2017

Social Innovation Fund Pay for Success

Feasibility Report:
San Diego Housing Commission
San Diego, California

CSH
The Source for Housing Solutions

About CSH

CSH is a national nonprofit organization and Community Development Financial Institution that transforms how communities use housing solutions to improve the lives of the most vulnerable people.

CSH offers capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends 25 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. For more information about CSH's work related to Pay for Success, please see www.csh.org/pfs

Acknowledgements

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In 2009, the Social Innovation Fund was created as part of the Corporation for National & Community Service to find solutions that work, and make them work for more people – by proving, improving and scaling effective models. SIF and its non-federal partners have invested nearly $1 billion in effective community solutions since the program's inception. Launched in 2014, the SIF Pay for Success (PFS) program is designed to help cities, states, and nonprofits develop Pay for Success projects where governments pay service providers only when there are demonstrable results.

This material is based upon work supported by CNCS under SIF Grant No.14PSHNY002. Opinions or points of view expressed in this document are those of the authors and do not necessarily reflect the official position of, or a position that is endorsed by, CNCS.

Note: Pay for Success is a general term for performance-based contracting between government and social service providers, where government only pays providers if target outcomes are achieved, e.g. reduced recidivism or improved health outcomes, as opposed to providing cost reimbursement payments.

Inquiries

If you are interested in learning more about efforts to address homelessness in the city of San Diego, please visit SDHC's website, at www.sdhc.org or contact Melissa Peterman, Vice President of SDHC's Homeless Housing Innovations Department, at melissap@sdhc.org. For information on CSH, please visit www.csh.org for additional online resources and materials. If you have questions or comments regarding this document, please contact Stephanie Mercier at stephanie.mercier@csh.org.

Executive Summary

This report summarizes conclusions and next steps resulting from the Technical Assistance provided by CSH to SDHC from approximately April 2015 to December 2016. The feasibility report for this Pay for Success framework in San Diego focuses on the components of feasibility outlined in the table below. The "status" column reflects the level of completion of that particular component as it relates to progress toward a Pay for Success program. "Green" items represent a key component in which the community is ready to move forward and "red" represents a key component where significant work remains before a Pay for Success effort can proceed on that front. The "yellow" represents a key component in which the community has made progress but final details and decisions have not been determined.

Key component	Successes	Next steps	Status
Pay for Success education	Discussions with City and County entities, providers and stakeholders	Deeper engagement with committed end payer partners	
Target population	Options for target population included in report	Following end payer commitment, agreement on eligibility criteria	
Cost/Benefit Analysis (CBA)	CBA draft created with some local data including that of a supportive housing program targeting frequent utilizers	Following confirmation of target population, revising current CBA that includes local criminal justice & health systems data, if needed	
Service design	Service design model established through Project 25 supportive housing pilot program	Following confirmation of target population, adjustments to service model if required	
End payer identification	Potential interest from health sector Managed Care Organizations (MCO) and the City of San Diego	Gain commitment from MCO or government partners to be an end payer	
Payment terms	Options for payment terms included in report	Following end payer commitment, agreement on terms	

CSH believes that in San Diego the opportunity exists to successfully finish designing, structuring and implementing a Pay for Success supportive housing program if there is commitment from an entity willing to make payments based on success, known as an "end payer." The most likely entities that could potentially play that role in San Diego are the County or City of San Diego or one or more Managed Care Organizations (MCOs). CSH has documented a number of options for finalizing a target population, outcomes of interest, success metric payment terms, and evaluation in the event that an end payer(s) is secured.

Background and Opportunity

In 2015, SDHC was selected by CSH as a subrecipient of the 2014 SIF Pay for Success grant award from CNCS. CSH committed to provide Technical Assistance to SDHC to determine whether its proposed Pay for Success initiative was feasible.

The program proposed by SDHC and its partners was to explore using Pay for Success as a tool to scale supportive housing targeting chronically homeless individuals with multiple emergency room and hospital admissions and a combination of identified high-risk conditions. In 2011, San Diego launched "Home Again, Project 25," (Project 25), a three-year permanent supportive housing pilot program, which enrolled and housed 35 chronically homeless individuals identified as "frequent utilizers," or the most frequent users of emergency medical services and law enforcement resources in San Diego. The target population was identified by comprehensive cross system data matching. Project 25 reduced emergency room visits by 76 percent and arrests were down by 73 percent within the first year, and the three-year program saved San Diego $3.5 million over two years.

The proposed Pay for Success program would scale the approach used in Project 25 to provide permanent supportive housing for 200-300 homeless individuals who cycle in and out of hospitals, jails and shelters. Pay for Success financing would be used to fund the gaps in existing housing and service resources for these individuals. The initiative is expected to generate positive results in housing stability, as well as reductions in health care, criminal justice and shelter costs.

This program was selected for support due to the many strengths of its community and proposal as outlined below.

A strong need for supportive housing: At the time of the application, San Diego had identified through their local Campaign to End Homelessness in Downtown San Diego that a significant portion of the population experiencing homelessness were most appropriate for supportive housing. In 2014, 2,369 individuals experiencing homelessness were assessed using the same screening tool in Downtown San Diego. Based upon results, 62 percent of the individuals surveyed identified as chronically homeless, 57 percent had serious medical conditions, and 75 percent had mental health conditions.

Existing data collection and analysis: The various partners in San Diego working with frequent utilizers provided access to several relevant sources of data, from which SDHC was able to establish the status quo cost and potential public cost savings for the target population. These included health utilization data from the University of California San Diego (UCSD) Health System Emergency Department Placement Project (EDCPP), and from the city of San Diego's Low Income Health Program (LIHP), as well as evaluation data from Project 25 and letters of support from the five managed care organizations that serve all Medi-Cal clients in San Diego County. At the time of the application, the managed care companies were partnering in efforts to share claims data for the purposes of targeting frequent utilizers.

Using this data, as well as applying the preliminary cost data from Project 25, SDHC estimated that a scaled Pay for Success supportive housing intervention program would result in a reduction in public costs yielding a savings of more than $11 million annually.

This access to information of frequent utilizers of the homeless systems and healthcare, as well as the established and proven supportive housing model already in place in San Diego, formed a sophisticated starting point for the analysis to be undertaken during the feasibility process.

Plans for data sharing: At the time of applying for support, a local work group had been established as part of the "Whole Person Care" initiative to develop a plan to share health system utilization and cost data. SDHC had access to the homeless systems data and indicated that a goal of the feasibility process would be to identify an entity to conduct a cross-systems data match for the purposes of narrowing the target population.

