABADA: http://dhss.alaska.gov/abada/Pages/default.aspx
Executive Director: Bev Schoonover, (907) 465-5114, bev.schoonover@alaska.gov

- Executive Committee – monthly via teleconference (Fourth Wednesday of the Month)
- Statewide Suicide Prevention Council Meeting: August 24, 2021 / 1pm-4pm (virtual)
- Fall Meeting: October 12-14, 2021 / Sitka

Governor's Council on Disabilities and Special Education
GCDSE: http://dhss.alaska.gov/gcdse/Pages/default.aspx
Executive Director: Kristin Vandagriff, (907) 269-8999, kristin.vandagriff@alaska.gov

- Fall Meeting: September 29-30, 2021 / location TBD

Alaska Commission on Aging
ACOA: http://dhss.alaska.gov/acoa/Pages/default.aspx
Executive Director: Lisa Morley, (907) 465-4879, lisa.morley@alaska.gov

- Fall Meeting: September 1-2, 2021 / location TBD
- Winter Meeting: November 16-17, 2021 / location TBD

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MEMO

To: Verné Boerner - Program & Planning Committee Chair
Date: August 26, 2021
Re: FY22 Housing and Home & Community Based Services Focus Area Allocation
Amount: $500,000.00
Grantee: Providence Health & Services Washington
Project Title: Providence Alaska House

REQUESTED MOTION:

Approve a $500,000 FY22 Housing and Home & Community Based Services Focus Area Allocation to Providence Health & Services Washington for the Providence Alaska House project. These funds will come from the Supportive Housing Projects Budget line in the FY22 budget.

Assigned Program Staff: Kelda Barstad

STAFF ANALYSIS

Providence Alaska House will develop 51 units of permanent supportive housing for chronically homeless adults who suffer from alcoholism, co-occurring disorders, and have a history of high emergency service utilization. The building will be located at the old Providence Extended Care site in Anchorage and designed so that future expansion is possible. This project will focus on a sub-population of seniors who are homeless. Access to supportive services at Providence Alaska House will include the behavioral health services that are typical for permanent supportive housing projects and also chronic medical condition support and functional supports that are commonly needed for seniors. 100% of the residents are Alaska Mental Health Trust Authority beneficiaries. This project is a collaboration between many community partners and is a priority for the Anchorage Anchored Home Community Plan.

Homeless beneficiaries are at great risk of institutionalization. Permanent supportive housing is an evidence-based intervention that disrupts the hospital, corrections, homelessness cycle to allow people to remain stably housed and to have the opportunity to engage in supportive services to meet their goals. A similar project in Juneau showed that after 6 months of being housed resident's: emergency room visits decreased by 65%, sleep off center usage decreased by 99%, and police contact decreased by 72%. Two years later, 25% of residents reduced drinking from daily use to once a month or less. This is significant for any population and especially impactful considering the median number of months of homelessness for this group was 180 months - approximately 15 years. This project is recommended for funding as it aligns with the focus areas

of Housing & Home and Community Based Services, and prevents the institutionalization of Trust beneficiaries. Providence Health & Services Washington has a proven track record of successful permanent supportive housing project implementation in multiple states. It is an incredible benefit to the state to bring in this additional expertise and capacity. This project provides the opportunity to end homelessness for our senior beneficiaries living in shelters and on the streets of Anchorage. Our senior beneficiaries deserve the dignity of permanent housing and accessing the medical care and support services needed to remain as independent as possible and to age well.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 3 Economic and Social Well-being	3.1 Housing	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

The Providence Alaska House will serve chronically homeless seniors and single adults. This permanent supportive housing project is the standalone first phase of a planned multi-phase development. This first phase consists of a single three-story residential building containing approximately 51 studio units and one managers unit as well as support space for the provision of social services including case management consult rooms, spaces for a reception area, administrative and service provider offices, exam rooms, and common space for other supportive service and residential programming.

Homelessness is a serious and growing problem in our community. The causes of homelessness are numerous and varied, with behavioral and mental health and substance abuse disorders being significant drivers. The Municipality of Anchorage is estimated to have over 1,111 persons experiencing homelessness according to the latest point-in-time count. Additionally, over 7,800 Alaskans accessed housing and homeless services in Anchorage a year ago. This data illustrates that the need for housing and services to lift up those experiencing homelessness is great.

Community providers recognize the importance of providing different types of shelter and services to meet the varied needs of those experiencing homelessness. One particularly large segment of the Anchorage homeless population includes chronically homeless single adults and seniors who require supportive services to be successfully housed. This difficult-to-house group in particular is afflicted with mental health and substance abuse disorders, and are beneficiaries of the Trust. Other beneficiaries such as individuals with developmental disabilities and traumatic brain injuries are also part of the chronically homeless demographic and will also be served by this project.

The July 2020 Gap Analysis & 2021 Community Priorities report by the Anchorage Coalition to End Homelessness recommends permanent supportive housing as a High Priority for the community as part of a comprehensive plan to make homelessness rare, brief and one-time. This report also identified a current unmet need of over 550 permanent supportive housing units for single adults.

The 51-unit Providence Alaska House project will house Trust beneficiaries and provide case management and supportive services to build independent living and tenancy skills so residents can stay permanently housed. The master plan for this development includes an additional future 50-unit PSH building and future third building for additional supportive service space to connect residents to community-based health care, treatment and employment services.

This PSH model is being developed to be replicable at other sites in Anchorage and around the state so that additional supportive housing development can be leveraged from this model to support more Trust beneficiaries in the future.

The Providence Alaska House will be located on a 4-acre parcel currently owned by Providence Health & Services at 4900 Eagle Street, Anchorage, AK. We anticipate residents of the project will be identified from the Municipality of Anchorage HMIS system without regard for the community they are from. There are homeless seniors and single adults in the local HMIS system who, although currently present in Anchorage, come from communities throughout Alaska.

This project has benefited from the support of many community partners and stakeholders. A stakeholder visioning session was conducted last year with over 20 organizations, including the Trust. We have also had multiple meetings with funding partners Rasmuson Foundation and Cook Inlet Housing Authority (also the project's developer consultant) as well as the Municipality of Anchorage leadership and planning & development department managers to explore City funding opportunities and ensure alignment with other capital improvement projects in the area. We have also presented this project to the Mid-Town Community Council. While no concerns were voiced during our presentation, we have committed to presenting periodic project updates to the community council. Letters of project support have been received from the Rasmuson Foundation, Municipality of Anchorage, Anchorage Coalition to End Homelessness, Catholic Social Services and Cook Inlet Housing Authority, and are available if the Trust would like them.