Policy environment: Pay for Success was seen as a particularly good fit, complementing several state and local initiatives related to health and housing, in particular those targeting Medicaid high-utilizers:

- **Whole Person Wellness pilot**
  As part of the State of California's Medi-Cal 2020 section 1115 waiver, counties are encouraged to develop pilot programs focusing on innovative approaches to provide Whole Person Care (WPC) to Medicaid frequent utilizers. San Diego County applied for and was awarded one of the pilot programs in fall of 2016. The local WPC program in San Diego is referred to as "Whole Person Wellness" (WPW) and will serve approximately 1,000 individuals over five years who are experiencing or at-risk of homelessness in San Diego and who also experience serious mental illness, substance-use disorders, and/or chronic physical health issues. The WPW initiative could provide the platform for the Pay for Success program to target a prioritized population of frequent utilizers of the health system and cross reference this with those experiencing homelessness.

- **Project One for All**
  Also launched in 2016, Project One For All is an extensive effort by the County of San Diego and its partners to provide intensive wraparound services, including mental health counseling and housing, to homeless individuals with serious mental illness. Project One For All directly aligns with WPW as the target populations for both initiatives overlap. Project One For All also represents the opportunity for a dedicated source of services funding for a potential Pay for Success target population. SDHC has committed more than 700 federal rental housing vouchers across both WPW and Project One for All initiatives to target vulnerable individuals.

- **Health Homes State Plan Amendment (SPA)**
  The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (ACA) Section 2703, allows states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long-term services and supports needed by beneficiaries with chronic conditions. California is specifically interested in using the health home program to address the nexus of health and housing. In pursuing this opportunity, California has engaged with stakeholders, developed and submitted a SPA to the Centers for Medicare and Medicaid Services and is waiting for final approval before beginning implementation. Once approved, the state will pursue a county-based rollout of the program. San Diego County is slated to begin its health home services for eligible Medi-Cal members with qualifying chronic medical conditions and substance abuse disorders (SUD) in July 2018. In January 2019, members in San Diego with serious mental illness will be enrolled in the program as well.

- **Drug Medi-Cal Waiver**
  Launched in 2015 as part of the Bridge to Reform waiver and continued through Medi-Cal's 2020 section 1115 waiver, counties are eligible to apply for pilot programs focused on testing a health care service and substance abuse benefit redesign for people diagnosed with SUD. The pilot is modeled after the American Society of Addiction Medicine (ASAM) continuum of care model, including: enhanced utilization controls; evidence based benefit design; requires specific quality reporting; and increased local control of administrative oversight.

Housing Strategy: At the time of application, SDHC had recently launched HOUSING FIRST – SAN DIEGO, its landmark three-year Homelessness Action Plan (2014-17). One of the components of the five-point action plan was to award development funds up to $30 million (up to $10 million per year) for three years to create permanent supportive housing rental units or to convert existing transitional housing to new permanent supportive housing units. In addition, SDHC committed up to 1,500 federal rental housing vouchers over three years to nonprofit agencies and affordable housing developments that are providing supportive housing. These resources uniquely positioned SDHC and the Pay for Success program with flexibility to create new units and/or use existing rental units.

It is important to note also that SDHC is one of only 39 public housing authorities nationwide, out of 3,400 to receive a Moving to Work (MTW) designation from the U.S. Department of Housing and Urban Development (HUD).Due in part to the flexibility afforded through this MTW designation, SDHC awards Federal Sponsor-Based Housing Vouchers to nonprofit or for-profit organizations, or "sponsors," through a competitive Request for Proposals, as well as Federal Project-Based Housing Vouchers to specific affordable housing developments to provide rental assistance linked to their units. This flexibility also provides the opportunity for SDHC to target rental assistance in a Pay for Success program through various models.

FEASIBILITY STUDY COMPONENTS AND ANALYSIS

The feasibility report documenting work undertaken with SDHC and its partners focuses on six primary areas of interest. While there are many other aspects of the feasibility process, these elements were chosen to highlight areas where progress has been made and others that can be further developed as SDHC and its local partners continue their work toward securing an end payer for Pay for Success financing.

Figure 1: Feasibility study areas of focus

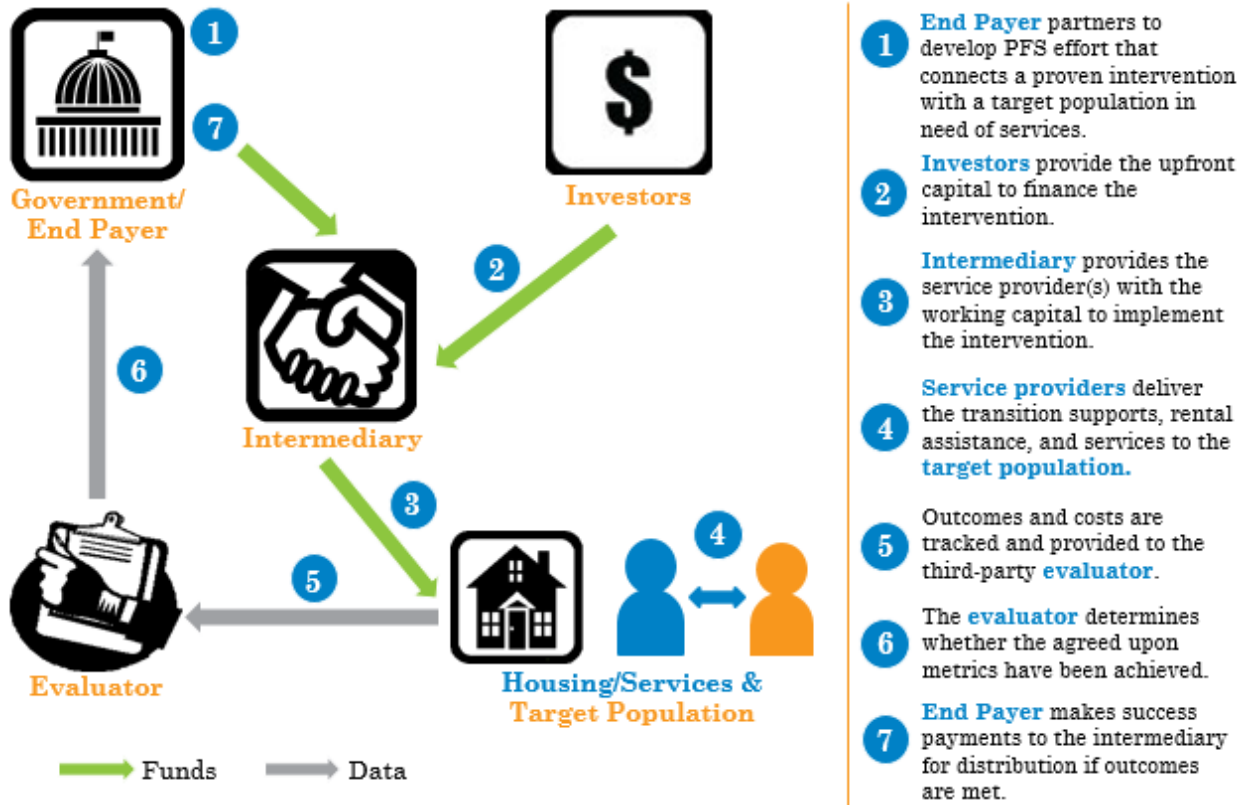
These elements are discussed in detail in the following sections.

PAY FOR SUCCESS EDUCATION

Pay for Success refers to the concept of paying for positive social impact, rather than paying solely for services performed. Under this model, impact is measured rigorously and "success payments" are made based on agreed-upon metrics. Pay for Success typically includes performance-based contracting between an entity paying for the achievement of outcomes (the "end payer"), often governmental entities, and the organizations responsible for implementing a given intervention, often nonprofit organizations.

Pay for Success financing varies, but most structures support Pay for Success programs by providing working capital to implement and/or scale an intervention that has been proven to produce desired outcomes, such as cost savings over time. This upfront capital investment can be provided by a variety of investors and/or philanthropic sources, which typically receive repayment via the success payments, along with a modest return on investment. In exchange for this, investors accept the repayment risk associated with the possibility that the program does not produce the required outcomes.

Figure 2: Example of a Pay for Success Model



Education with stakeholders in San Diego

SDHC put together a strong team of individuals within their organization to work with CSH in this feasibility process:

- Julia Sauer, Director, Grants Compliance & Special Programs, SDHC
- Denise Johnson, Project Manager/Grant Writer, SDHC
- Suket Dayal, Senior Vice President of Business Administration, SDHC

- Melissa Peterman, Vice President of Homeless Housing Innovations, SDHC
- Simonne Ruff, Director, CSH San Diego

These team members participated in biweekly calls on Pay for Success education and progress on the feasibility process. The team also participated in cohort learning opportunities organized by CSH as part of the feasibility technical assistance process. This included webinar opportunities with comparable programs in Austin, Texas, and Camden County, New Jersey, as well as an in-person cohort convening in Austin in February 2016. The San Diego team also further organized into three workgroups to further particular aspects of the work: finance, intervention, and data.

In addition to these sessions, SDHC hosted a kick-off meeting on May 27, 2015, which was attended by the individuals named above and additional critical stakeholders. Several additional organizations were represented at the kick-off meeting, including finance and leadership staff from both the City of San Diego and the County of San Diego; funding partners, including the local United Way; and other local healthcare providers and managed care organizations. Please see Appendix A for the full list of attendees.

Throughout the feasibility process, SDHC has been a strong proponent of Pay for Success in the community in partnership with the local CSH office. Their work educating community stakeholders about Pay for Success included, but was not limited, to: The Healthy San Diego Behavioral Health Work Group (Health & Housing work team); San Diego County Department of Human Services; San Diego County Public Safety Group; both City & County criminal justice departments; key California MCO partners, including Molina Healthcare and Community Health Group; Care First; the County Public Housing Authority; San Diego Foundation; and LeSar Development Consultants, a local leader in new affordable housing development.

Stakeholder feedback

The concept of Pay for Success was well-received despite being new to the majority of stakeholders engaged during the process. Stakeholders quickly grasped the value of using Pay for Success financing to scale supportive housing in San Diego, particularly with SDHC as the program lead able to leverage federal housing vouchers, and that Pay for Success aligns closely with the County's work to expand Medicaid reimbursement for Community and Tenancy Support Services using a 1115 waiver via Whole Person Care (Whole Person Wellness in San Diego). If the target population for the Pay for Success program were to overlap with the serious mental illness population prioritized under Whole Person Wellness, the program would be able to leverage a significant amount of Medicaid funding and minimize the amount of private capital required to pay for the services up front. Similarly, it was recognized that the Project One For All initiative fit well with Pay for Success as a resource for service funding, with the County Behavioral Health Services department funding intensive services for up to 300 homeless individuals experiencing serious mental illness.

While stakeholders were excited by the potential for alignment, Pay for Success was one initiative among several (including other Pay for Success program exploration) that were taking place in San Diego for this particular target population, making it difficult for this Pay for Success work to remain a priority among key stakeholders. CSH believes that Pay for Success can take a substantial amount of time to both plan and structure, and that it is best to work alongside other active initiatives that align with the Pay for Success frequent utilizer target population to align resources and to increase capacity and priority for the program.

TARGET POPULATION AND ANALYSIS

When selecting a target population that could fit well with a Pay for Success initiative, the questions summarized in Figure 3 can be used as guides.

Figure 3: Considerations for selecting a target population

Identifying high-impact populations

1. Is this a high-need population?
2. Is this population not well-served by existing initiatives?
3. Does this population fit with the priorities of my local partnership?

Implementation risk

4. Is there an existing process for identifying this population?
5. Is there an existing process for engaging and referring this population?
6. Will the end payer commit to paying for outcomes for this population?

Data analysis is also key to selecting and understanding a particular population of interest to stakeholders in the feasibility process. SDHC and its partners are well-positioned to facilitate this effort based on their existing relationships in the community, including partnering on WPW, which is leading data collection across local MCO partners to determine healthcare frequent users. SDHC already has access to homelessness data, including those prioritized as highly vulnerable, and with the appropriate data sharing agreements in place, there can be a data match to determine the overlap between these systems and users. The feasibility work dovetailed with other initiatives, principally WPW, to integrate homelessness data into the existing healthcare information in early 2017, and SDHC did not want to separately pursue a duplicative data matching effort. Once the data is available via WPW regarding healthcare frequent users across health plans, the data match can be completed, yielding a data analysis to accomplish the following:

1. Enable selection of a target population of interest to stakeholders and the end payer
2. Understand public sector costs associated with the selected population
3. Estimate the impact of housing on public sector costs pre- and post-tenancies

At the time of feasibility project wrap-up, an interested end payer had not been confirmed. Therefore, criteria for the target population that was known to be of interest to the end payer could not be selected. Instead, we proceeded with the assumption that a population with high healthcare costs and frequent healthcare service utilization would be the likely target population.

This group comprises the target population for both the WPW initiative and Project One For All and is therefore a key focus of the feasibility study.

SDHC was able to achieve the third aim of this analysis by estimating costs for this population pre and post supportive housing tenancy. This analysis was limited in scope, as the outcomes were assumed based on the results of Project 25 because of the project's similar target population and service design, which only had evaluation and outcome data available for 35 individuals to date, without a significant amount of time passed to collect post-housing data. However, early evaluation efforts have shown that, compared to utilization prior to move-in, the Project 25 client population experienced a 76% reduction in the number of Emergency Department visits and a 63% decrease in hospitalizations.

Options for the target population

The target population could take a number of forms depending on the priorities of the final end payer. It is likely to look like one of the two examples below:

1. Frequent utilizers of healthcare systems who are homeless

Several major initiatives in San Diego focus on this population: homeless or chronically homeless individuals with multiple emergency room and hospital admissions and a combination of identified high-risk conditions. Individuals meeting these criteria are currently served through the intensive case management services tested with Project 25. San Diego, with its service provider partners, has a track record of delivering services to this population. This makes it attractive from an external investor perspective and would help to draw private capital to the program to cover its upfront costs if a scaled up service were contracted to government on an outcomes basis.