EVALUATION CRITERIA

The project will serve chronically homeless individuals who are frequent users of healthcare resources at any of the three partnering healthcare institutions (Providence, Alaska Regional, ANMC). Providence Supportive Housing expects to reduce the rate of hospitalization for its residents significantly over each person's rate of hospitalization for the previous three years, and to increase housing stability measured by length of successful tenancy. Data on homeless patients served at each hospital will enable the team to track hospital bed nights for residents of the project year-to-year. Data recorded by service partners will show number of contacts made with residents, the types of referrals and services utilized, and frequency of services accessed by residents. Data maintained in our tenant management software will record length of tenancy which is an indicator of stability.

1) To track how much Providence is doing, we will track occupancy/vacancy and turnover per unit per quarter, giving an indication of housing stability. Our Service Coordinators and partners will track contacts made with residents, services provided, and conduct annual assessments with each resident to determine individual needs and make referrals. We will also track participation in community events, small group educational events, and socialization.

2) To track how well Providence is doing, we will monitor unit turnover rates to evaluate housing stability; persons remaining housed for a year or longer are considered successful in their tenancy. We will also utilize data from our hospital partners to compare hospital usage by residents prior to residency and in the years following their move into housing.

3) As a way to report residents' overall quality of life, we will conduct our annual health and wellness survey which measures tenant-reported use of medical services and their feelings of overall health, mental/behavioral health, and where they want more assistance. In addition, an initial assessment will be completed with each tenant, reviewing their overall health, mental health, service needs, assistance needed with ADLs or chores, and their general history. This assessment will be completed each year, and we expect to see stability improve as residents remain stable in housing.

SUSTAINABILITY

Providence Alaska House is expected to continue well after the Trust's investment. Project sustainability will be achieved through a number of strategies. First, the objective will be to raise as much capital as possible to minimize the need for assuming project debt. To the extent necessary, the project will assume only as much debt as the project pro forma shows is viable. Second, Providence intends to submit a GOAL application to Alaska Housing Finance Corporation (AHFC) for both capital resources and operational resources in the form of rental vouchers. AHFC has indicated that this year's GOAL round will include such voucher resources. These rental vouchers will be important for operational sustainability. Providence believes this project will result in a very competitive GOAL application. Third, Providence has significant experience in efficiently operating the permanent supportive housing developments in its existing portfolio. Providence intends to use this expertise along with existing resources from its Providence Anchorage organization to realize efficiencies and keep operating costs down. Fourth, Providence Alaska House will be designed and constructed to be energy and operationally efficient. The building will be designed to achieve an extremely efficient 5-star plus energy rating. The building will also be well-insulated and appropriately ventilated using post-pandemic recommendations for appropriate HVAC equipment and air flow. Building materials used will be durable and low maintenance products to keep operational costs associated with maintenance and replacements low. The building will also incorporate photovoltaic panels to generate electricity which will help defray ongoing utility costs.

WHO WE SERVE

As mentioned above, a large segment of the Anchorage homeless population includes chronically homeless single adults and seniors who require supportive services to be successfully housed.

This demographic group in particular is afflicted with mental health and substance abuse disorders, and are beneficiaries of the Trust. Other Trust beneficiaries such as individuals with developmental disabilities and traumatic brain injuries are also part of this homeless population. Based on this demographic information, we believe it is very likely that all units at Providence Alaska House will serve Trust beneficiaries. The onsite health and social service component of this permanent supportive housing development will reduce beneficiary hospitalizations. Resident health and independence will also be promoted through the onsite support services. Trust beneficiaries will also have available onsite case management and other services with the goal of building independent living and tenancy skills so residents can stay permanently housed. The project will also have a fidelity to the aging-in-place model for senior housing.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	51
Developmental Disabilities:	23
Substance Abuse	51
Traumatic Brain Injuries:	15
Number of people to be trained	83

BUDGET

Space or Facilities Costs	$500,000.00
Space or Facilities Costs (Other Sources)	$14,500,000.00
Space or Facilities Narrative:	Funds from the Trust would go towards direct construction costs of Providence Alaska House. The building is currently contemplated as approximately 37,000 sf, and will consist of fifty (51) studio units and one residential manager unit, as well as support space for the provision of services including case management consult rooms, spaces for a reception area, administrative and service provider offices, exam rooms, and other common space for programmed support services.

Total Amount to be Funded by the Trust	$500,000.00
Total Amount Funded by Other Sources	$14,500,000.00

OTHER FUNDING SOURCES

Rasmuson Foundation (secured)	$2,000,000.00
Cook Inlet Housing Authority (secured)	$1,750,000.00

Federal Home Loan Bank Des Moines Affordable Housing Program Grant (pending)	$750,000.00
National Housing Trust Funds (pending)	$495,000.00
Low Income Housing Tax Credits/Energy Credit equity via AHFC GOAL program (pending)	$8,300,000.00
Other partner/philanthropic/owner sources	$1,205,000.00
Total Leveraged Funds	**$14,500,000.00**