However, SDHC would need to consider the overall scale of the Pay for Success program. The nature of contracting with multiple entities, including external investors, and the development work that goes into determining whether a program is feasible, generally requires that programs are large enough in scale to justify the upfront costs. This benchmark has previously been set at 150-200 individuals housed over the course of two to three years. With the broad population identified here, SDHC estimates there are between 200-600 eligible individuals currently in San Diego, which is a large enough number to make a Pay for Success effort feasible. However, in the coming year there will be a significant effort to extract data from all five of the local health plans to focus on high utilizers of the health system, which will then need to be matched with the homeless systems data. Upon this data match, SDHC will know more about the size of the target population and other criteria that may further narrow the population (e.g., eligibility for Project One For All or WPW) and whether or not it is still a large enough pool to draw from for a Pay for Success initiative. Additionally, Project 25 aimed to serve only 35 homeless frequent utilizers, and to identify the target population, program partners completed a manual data match between systems, which was extremely time intensive and would not be a viable model for a Pay for Success program aiming to serve five times that population size.

The problems of scale and capacity are surmountable, particularly with an end payer, such as an MCO that is willing to invest based on the prospect of better health outcomes and a more cost-effective approach for their members that they are already serving which are not currently housed. In San Diego, a Pay for Success program with this identified target population is well-positioned, in that there are existing sources of funding to be leveraged for both services and rental assistance (early estimates are that service and rental assistance funding can be leveraged for 100 out of 150 potential Pay for Success participants), and initiatives moving forward to access the relevant data.

2. Frequent utilizers of healthcare and criminal justice who are homeless

Though the Pay for Success feasibility work did not complete a focused data analysis for this potential target population in San Diego, the national supportive housing evidence base, as well as the outcomes of Project 25, indicate that there is significant overlap between frequent utilizers of the health, homeless and criminal justice systems. In San Diego, the frequent utilizers targeted and served with supportive housing through Project 25 included those with frequent arrest and jail stays, and the outcomes so far have indicated that

once housed, the cohort experienced 64 percent annual reduction in the total number of jail days and a 73 percent annual reduction in the number of arrests[1].

An emphasis on the overlap between healthcare and criminal justice systems is beneficial for a local government as a potential end payer (the City and/or County of San Diego), which would expect to see an impact in both of their budgets. However, there is work to be done in accessing and analyzing the data for the overlap between systems once homeless/healthcare frequent utilizers have been identified, and it has been difficult for SDHC to connect and prioritize the Pay for Success initiative with key partners among all of the other local efforts. In addition, the same concern of scale as discussed in option 1 applies here. This can be addressed by reviewing the criteria for these individuals and potentially lowering the barrier to entry to contact with both systems within a single year to have a target population large enough for Pay for Success and with significant potential for positive budget impact on local criminal justice systems.

Next steps

In order to determine the criteria for the target population, while taking into consideration the size of the potential participant pool and the interests of the end payer, an initial data match needs to be completed to analyze (at a minimum) the size and system utilization of homeless frequent utilizers of the health system. This would dovetail with the WPW efforts currently underway in San Diego to access Medicaid claims data from the health plans, which can then be matched with the homeless systems data; after which a data match with the criminal justice system may also be worth exploring. Once this information is available, SDHC will know more about the Pay for Success target population and the potential impact that supportive housing may have on public costs and outcomes. Follow-up conversations with MCOs and perhaps local governments as potential payers should focus on these two options and seek to answer questions about the funding restrictions that may be part of a Pay for Success eligible cohort.

In order to request the most actionable data from the MCOs, the program should focus on adult Medi-Cal members with no less than four months of Medicaid eligibility in a 12-month period who are residing in San Diego County. The request should also include three years of individual member-level data, paid claims by category of service, hospital admissions per year, emergency department visits per year, and identified high-risk conditions, for members that meet some or all of the criteria, as noted, by major service categories listed below. See Appendix B for a detailed sample memo outlining this criteria created for the Pay for Success feasibility team by the Center for Health Care Strategies

- Costs at least $20,000 in last 12 months or predicted to have high costs (required);
- At least two inpatient stays and/or at least six emergency department visits in last six months (required);
- Polypharmacy at least five outpatient medications (optional); and
- Diagnosis of at least two chronic conditions (e.g., asthma, diabetes, hypertension, etc.); or one chronic condition and is at risk of developing a second (optional).

Exclusion Criteria:

- Age over 18;
- Costs for long-term/residential/rehab care/ nursing home stays;

[1] https://uwsd.org/files/galleries/Project_25_Report.pdf

- Other disease specific conditions (e.g., rare diseases, brain injury, obstetrics/ gynecological, cancers); and
- Eligible for Medicare.

PUBLIC SECTOR VALUE CASE

The value case element of the feasibility study aims to assess different approaches to funding supportive housing by highlighting the public sector systems that currently accrue costs. It uses the best available evidence of impact to estimate cost avoidance to those systems. We have not used the term 'cost benefit analysis' because we have included notional value for outcomes that cannot be quantified, such as improved quality of life.

Benefits of supportive housing

Supportive housing is an evidence-based intervention with a track record of producing positive outcomes for vulnerable people. Its evidence spans 20 years and dozens of studies measuring its effectiveness and cost-effectiveness. Supportive housing has been repeatedly proved as an effective intervention that improves housing stability, reduces the use of expensive crisis care, and improves outcomes even for the most vulnerable individuals with complex needs. Based on this body of research, the Substance Abuse and Mental Health Services Administration (SAMHSA) has long regarded supportive housing as an evidence-based practice that is "the most potent" intervention to impact housing stability and one that consistently helps people with disabilities achieve their desired goals.

Evaluations of supportive housing suggest that its impact includes:

1. Dramatic reductions in hospitalizations, emergency department usage, and criminal justice encounters for persons with complex co-occurring disorders, including chronic health conditions, mental illness, and substance abuse disorders
2. Improved health and mental health for individuals when comparing the period before and after they enter supportive housing
3. A positive impact on housing retention, even among tenants with long histories of homelessness and the most severe psychiatric, substance abuse and health challenges
4. Improved self-reported empowerment, as measured by tenants' degree of choice in housing

Current public sector costs

The below chart lists the definable public sector costs of homeless high utilizers of healthcare and includes unit costs for each figure where applicable. Local unit costs are used where possible.