PROJECT SUMMARY

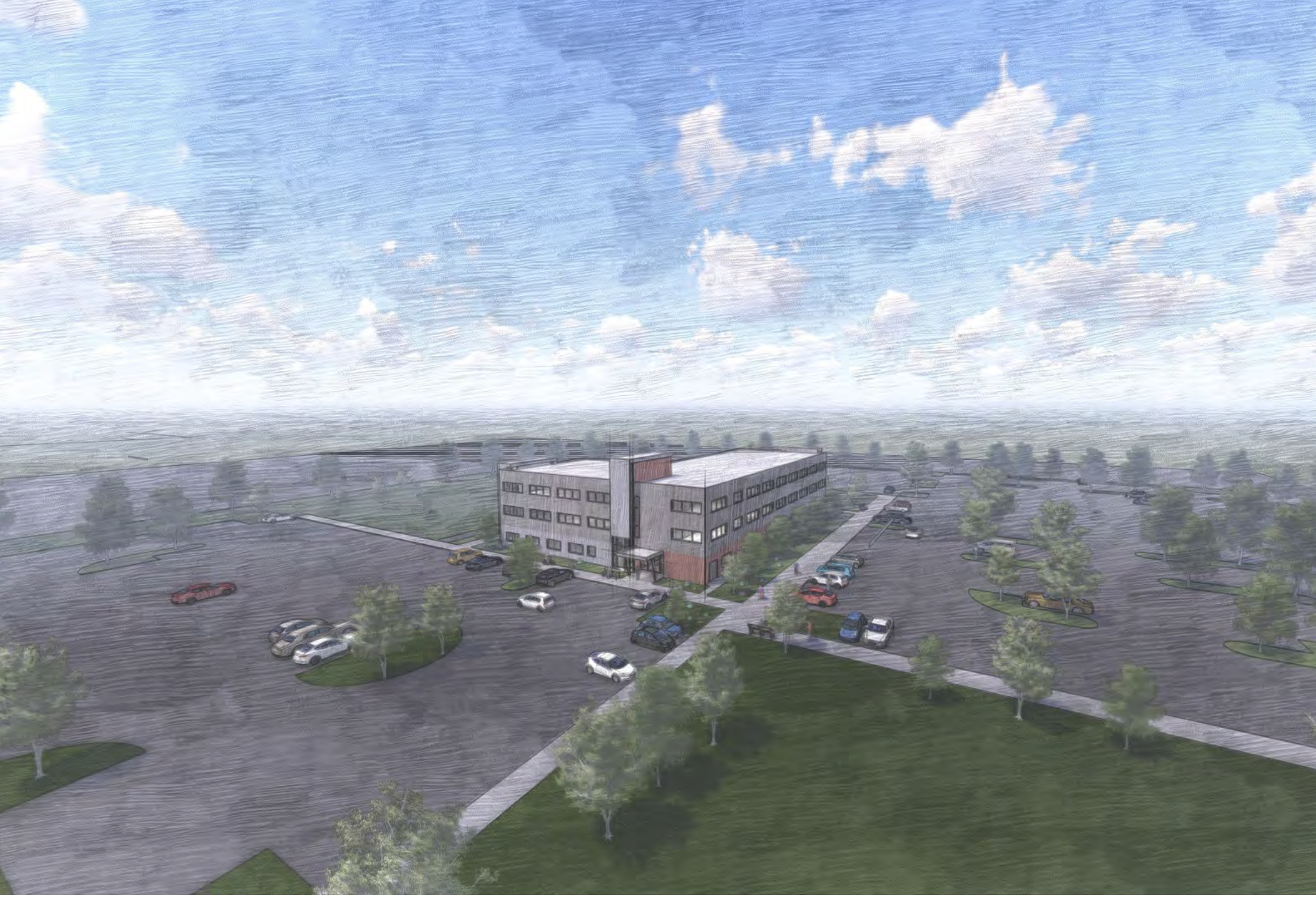
- Providence Owned site (4900 Eagle)
- Project Type – New Construction
- Serving: high acuity chronically homeless seniors
- Phase I - 50 units
- Common areas for supportive services, resident activities
- 24/7 security and secured access
- Total Phase I building square feet = 38,250
- Total Project Cost = $15,134,273
- Committed funding as of 04/2021 = $2.25 m (Rasmuson & CIHA)
- Current Funding Gap = $4 million
- Estimated Construction Start – Summer 2022

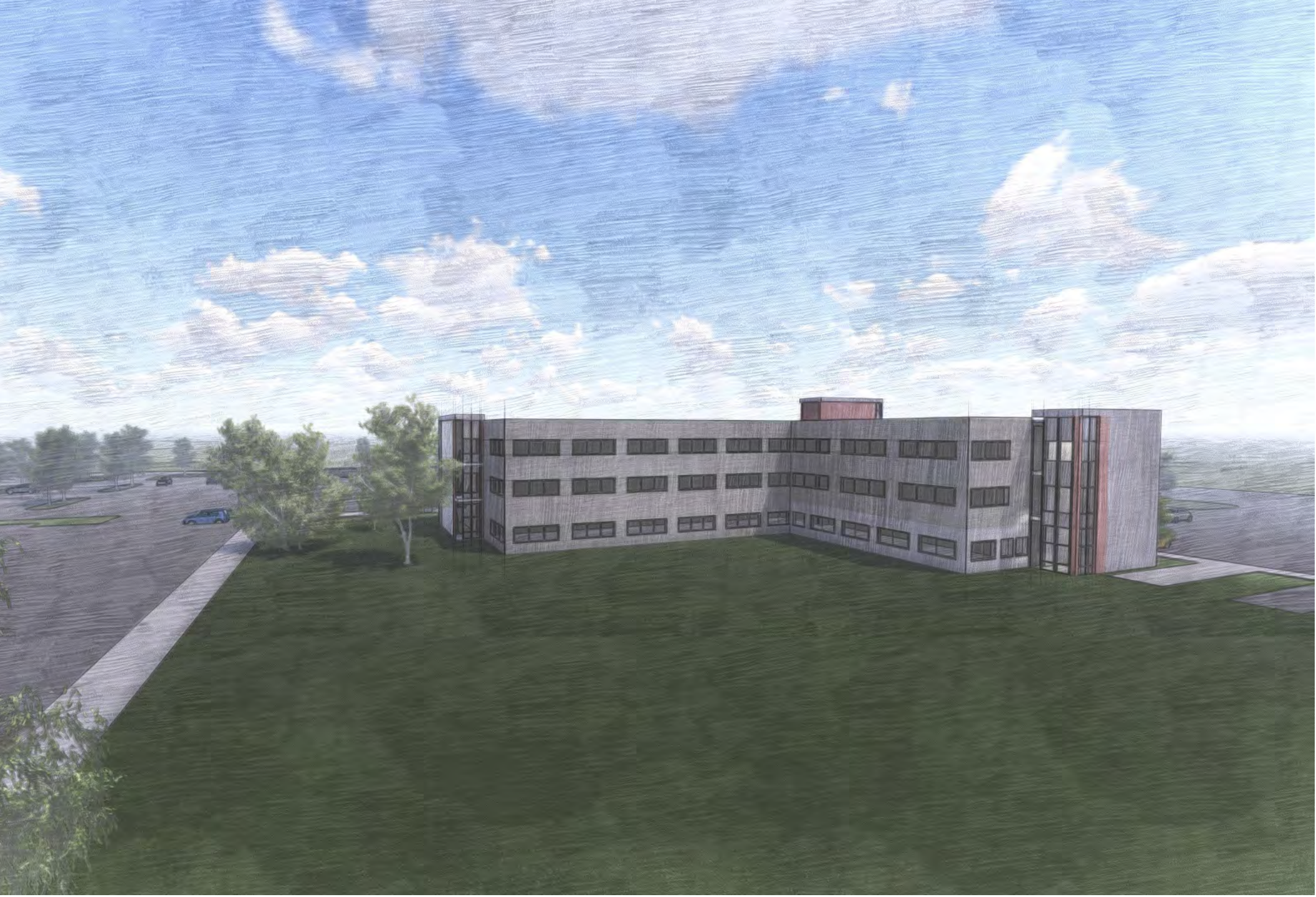
Providence Alaska House is a Permanent Supportive Housing project designed to address the health, safety and housing needs of high acuity chronically homeless seniors and single adults. Located at 4900 Eagle St. in Anchorage, this project is the first phase of a multi-year development. This first phase consists of a single three-story residential building containing fifty (50) studio units, including a residential manager's unit, as well as support space for the provision of social services including case management consult rooms, spaces for a reception area, administrative and service provider offices, exam rooms, and a computer lab area. There will also be common area laundry and common gathering spaces for residents in the building. Future development phases contemplated on the 4-acre parcel owned by Providence includes a similar 50-unit PSH building, outdoor amenity spaces for residents, and parking. Total development budget for this first phase 50-unit PSH project is $15.1 million.