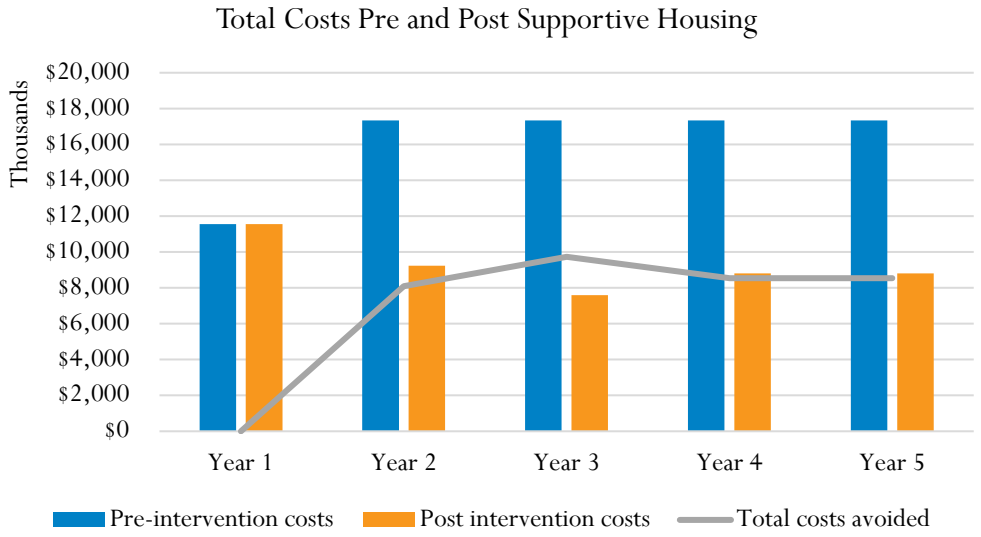
Value Case Items	Average usage	Average unit cost	Total cost
Emergency shelter days	90	$75	$6,750
Emergency Room visits	10.0	$641	$6,410
Hospitalizations	6.0	$7,661	$45,966
Ambulance trips	11.0	$451	$4,961
Detox visits	7.0	$400	$2,800
Jail bed days	40.0	$137	$5,480
Number of arrests	3.0	$150	$450

While the majority of known costs accrue to the healthcare system, it is likely that there are many more impacts of supportive housing on economic development.

Public sector benefits

The many evaluations of supportive housing across the US have provided a wealth of evidence for impacts on these public sector costs after 12 and 24 months. The costs included in this section are based on locally observed numbers but are in line with ranges seen in national research as well. Specific sources are available on request.

Value case items	Average cost	Average impact	Average cost avoidance
Emergency shelter days	$6,750	-78%	$5,265
Emergency Room visits	$6,410	-78%	$5,000
Hospitalizations	$45,966	-63%	$28,959
Ambulance trips	$4,961	-67%	$3,324
Detox visits	$2,800	-78%	$2,184
Jail bed days	$5,480	-62%	$3,398
Number of arrests	$450	-78%	$351
Total per person cost avoidance	**$48,481**		



Although not as easily quantifiable as the outcomes listed above, there are multiple national studies that document further value that can be created through connecting individuals with community-based housing in terms of improved quality of life and enhanced wellness:

- A 2003 study by Robert Rosenheck, et. al., found that participants in supportive housing had greater social contacts and support, as well as improved overall quality of life, when compared to participants receiving usual care.[2]
- The intervention group in a 2004 study led by Sam Tsemberis reported significantly more choice in their own lives as compared to a control group at 6, 12, 18 and 24 months.[3]
- A study of the Denver Housing First Collaborative showed that 50 percent of participants documented improved health status once entering supportive housing, and 64 percent demonstrated improved quality of life[4].
- Research also shows housing and recovery to be closely linked, demonstrating an association between community-based housing and enhanced effectiveness of treatment and rehabilitation services, as well as maintenance of treatment gains.[5]

Further potential benefits to consider when evaluating the overall value proposition of connecting vulnerable individual and families with supportive housing include:

- Increased likelihood of employment / decreased dependence on benefits
- Improved lifestyle leading to reduced probability of the onset of health conditions, such as diabetes and Chronic Obstructive Pulmonary Disease (COPD)
- Improved aesthetics of local areas, leading to further business development
- Increased empowerment through choice of housing
- Improved relationships with family and friends

Costs of supportive housing

In Project 25, participating tenants have access to flexible and comprehensive supportive services delivered through an intensive case management model provided by Father Joe's Villages and Telecare Corporation. It is anticipated that the scaling that would take place through Pay for Success would utilize a similar model with a small staff-to-client ratio (approximately 1 to 10). The models impose no arbitrary time limits on the receipt of services, and services may be delivered on-site at a supportive housing property, or through mobile service teams that proactively work to engage tenants throughout the community.

A detailed budget is in development, but it is likely that scaled up operations will cost $20,000-$30,000 per person for a total program cost of approximately $19 million over five years. These costs may be offset by leveraging existing sources of funding, such as rental assistance and service contracts. So far, in the Pay for Success feasibility work, SDHC has committed vouchers to cover all of rental assistance for participants; and the goal is to narrow the target populations so that the majority of Pay for Success participants will also be eligible for services funded via WPW or Project One For All. This preliminary modeling accounts for

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[2] Rosenheck R, Kasprow W, Frisman L, Liu-Mares W. Cost-effectiveness of Supported Housing for Homeless Persons With Mental Illness. Arch Gen Psychiatry. 2003;60(9):940-951. doi:10.1001/archpsyc.60.9.940

[3] Tsemberis, Sam, Leyla Gulcur, and Maria Nakae. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." American Journal of Public Health 94.4 (2004): 651–656.

[4] Perlman, Jennifer and John Parvensky. "Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report." Denver Housing First Collaborative (December 2006).

[5] Moxham, L., Pegg, S. (2000). Permanent and stable housing for individuals living with a mental illness in the community: a paradigm shift in attitude for mental health nurses. Aust N Z J Ment Health Nurs. 9(2):82-8.

leveraging over $14 million in housing and services costs leaving a gap of approximately $5 million to be raised via Pay for Success financing. This chart also demonstrates that the costs avoidance potential noted herein is greater than the costs to finance a Pay for Success intervention:

Program overview

Operating assumptions	
Number of people housed	150
Program length	5 years
Financing assumptions	
Non-PFS housing funding	100%
Non-PFS service funding	67%
PFS financing assumptions	
PFS investment amount	$5,026,500
Investment as % of program cost	24%
PFS investment period	6 years
Value creation	
Gross cost savings / value created	$34,886,341
Total cost of intervention	$20,529,164
Net value for public	$14,357,177

Next steps

A conversation with the potential end payer will highlight additional areas of interest to explore for public sector costs and benefits. Access to the relevant data systems could help to quantify additional benefits resulting from supportive housing. Additionally, all parties should agree to the final program budget to finalize this value case for the end payer.

SERVICE DESIGN

Intervention Working Group

As part of the Pay for Success feasibility work, SDHC convened and led a working group focused on determining the components of an intervention that would meet the needs of the anticipated target population. Representing a cross-section of community providers and funders, this group developed an intervention design that is focused on three key phases of work with members of the target population:

- **Phase 1—Outreach and Engagement**—Significant work will be needed to successfully identify and engage clients. Models such as Assertive Community Treatment, which provide an intensive team-based approach, should be strongly considered. As part of this model, peers can play an important role, and services can be delivered in a mobile format, ensuring that clients can receive services wherever they are.
- **Phase 2—Transition into Housing and Stabilization**—Phase 1 will set up the work of transitioning individuals into supportive housing through ongoing support and the use of evidence-based practices, such as the housing first model, harm reduction and trauma informed care. Further, through the service provision team, clients should have timely and facilitated access where needed to psychiatric care, medication management and physical health supports.

- **Phase 3—Long-Term Retention and Step-Down/Turn Over**—As some individuals may increase their self-sufficiency over time, it is important to build in and acknowledge opportunities for individuals to be empowered. In some cases and where the client chooses, this may mean offering individuals an opportunity to move on to an affordable housing setting in the community.

Further details on the intervention working group and its recommendations is provided in Appendix C.

Program philosophy

The program will follow a "high fidelity" housing first model:

- **Low barriers to entry** – Individuals will not be screened out on the basis of sobriety, compliance with medication, participation in program, criminal history (very limited exceptions), or credit history.
- **Intensive engagement** – The program will engage participants through consumer-centered, acceptance-driven approach (e.g., motivational interviewing, consumer driven goals, etc.). Many of the participants will already have been engaged by WPW and/or Project One For All through its intensive care coordination program.
- **Separate housing and service**s – Participants will be supported with wraparound services, but they will not be required to participate in any particular services or programs to remain in housing, so long as they comply with basic rules of lease and housing tenancy.

Program roles & responsibilities

SDHC will direct the process by providing the rental assistance housing resources and coordinating a collaborative program to house individuals with a history of long-term homelessness and high utilization of hospitals due to unmanaged chronic illness. To move forward, SDHC will need a proven, high-capacity service provider that will engage Pay for Success participants, potentially with whom they are already providing community-based care coordination (e.g., a provider engaged through WPW or Project One For All) and assist them to obtain admission to the supportive housing program, selecting an apartment, and moving in. The service provider team will continue to work with the participant through an extended engagement period and transition the participant into their rental housing unit. By partnering with the San Diego County Behavioral Health Services Division through Project One For All, and potentially with the health plans which would make care coordination services available, a potential Pay for Success initiative would focus on medical and healthcare needs, as well as offer behavioral health and critical wraparound services for participants to have the integrative support needed to remain housed.

As with other models in San Diego, a service provider partner will administer the Section 8 Federal Housing Choice Vouchers that will be provided by SDHC. The partner will be responsible for identifying apartments, either those in their current housing stock or through private or nonprofit landlords, coordinating inspections, certifying paperwork, and collecting the tenant's portion of the rent. In some cases, the agency may enter into a master lease between the landlord, the agency, and the tenant. The housing agency will be responsible for managing relations with the landlord, including repairs, etc. The housing agency will also look to leverage the flow of future rental housing vouchers to support new renovation and developments with units set-aside for participants in the Pay for Success program.

Service provider partners will provide 24-7 wraparound support services following a housing first model to program participants. They will staff an interdisciplinary team that works intensively with program participants – meeting them face-to-face at least weekly or as necessary. The service provider will work

with participants to develop and achieve individualized goals across a wide range of areas, including behavioral and physical health, socialization, education and employment. A strong local service provider is critical to help connect participants to resources in the community, including day programs and outpatient behavioral health services. The service provider will also make available psychiatric and other professional behavioral health staff to address crisis situations. These services will be more accessible and funded via Medicaid as a result of WPW. The primary goal of the service provider will be to ensure that individuals remain in stable housing.

All program roles and responsibilities are subject to any procurement process the end payer may be required to put in place. The unique nature of this program and the comprehensive group of providers collaborating to develop it may mean it does not have to go through a full procurement process.

Building on the successes and challenges of Project 25

Project 25 and its service provider partners can be an in-built problem-solving apparatus, and many local leaders involved with Project 25 have been involved with Pay for Success strategy discussions. CSH believes that if the Pay for Success supportive housing initiative moves forward, it will benefit greatly from a learning collaborative model with the existing housing first program serving high utilizers. Other communities also have used this approach when launching new programs that build off existing models, and in some cases, CSH, which has experience leading learning collaboratives across the country, facilitates this process.

Project 25 has deepened the capacity of a range of service providers to gather and analyze data to identify the most frequent users of various high-cost systems of care, including emergency response systems, hospitals, and other healthcare providers, in addition to the homeless service system. This foundation is providing a strong starting point for the WPW pilot program, as various systems work to identify homeless individuals who are struggling to receive the services and housing supports needed to leave the streets and work on their wellness goals. This continued capacity and ongoing partnership among a variety of health sectors would be valuable to a future Pay for Success initiative in San Diego.

Next steps

Narrowing the target population to a group sharing particular characteristics will enable the service to be tailored to best support its population's needs. For example, if the majority of the identified population has drug and alcohol support concerns, the above intervention design could partner with relevant services as part of its offer. A review of evidence-based services should also be carried out for the identified population so that the most appropriate and effective services can be offered.

END PAYER IDENTIFICATION

Most critical at this stage is confirming which partner entity or entities will enter into more concrete discussions with the intention of establishing a program design, success metrics, and investment structure that could induce them to serve as an end payer as part of the Pay for Success program.

Figure 4: Considerations for selecting an end payer

1. Which organizations benefit most from the identified outcomes for this population?
2. Which organizations are committed to expanding supportive housing or service offerings?
3. Which organizations have identified budgets that could be used to expand supportive housing or service offerings?
4. What process is needed to secure a commitment from each potential end payer?
5. Which potential end payer has the most expedient timeline for providing commitment?

End payers in existing Pay for Success programs are state or local governments. The savings associated with scaling supportive housing can be attractive to state and county governments, because they should be able to see a large-scale program impact bottom lines in their criminal justice, homelessness and certain healthcare budgets. However, there is no reason that other organizations cannot be end payers, and in San Diego, we also considered Managed Care Organizations as potential end payers.

Entity	Primary incentive	Conclusion / next steps
Managed Care Organizations (MCO), with primary focus on Molina Healthcare	Potential cost avoidance for clients' healthcare expenditure	Not yet able to engage MCOs in concrete discussions to explore a Pay for Success partnership; a follow-up with Molina Healthcare has been identified as a critical next step in 2017
County of San Diego	Committed to supportive housing service expansion, evidenced through Whole Person Wellness and Project One For All. Potential cost avoidance for local jails and homelessness services, and emergency medical/crisis services	Interest in allocating service funding subsidies, but not in end payer role
City of San Diego	Potential cost avoidance for local jails and homeless services	Not expecting significant savings at the City level, other possible end payers were prioritized

Molina Healthcare

Early analysis indicated that individuals in the target population were primarily served by three health plans: Molina Healthcare, Community Health Group (CHG) and Care First. Molina Healthcare indicated initial interest in Pay for Success and holds strong existing relationships in the community.