In addition to creating supportive housing, the project creates new partnerships between Anchorage's three major hospitals by coordinating housing placements in the PSH project for homeless seniors who rely on frequent hospitalizations for health care and social supports.

Project Key Roles, Stakeholders and Partnerships

Project Development Team:	Healthcare Partners:	Funding Partners:
Owner- Providence Health & Services Developer- Providence Supportive Housing Development Manager- Cook Inlet Housing Authority Architect- Spark design	Alaska Regional Hospital Alaska Native Medical Center Providence Medical Center Alaska VA Health System Community Partners: Southcentral Foundation Cook Inlet Tribal Council Rural CAP Providence Behavioral Health Anchorage Coalition to End Homelessness Catholic Social Services	Rasmuson Foundation AHFC Alaska Mental Health Trust Municipality of Anchorage Cook Inlet Housing Authority Federal Home Loan Bank, Affordable Housing Program





Site Plan

PROV Supportive Housing Concept 2020

SALT . RIM . DOWL

First Floor

PROV Supportive Housing Concept 2020

SALT . RIM . DOWL

Second Floor

PROV Supportive Housing Concept 2020

SALT . RIM . DOWL

Community Space

Living Space

Housing Support Space

Clinic Space

Third Floor

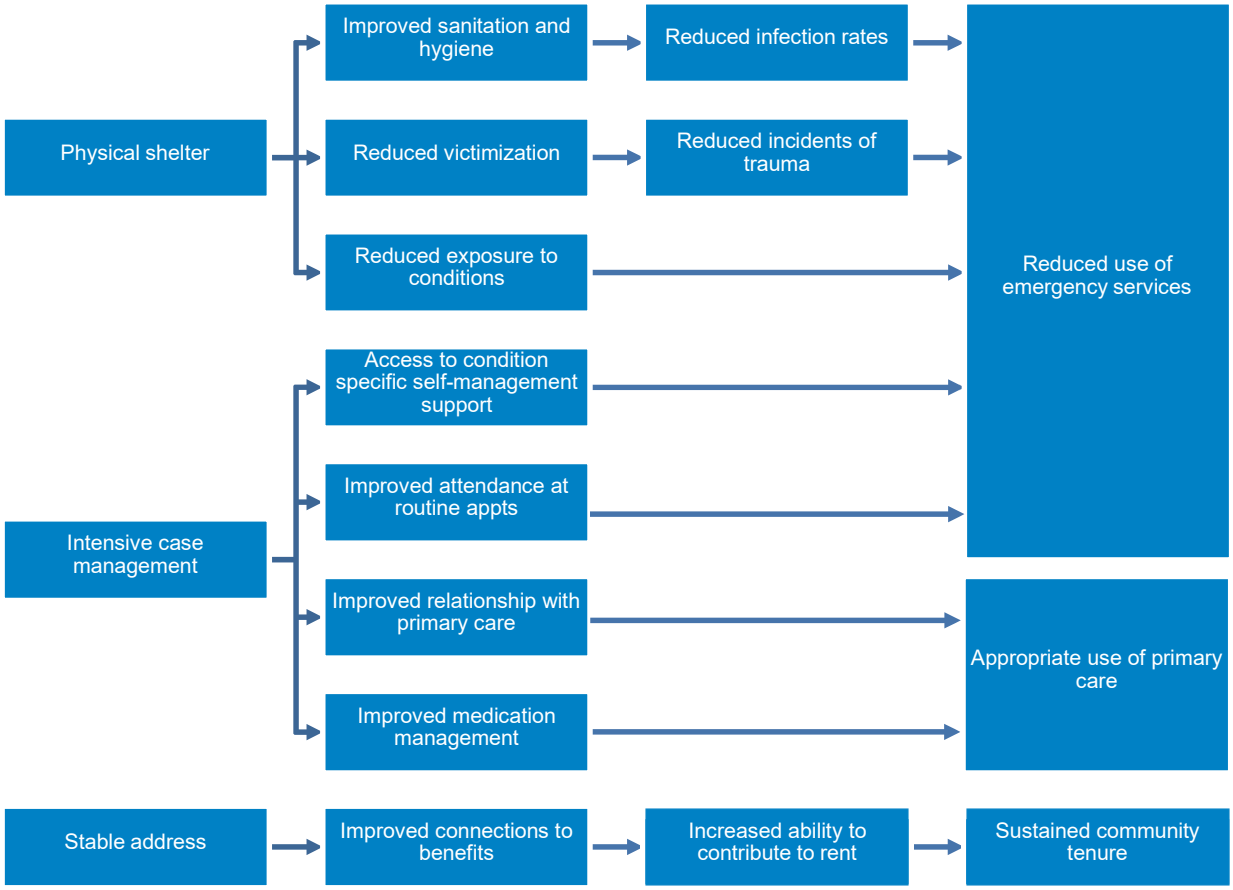
PROV Supportive Housing Concept 2020

SALT . RIM . DOWL

"Housing as healthcare" is the mantra often used to describe the critical impact of housing on the health needs of vulnerable populations. Homeless individuals have been known to accrue healthcare expenditure nearly four times greater than the average Medicaid recipient.[1] The costly episodes, which often result from the use of acute services, can also be associated with worse health and quality of life outcomes and increases in health disparities.