The MCO partners actively participate in shaping policy to better serve homeless frequent utilizers of health systems through regular coordination meetings, as well as outreach to County Health and Human Services.

SDHC and the Pay for Success team, including local CSH leadership, determined that approaching Molina as a potential end payer first was the right strategy because of their interest in supporting innovative models for this population. Also, locally, the consensus was that obtaining Molina's commitment to participate may help to encourage partnership from additional MCO partners, including CHG and Care First. The initial feedback from Molina after preliminary conversations was that they were open to additional conversations; however, Pay for Success was one of more than 700 initiatives that they had been asked to partner with, and they needed to know more about the specific value proposition of Pay for Success and the role that other MCOs have played in Pay for Success programs nationally. See Appendix D for the detailed four-page program summary created by CSH and the SDHC team as a tool to engage with Molina about the opportunity.

It is also anticipated that additional MCO partners in the San Diego area will continue to be approached in workgroup settings, as well as individually, to understand the potential to grow their involvement in supportive housing via a Pay for Success model.

County of San Diego

Given its significant investment in services for members of the anticipated target population, there is potential for the County of San Diego to realize improved outcomes and cost savings or avoidance if highly vulnerable individuals were connected with supportive housing. This potential value proposition could be further expanded if individuals with significant involvement in the county criminal justice system, as well as histories of homelessness and high utilization of health care resources, were targeted. The County of San Diego is progressive and innovative in meeting the needs of its most vulnerable citizens. They were a key partner in the feasibility analysis for this effort and are currently engaged in data matching between the criminal justice and homeless systems through a HUD grant and Cloudburst, and there is strong potential for the County to serve in a role as end payer.

City of San Diego

SDHC works closely with the City of San Diego, and the City was supportive of SDHC's involvement in the Pay for Success feasibility effort. Although the City could certainly play a catalytic role in a potential Pay for Success program, their anticipated savings in such an effort is not as significant as that of the County or a potential MCO healthcare partner. The City will continue to be an important stakeholder and partner if a Pay for Success program moves ahead, but to date there have not been focused conversations with the City about their potential to serve in an end payer role.

Next steps

When one or more end payers has committed to engaging in a further exploration of this Pay for Success model, more focused conversations should occur to determine the program's scale, target population, and success metrics.

Potential Roles for the San Diego Housing Commission

SDHC serves a key role as a catalyst for the consideration of the Pay for Success effort outlined in this feasibility report. SDHC leads and participates in a variety of efforts to meet the need for affordable rental housing with supportive services for multiple target populations in the City of San Diego. Although it is unlikely that SDHC could justify participation in a Pay for Success effort as an end payer, there are a number of other roles that it could consider, some of which are not dependent on a specific Pay for Success program moving forward:

- **Shift to Outcomes and Performance Based Accountability:** SDHC already has performance-based components to its contracts with service providers. It could consider enhancing these contracts to further incentivize and/or make payments on the basis of outcomes, such as housing stability and/or reduced jail days. Such a shift could be coupled with providing training and technical assistance to providers in the community, as well as participation in county-wide data analysis and tracking efforts such as ConnectWell SD.
- **Outcomes Payment Catalyst:** SDHC could consider contributing funding to an outcomes payment pool in partnership with other end payers. This could accelerate the transition to an outcomes-focused system and build on the performance-based contracting efforts described above.
- **Provider of Leverage:** SDHC is willing to provide federal rental housing vouchers as part of a potential Pay for Success effort. Doing so would allow Pay for Success financing to focus on filling critical gaps in service funding and enable additional units of supportive housing to be created. This will continue to be important for any Pay for Success efforts that move forward.
- **Investor:** In addition to providing leverage, SDHC could also consider participation in a Pay for Success program as an investor. Pay for Success investors are generally those interested in what are sometimes called "double bottom line" results, in which they want to both have the potential to receive a financial return while also having a positive social impact. To the extent that SDHC has flexible funds available to invest, its knowledge of the intervention and community could make it an ideal investment partner for Pay for Success.

Payment Terms

Payment terms for Pay for Success programs describe how and when the end payer will make financial contributions to the program in recognition of the outcomes it has achieved.

Success metrics

Pay for Success programs are generally contracted to a government entity or end payer entirely on the basis of achieving outcomes identified as "success metrics." These metrics are pre-agreed outcomes of interest that trigger payments to the service provider or the investors, depending on the structure of the program. The primary metric used in three existing supportive housing Pay for Success programs is housing stability. In the Denver Pay for Success program, there is an additional payment triggered by a reduction in jail days across the cohort.

Figure 5: Considerations for selecting success metrics

1. Does this represent a positive outcome for the target population?
2. Is this metric of value to end payers? Can it be tied to cost avoidance?
3. Are there existing methods of collecting and verifying the metric?
4. Is this metric simple to understand and explain to all stakeholders?
5. Is there an evidence base / track record of achieving this metric through supportive housing?

Success metrics must ultimately represent value for the end payer agreeing to make payments, but it is equally important that supportive housing has an evidence base for achieving these metrics. The service providers, and any private investors funding those providers up front, must be comfortable that they are able to achieve the metrics if they use best practice in service delivery.

It is for this reason that we recommend strong consideration of paying on the basis of housing stability, an outcome which should be achieved if the provider delivers high-quality supportive housing. Other payment triggers, including reductions in jail days or improvements in particular health outcomes, could be considered once the target population has been identified, if there is evidence for this group achieving those additional outcomes of interest.

Payment thresholds

Once the success metrics are selected, end payers, investors and service providers must agree when payments are made. Three examples of different payment methods for the metric 'housing stability' are below:

Denver Pay for Success	Santa Clara Pay for Success	Massachussetts Pay for Success
• An agreed amount is paid after clients have maintained housing stability for one year • Payments after one year are made quarterly for each day spent in stable housing	• Payment made for 3, 6, 9, and 12 months thresholds of continuous tenancy • Payments after 12 months are made monthly thereafter	• An agreed amount is paid after clients have maintained housing stability for one year • Payments after one year are made for each day spent in housing stability

We recommend using a model that focuses on paying for time that participants have a valid lease and are in stable housing as with the above. The values paid either per diem or quarterly for time spent in stable housing should be valued based on a discussion between the end payer and service providers to agree a figure that both creates value for the public sector and enables the upfront investment in the services to be repaid, dependent on the success of the program.

Evaluation methodology

Pay for Success programs focus on data and evaluation to a larger degree than fee for service contracts, but there is variation among the current programs in the level of evaluation applied to the success metric. Options for evaluation include:

- ***Tariffs***: Payments are made for each day/month/year of housing stability achieved. This is the most straightforward option and simplifies the calculations required to make payments. However, it does not account for the counterfactual, or what would have happened to individuals without the

intervention. It is possible that the end payer is paying for some outcomes that could have been achieved without support, though this can be included through an adjustment of the rate paid for housing stability.