Supportive housing can facilitate stronger connections to primary care and more appropriate healthcare utilization by providing a stable environment in which to manage health and by connecting individuals to services that support relationships with primary healthcare providers. Based on this mechanism, we would expect to see an initial increase in routine services as individuals stabilize their health, particularly after first coming into contact with support services, and a decrease in emergency or acute services or levels of care. In addition to these impacts, housing stability may improve nutrition, improve hygiene and sanitation conditions, and reduce incidents of victimization and abuse. These mechanisms are summarized in Figure 1.

Figure 1: Impact of supportive housing on healthcare utilization outcomes



[1] Bharel, Monica et al. "Health Care Utilization Patterns of Homeless Individuals in Boston: Preparing for Medicaid Expansion Under the Affordable Care Act." *American Journal of Public Health* 103.Suppl 2 (2013): S311–S317. *PMC*. Web. 13 Oct. 2016.

While these links between poor health and living on the streets or in unstable accommodation are intuitive for many stakeholders in the supportive housing sector, the literature on this topic is wide-ranging and immense. In order to clarify the scope of existing literature, we have reviewed twenty-five studies published between 2002 and 2017 to determine:

- Healthcare metrics best evaluated in the evidence base
- Studies that describe anticipated cost avoidance and cost savings for the healthcare sector

In addressing these topics, we highlight areas of concern with the current evidence base and the limitations of studies published to date. We hope that supportive housing and healthcare providers can use this briefing as a starting point for further exploration of the studies that most closely align with their interests.

Please note that this is not an academic meta-analysis of supportive housing studies nor has it been peer reviewed. We do not make any claim as to the strength of individual studies. Instead, this briefing describes the content of a subset of publicly available evaluations in order to draw attention to studies that may be of interest to our audience.

Overview of Studies

Studies included in this analysis (see Figure 1 below) were selected on the basis that they measured the impact of housing interventions on healthcare service metrics. We drew from existing compilations of the literature, including the Supportive Housing Network of New York's research archive, web searches of medical journals such as the *Journal of the American Medical Association*, and internal CSH documents. Studies were not included if they included non-US geographies, as cost data was not considered comparable. We do not claim this sample is comprehensive or systematic, and we encourage stakeholders to conduct their own reviews as well.

One challenge when reviewing the literature is understanding the implementation of 'supportive housing' as an intervention. We have tried to ensure that the included studies adhere to the CSH definition of supportive housing – affordable housing with voluntary service offerings – but the implementation of this model varies widely and some of its tenets may be applied differently between studies. We encourage organizations looking to replicate results from a study listed here to examine in detail the service delivery models used.

The number of participants in each study recorded in Figure 1 is matched as closely as possible to the number of participants for whom healthcare data was collected. For example, if only 500 out of 1,000 participants were sampled for healthcare data, we have used 500 as the participant number.

The majority of studies utilized pre/post methodology for data analysis related to healthcare service metrics. Pre/post methodology uses data from the same individuals collected at points before and after the intervention in order to determine the intervention impact. It is considered the least robust evaluation methodology, as it does not take into account what would have happened to the individuals without the intervention. It is also susceptible to a phenomenon called 'regression to the mean' in which individuals with unusually high service usage at baseline will naturally have less service usage at follow-up. Results should therefore be treated with caution.

Chart 1: Overview of studies

Study	Year	Geography	Participants	Study design	Metrics
Culhane (2002)	2002	New York, NY	3,365	Pre/post study	Outpatient stays Hospital bed days Medicaid costs
Tsemberis et al (2004)	2004	New York, NY	225	RCT	Substance abuse treatment services
Direct Access to Housing (2004)	2004	San Francisco, CA	483	Pre/post study	ER visits Inpatient stays Outpatient stays
Denver Housing First Collaborative (2006)	2006	Denver, CO	19	Pre/post study	ER visits Inpatient stays Outpatient stays Detox visits
Martinez et al (2006)	2006	San Francisco, CA	236	Pre/post study	ER visits Inpatient stays
Mondello et al (2007)	2007	Portland, ME	99	Pre/post study	ER visits Ambulance trips
Linkins et al (2008)	2008	State of California	1,180	Pre/post study	ER visits Inpatient stays Hospital bed days
Hirsch et al (2008)	2008	State of Rhode Island	50	Pre/post study	ER visits Inpatient stays

Hall (2008)	2008	Seattle, WA	20	Pre/post study	ER visits Inpatient stays Detox visits
Mondelo et al (2009)	2009	State of Maine	163	Pre/post study	ER visits Inpatient stays Ambulance trips
SH in Illinois: A Wise Investment (2009)	2009	State of Illinois	177	Pre/post study	ER visits Hospital bed days Outpatient stays Ambulance trips
Flaming, Burns, Matsunaga (2009)	2009	Los Angeles, CA	279	Pre/post study	Inpatient stays
Sadowski et al (2009)	2009	Chicago, IL	201	RCT	ER visits Inpatient stays Hospital bed days
Larimer, Malone, Garner et al (2009)	2009	Seattle, WA	95	Quasi-experimental design	Medicaid costs Ambulance trips
Basu et al (2012)	2012	Chicago, IL	407	RCT	ER visits Inpatient stays Hospital bed days Outpatient visits Substance abuse treatment days Nursing home days
MA Housing & Shelter Alliance (2012)	2012	State of Massachusetts	96	Pre/post study	ER visits Inpatient stays Detox visits Ambulance trips
City of Knoxville (2012)	2012	Knoxville, TN	47	Pre/post study	ER visits Inpatient stays Outpatient stays Primary care visits
Flaming, Lee, Burns, Sumner (2013)	2013	Los Angeles, CA	36	Pre/post study	ER visits Inpatient stays Hospital bed days

Aidala et al (2013)	2013	New York, NY	72	Comparison group (constructed via propensity score matching)	ER visits Inpatient stays Detox visits Ambulance trips
NY/NYIII Supportive Housing (2013)	2013	New York, NY	1,695	Comparison group (constructed via propensity score matching)	Medicaid costs
Thomas et al (2014)	2014	Charlotte, NC	73	Pre/post study	ER visits Inpatient stays Hospital bed days
CORE (2014)	2014	Portland, OR	59	Pre/post study	ER visits Inpatient stays Outpatient stays
CSH Social Innovation Fund Initiative (2017)	2017	Multiple locations, United States	726	RCT & quasi-experimental study	ER visits Hospitalizations Hospital bed days Outpatient visits
Hunter e al (2017)	2017	Los Angeles County	890	Pre/post study	ER visits Inpatient stays Outpatient stays Health costs
Listwan and LaCourse (2017)	2017	Mecklenburg County, NC	42	Pre/post study	Hospital costs Ambulance costs

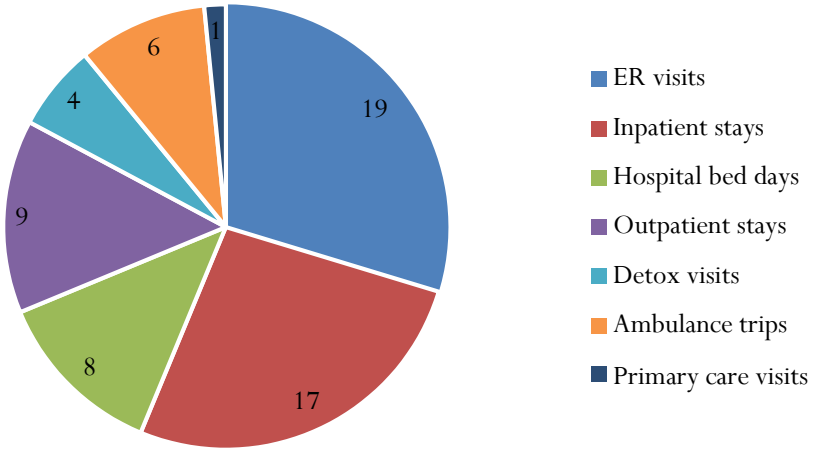
Healthcare Metrics

The seven healthcare service most frequently evaluated in the studies are examined below. Emergency room visits and inpatient stays are the most frequently measured, followed by hospital bed days, outpatient stays and ambulance trips. The less well evidenced metrics include detox visits and primary care visits.

While we have focused on physical health service usage, some studies included psychiatric inpatient visits within their physical inpatient data. We did not include data that only examined psychiatric inpatient

data, such as in Culhane (2002). If using these papers to predict impacts on services, we recommend further understanding the papers' treatment of psychiatric services.

Figure 1: Number of studies in sample evaluating healthcare metrics

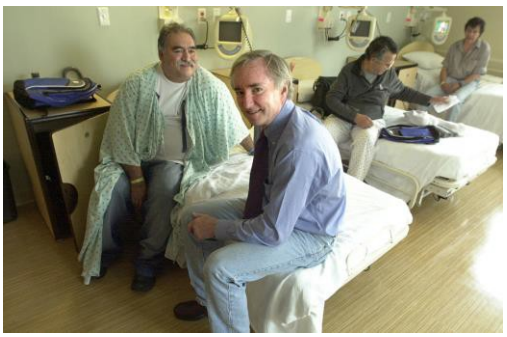


Evaluation metrics are often selected on the basis that there is a theory of change linking the intervention to the measured outcomes. In the case of these supportive housing studies, the theory of change is that a stable home environment is likely to lead to improved health.

Impact on Healthcare Metrics

The majority of studies included in this report found reductions in one or more of Emergency Room (ER) visits, inpatient stays, hospital bed days and ambulance trips post-housing. The data underpinning these impacts was largely collected from hospital and medical records and analyzed using matching based on participant names. However, some studies used patient-reported data which is limited by patient recall and should be treated with caution.

For each study, we determined the change in service usage from the baseline to the end of the first year in supportive housing. Figure 2 below shows an average of these impacts for each metric that was most frequently evaluated. Some studies that measure the outcomes are not included in our description because the data was not available in a format that could be easily used or compared to other studies. For example, one study reported data only for baseline and the end



of the second year. Additionally, the CSH SIF Evaluation study reported impacts for each site but the pooled impacts across the sites were not significant, so those numbers are not included.

Figure 2: Average reductions in healthcare service usage across studies*

	Number of studies	Baseline to year 1	Impact range
ER visits	17	-44%	-78%, -2%
Inpatient stays	13	-39%	-79%, +5%
Hospital bed days	9	-45%	-84%, +3%
Outpatient stays	6	36%	-25%, +132%
Detox visits	4	-47%	-82%, 0%
Ambulance trips	6	-34%	-60%, +50%

*In some cases data has been transformed to obtain comparable information between studies, e.g. calculating service usage from the total reported costs and the cost per service. Average reductions have not been independently verified.

Anticipated Cost Avoidance and Cost Savings in the Healthcare Sector

Some but not all of the twenty-five studies included in this report record healthcare costs as an outcome. Cost items included in the analysis vary widely between studies. Questions to consider when interpreting cost outcomes include:

- What year are the costs recorded or relevant to? Should costs be inflated for older studies?
- Does the cost data include Medicaid and non-Medicaid costs? In what proportion?
- Are these costs gross or net of the intervention cost? Over what time period?
- Did local variations in hospital costs influence the data?
- Has the Medicaid reimbursement system changed since costs were reported?
- What data sets were matched to participants and what services and systems are covered in those data sets? What systems and data sets are missing that might also show cost savings?

With these caveats in mind, Chart 2 shows the estimated annual per-person cost savings related to supportive housing reported across studies in this sample.

Chart 2: Cost data by study

Study	Net cost saving reported	Costs included
Culhane (2002)	$16,282 per person	Emergency shelter days Hospitalizations Hospital days Days incarcerated

Colorado Coalition for Homeless (2006)	$4,745 per person	Emergency Room Hospitalizations Outpatient medical Detox services Incarceration Emergency shelter days
Mondello et al (2007)	$944 per person	Health Care Mental Health Care Emergency Room Jail Ambulance Police
Hirch et al (2008)	$7,946 per person	Hospital days Mental health days Alcohol/drug days Emergency Room Jail/prison days Shelter days
Mondello et al (2009)	$1,348 per person	Mental Health Care Emergency Room Jail Ambulance Emergency shelter
MA Housing & Shelter Alliance (2012)	$17,675 per person	Emergency Room Hospitalizations Ambulance Respite days Detox days Days incarcerated
Basu (2012)	$8,593 per person	Hospitalizations Emergency Room Outpatient Residential Substance Abuse Treatment Nursing home
Listwan and LaCourse (2017)	$9,082 per person over a three-year period / $1,119 per person	Hospital charges / Ambulance charges
CSH Social Innovation Fund (2017)	$7,800 per person in Connecticut site	Emergency Room Hospitalizations
Hunter et al (2017)	$22,732 per person	DHS Emergency Services DHS Inpatient & Outpatient DMH Inpatient & Outpatient DMH Residential DMH Crisis Stabilization

While many studies use the terms ‘cost savings’ and ‘cost avoidance’ interchangeably, there is in fact a distinction that may be helpful for potential beneficiaries of reduced services.

Cost savings refers to a reduction that causes future spending to fall below the level of current spending. These cost savings may then be removed from budgets, reinvested, or redirected to other spending priorities.

Cost avoidance refers to reductions that cause future spending to fall, but *not* below the level of current spending. Often cost avoidance involves slowing the rate of cost increases. In other words, future spending would have increased *even more* in the absence of cost avoidance measures. Cost avoidance may incur higher (or additional) costs in the short run but the final or life cycle cost would be lower.

For example, individuals experiencing homelessness have shorter life expectancies than the average population. As such, people who have been homeless and are engaged in supportive housing in their forties or fifties may be presenting with physiological challenges of medically fragile people in their sixties or seventies. The cost of stabilizing their healthcare may be immediately expensive but could delay the onset of even more severe conditions that are likely to present in the next few years.

From the standpoint of cost-benefit analysis, both cost savings and cost avoidance can be considered payer benefits, because both reduce the amount of resources necessary to fund operations. However, the difference between cost savings and cost avoidance has practical implications from a budgetary perspective. If strategies focus on cost avoidance rather than on cost savings, surplus dollars for reinvestment may be slower or more difficult to generate. On the other hand, cost avoidance initiatives can help to contain and control costs and may create cost savings in the future.

The reductions in service usage highlighted in the previous section make it clear that there is both cost saving and cost avoidance potential for healthcare providers and funders of supportive housing tenants. The exact amounts will depend on the existing levels of service usage per participant and the way individual healthcare costs are funded. When basing budget decisions on programs similar to the ones highlighted in these studies, it is perhaps helpful to consider the program part of a wider array of cost savings or cost avoidance measures.

Discussion

The studies described here report impacts of supportive housing on healthcare metrics, including a majority that show reduced utilization of emergency healthcare services. The noted reductions in service usage are likely to lead to cost savings, although all cost considerations should be viewed in the context of their funding system. It should also be noted that cost savings and cost avoidance are not the only political drivers of

supportive housing. Supportive housing can be created or scaled for reasons that include a focus on supporting priority populations, community integration for persons with disabilities, community focus on ending homelessness, or an understanding that housing is a platform for individuals or families to stabilize chaotic lifestyles, improve health and increase community engagement.

A further area for consideration is the impact of supportive housing by sub-population group. It is likely that high utilizers of healthcare services and the chronically homeless will have higher levels of baseline service usage and may see a greater proportional reduction in that usage after entering supportive housing. In addition, some studies, including the CSH Social Innovation Fund evaluation, examine impacts of housing on populations segmented by chronic health conditions. This understanding of how housing can stabilize particular sub-populations or particular health conditions should be explored further.

Finally, there are many benefits of supportive housing that accrue to sectors beyond healthcare. The estimation of cost savings across multiple public sector budgets could lead to partnerships between healthcare and prison or other criminal justice providers with similar incentives to increase access to supportive housing. Data integration challenges have slowed the ability of studies to include outcomes from across systems, but the impacts of supportive housing as a holistic intervention cannot be fully understood without this cross-sector view.

To complete this paper, CSH leveraged resources made available through the Corporation for National and Community Service (CNCS), a federal agency for volunteering, service, and civic engagement. The CNCS Social Innovation Fund (SIF) engaged CSH to help create a learning network of organizations working to implement innovative and effective evidence-based solutions to local and national challenges. For more information on CNCS, visit NationalService.gov.

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MEMO

To:	Verné Boerner - Program & Planning Committee Chair
Date:	August 26, 2022
Re:	Mental Health & Addiction Focus Area Allocation
Amount:	$300,000.00
Grantee:	Anchorage Community Mental Health Services, Inc dba Alaska Behavioral Health
Project Title:	Fairbanks Adult Mental Health Residential Treatment

REQUESTED MOTION:

Approve a $300,000 FY22 Mental Health & Addiction Focus Area Allocation to Anchorage Community Mental Health Services, Inc. dba Alaska Behavioral Health *for the Fairbanks Adult Mental Health Residential Treatment project. These funds will come from the Treatment Access and Recovery supports line in the FY22 budget.*

Assigned Program Staff: Eric Boyer

STAFF ANALYSIS

Alaska Behavioral Health (AKBH) is requesting start-up operational funding for an adult residential treatment center in Fairbanks. Adult residential services under the Behavioral Health Medicaid 1115 Waiver are a critical part of the community-based treatment for Trust beneficiaries who suffer from severe mental illness (SMI). Currently, this line of service does not exist in the Fairbanks region, so these mental health treatment beds would help to meet the clinical care needs of beneficiaries with SMI. Further, this new residential treatment center would help keep residents of Fairbanks and the interior closer to home and provide an opportunity for Fairbanks beneficiaries being served in Anchorage to return home for care.

The requested funds are needed to ramp-up the staffing for the new inpatient residential unit. There are more than 15 staff positions necessary to implement and carry out the programmatic component of the new treatment center. As this is a new service, the requested funds will be used for on-boarding and sustaining the staffing pattern during the first three months of operation – during which time the clinical team will assess and admit clients, allowing billable services to sustain the operations beyond this three-month period. This funding and staffing ramp-up are necessary to create the milieu required for the level of treatment and care associated with adult residential treatment services. Ultimately, this service will allow the AKBH residential treatment team to provide the right level of care to individuals with SMI at the right time. Residential programs such as this also decrease the use

of more expensive and restrictive interventions and keep Trust beneficiaries closer to their home of origin.

Agnew::Beck provided consulting and technical support to AKBH in building the business plan, which led to the operational funding request to the Trust. The business plan was developed around an 83% occupancy, which AKBH believes can be met in this three-month startup period. AKBH has committed funds to securing the property, which they will be closing on in the next few weeks. It is recommended by Trust staff to fully fund this proposal request.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 2 Healthcare	2.1 Access & receive quality healthcare	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

Alaska Behavioral Health (AKBH) is seeking funds to start adult mental health residential treatment services for the Fairbanks community. The 1115 Behavioral Health Medicaid Waiver created several additional levels of care that did not previously exist in the State of Alaska including residential treatment for adults with serious mental health issues. This level of care provides treatment services by an interdisciplinary treatment team in a therapeutically structured, supervised environment for adults with acute mental health needs whose health is at risk while living in their community and have not responded to outpatient treatment, needs cannot be met in a less-restrictive setting, or who need further treatment following discharge from inpatient care.

For many years, Recipient Support Services (RSS) helped support Alaskans who needed a higher level of care. Those receiving RSS services had a mental health diagnosis, a history of violence, and presented with either: a) assaultive or threatening behavior or delusions or b) command hallucinations of violent content. When receiving RSS, clients were often prevented from doing harm to themselves or someone else because of the intervention of the staff. If RSS was not sufficient, some Alaskans were sent to residential facilities out of state. For over a decade, Alaska Behavioral Health (AKBH) served between 50 to 100 individuals per year who required RSS services. Many of the individuals served in Anchorage were from Fairbanks because adequate resources did not exist in the Fairbanks community.

In spring 2021, Alaska Behavioral Health and other providers were notified by the Alaska Department of Health and Social Services, Department of Behavioral Health that RSS was no

longer a service available for federal reimbursement. By that time, AKBH had created 32 beds of capacity for adult mental health residential treatment and was able to transfer all the interested individuals in Anchorage, who qualified for this new 1115 service, from RSS to residential treatment. This addressed the needs of those who had been served by the RSS system, but this was only the beginning. In Alaska, but particularly in the Fairbanks community, there are many more who need this service so expanding the capacity is essential. Additionally, with the expansion of crisis services in Fairbanks, specifically the mobile crisis team and future crisis stabilization center in Fairbanks, this program will provide treatment options for those in crisis who do not need inpatient care but require intensive treatment to achieve stability. Agnew Beck forecasted demand of 91 annual admissions for Fairbanks. With the assumption of a 90-day average length of stay, this would require 35 beds in Fairbanks. Medicaid regulations (IMD Exclusion) require that each facility have 16 beds or less.

The target population for adult mental health residential treatment is adults (18 and older) experiencing a serious mental illness and diagnosed with a mental health or co-occurring disorder with a prior history of continuous high service needs. Adults will come to residential treatment because their health is at risk while living in their community and they have not responded to outpatient treatment, needs could not be met in a less-restrictive setting, or who need further treatment following discharge from inpatient care. Everyone admitted to adult mental health residential treatment will receive treatment services by an interdisciplinary treatment team of qualified professionals including advanced nurse practitioners, mental health clinicians, peer support specialists, and clinical associates in a therapeutically structured, supervised environment.

The service components of adult mental health residential will include clinically directed therapeutic treatment; comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs, and support those needs safely; medication services including medication prescription, review of medication, medication administration, and medication management; individual and group therapy focused on skill development including communication, problem solving, and conflict resolution; life and social skills to restore functioning; self-regulation, anger management, and other mood management skills; and individual plans of care that highlight interventions aimed at assisting the individual attain goals designed to facilitate discharge to a lower level of care as soon as possible.

EVALUATION CRITERIA

In order to measure project success, AKBH will track the following performance metrics: the number of individuals served, the number of services provided, the average length of stay, number of readmissions, and client satisfaction with care. Additionally, AKBH will administer the National Outcome Measures (NOMS) once an individual is linked to services (at intake) and every six months thereafter, which tracks whether the individual is demonstrating an improved quality of life. AKBH also administers the PHQ-9 and other assessments and then reassesses every 3 months thereafter to better understand the impact treatment is having on an individual's mental health.

SUSTAINABILITY

In January of 2021, AKBH, with technical assistance support from the Alaska Metal Health Trust, began working with Agnew Beck to develop a business model for the provision of adult mental health residential treatment services in Fairbanks. Agnew Beck found that, based on an 83% occupancy and a 70-30 split between Level 1 and Level 2 clients, a proposed Fairbanks facility would operate with annual net loss of $72,041. This model used some conservative assumptions and AKBH believes that we can operate a Fairbanks facility with a positive margin once it is operating to full capacity.

WHO WE SERVE

This project will provide adult mental health residential treatment services to The Trust's beneficiaries which include those who are mentally ill (i.e. those diagnosed with schizophrenia, delusional disorder, mood disorders, anxiety disorders, somatoform disorders, personality disorders, dissociate disorders, and other psychotic or severe and persistent mental disorders); chronic alcoholics suffering from psychosis; and other persons needing mental health services. As highlighted in the Alaska Statues, the integrated comprehensive mental health program, for which expenditures are made by The Trust, shall give priority in service delivery to persons who, as a result of a mental disorder, may require or are at risk of hospitalization or are experiencing such a major impairment of self-care, self-direction, or social and economic functioning that they require continuing or intensive services. By providing adult mental health residential services, Trust beneficiaries who need a higher level of care will receive the right care, in the right setting. Beneficiaries will be better off because they will be able to receive the care they need, in a safe and supportive environment, and eventually step down to lower levels of care.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	80
Developmental Disabilities:	2
Substance Abuse	2
Traumatic Brain Injuries:	2
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	5
Number of people to be trained	2

BUDGET

Personnel Services Costs	$225,000.00
Personnel Services Costs (Other Sources)	$0.00
Personnel Services Narrative:	All positions below include salary and benefits. Floor Staff 12.6 FTE x 3 months = 163,000 Master's Level Clinician 1.0 FTE x 3 months = $30,500 Clinical Associate 1.0 FTE x 3 months = $17,700 Manager .25 FTE X 3 Months = $13,800

Other Costs	$75,000.00
Other Costs (Other Sources)	$0.00
Other Costs Narrative:	Indirect costs: $75,000 Indirect cost pull includes: Administrative and general expenses including salaries and fringe benefits of administrative personnel, travel, administrative facility costs, supplies, audit, legal services, and other administrative overhead costs.

Total Amount to be Funded by the Trust	$300,000.00
Total Amount Funded by Other Sources	$1,300,000.00

OTHER FUNDING SOURCES

Anchorage Community Mental Health Services, Inc. DBA Alaska Behavioral Health - Secured	$1,300,000.00
Total Leveraged Funds	**$1,300,000.00**