- ***Baseline threshold:*** Payments are made for achievements above a defined threshold, e.g., 50 percent of the population achieving housing stability for a year. This threshold could be set with reference to a historical baseline previously achieved by the identified target population or measuring outcomes for a similar group to the target population. While this method in theory takes account of the counterfactual, it is open to criticism on how the threshold is set.

- ***Propensity score matched control group:*** Payments are made for outcomes that exceed the outcomes achieved by a control group. Propensity score matching is a way of defining that control group and enables each program participant to be matched to one or multiple individuals with similar characteristics. If that individual achieves outcomes beyond those achieved by his/her matches, it is considered the result of the intervention and payments are made. While this methodology takes account of the counterfactual, it also requires access to a broad set of data for many individuals not participating in the program and can therefore be lengthy to deliver. It may also be more complex to explain to stakeholders.

- ***Randomized control trial (RCT):*** RCT is the gold standard evaluation methodology in which all individuals referred to and eligible for the program are randomly allocated to either a group that received the intervention or a group that does not. While this is a methodologically sound approach, it also raises ethical considerations about not offering the intervention to individuals who could benefit from it. A mitigating approach may be to use a waiting list of individuals who are not yet enrolled in the program to measure control group outcomes. However, RCT evaluation also relies on having enough potential program participants to meaningfully separate into two groups.

We recommend using a tariff-based approach for housing stability metrics. If end payers wish to make a stronger case for the impact of supportive housing on public sector costs, we recommend commissioning an independent third-party evaluator able to design a propensity score matched control group for a wider program evaluation rather than for the success metrics.

CONCLUSIONS AND RECOMMENDATIONS

SDHC and its partners have developed the outline of a Pay for Success program that, if taken forward, could prove successful for a number of reasons:

- Pay for Success aligns directly with local prioritized initiatives that will provide significant sources of leverage to fund services and housing.
- Health utilization data access and analysis efforts are currently underway and prioritized.
- SDHC's commitment and leadership ensures the alignment of housing resources for Pay for Success.

- Supportive housing program delivery infrastructure and partnerships are in place with a strong local model.

The successes of this feasibility work have included the partnership work undertaken by SDHC and the local CSH office to ensure that Pay for Success was integrated with other initiatives and resources to serve homeless frequent utilizers. Specifically, this includes integrating Pay for Success into key discussions and policy conversations relating to Project One For All.

To move forward with this program, a committed end payer must be identified. Once that has been achieved, the end payer should work in collaboration with partners to establish:

- Eligibility and enrollment criteria for the target population;
- Outcomes of interest for this population and an understanding of current outcomes achieved;
- Estimation of the outcomes that would be achieved through supportive housing;
- The payment terms of an agreed success metric; and
- The structure of a Pay for Success program, including the involvement of private investors.

While all of the above aspects should be discussed with the end payer, CSH recommends as of the date of publication of this proposal, that the following elements should be included. These recommendations may change following further conversations with the identified end payer.

Program element	Viable options	Recommendation
End payer entity	• Molina Healthcare • San Diego County	Further conversation with Molina Healthcare to be prioritized. Conversations with the County should be re-visited upon commitment or deeper interest from an MCO end payer.
Eligibility and enrollment criteria	• Population of homeless and/or chronic homeless • Population of healthcare frequent utilizers	Serving a population of homeless/chronic homeless aligns with current initiatives able to provide service funding. This population is also more likely to meet any criteria attached to end payer funding.
Outcomes of interest	• Housing stability • Healthcare service usage • Medicaid spending • Criminal justice service usage	Housing stability is most tightly linked to supportive housing interventions and has good evidence to suggest it leads to cost avoidance across the public sector.
Estimation of outcomes achieved	• Evidence for a range of housing stability outcomes	The Project 25 population should be used to estimate rates of housing

	from 50-95 percent of cohort maintaining housing over one year	stability, and evaluations of other sites should be used for longer term outcomes.
Payment terms of agreed success metric	• Per diem • Quarterly • Annually + per diem	Quarterly payments made on the basis of a tariff per quarter multiplied by the number of participants meeting that threshold

Additionally, CSH would like to point out that competitions for program structuring funding and support are currently being run. Once an end payer has been secured and commits to the options above, it would be appropriate to apply for funding to begin the structuring phase of the Pay for Success program.

The biggest obstacle for SDHC with the Pay for Success feasibility work was that the work was happening among several other related but separate initiatives, and it became difficult for Pay for Success to become a priority. SDHC made PFS a priority by participating in the feasibility analysis and actively partnering in other efforts that align with Pay for Success such as WPW and Project One For All. This obstacle though also remains one of the biggest opportunities for feasibility in San Diego in that Pay for Success is very aligned with these efforts and can help to scale access to supportive housing as well as leverage private investment toward the outcomes. Going forward, SDHC and its community partners play a key role in leading multiple related initiatives such as Whole Person Wellness and Project One For All and ensuring that any Pay for Success initiative will be complementary to existing efforts.

APPENDICES

APPENDIX A: Full list of Attendees, Pay for Success Kick-off Meeting, May 27, 2015:

*= PFS Core Leadership Team

Name	Agency/Organization	Position	Stakeholder/Interest/Area of Expertise
Melissa Peterman*	SDHC	Director, HHIT	SDHC resources, CAHP, Homeless Services Administration, political issues
Suket Dayal*	SDHC	Senior Director of Strategy	Strategic alignment of project w/SDHC priorities, SDHC executive team representative
April Joy Galka*	SDHC	SPA/HHIT	Target Population, Service Delivery, CAHP
Julia Sauer*	SDHC	Director, Spec Programs	PBC knowledge / Healthcare
Denise Johnson*	SDHC	PM/Grant writer	Team management
Susan Bower*	County of SD/HHSA	Integrated Services Manager	HHSA/ MH / BHS
Dr. David Folsom*	UCSD, SVdP	Clinical Director	Target population, psychiatry
Dr. Nora Fain*	Molina		Healthcare
Alexei Ochola	La Maestra Health Clinic	Director	Overview / PFS
Katherine Johnston	City of San Diego	Director of Infrastructure and City Budget Policy	City Finances
Jessica Lawrence	City of San Diego	Policy Advisor-Todd Gloria	Homelessness, active in RCCC / Governance Board
Jonathan Hunter	LeSar Development Corp	Consultant	SIB, Supportive Housing, Healthcare reform
Michael McConnell	Funders Together, 25 Cities	Business Owner	Housing First, CAHP, local data
Maurcell Gresham	SDHC	Director of Procurement	Procurement, contracting
Carol Williams	United Way	Vice President, Foundation Relations, Pay For Success Liaison	Community Impact, convener
Ellen Birrell	Family Health Centers	Associate Director, Homeless Programs	Target population, health care systems

Catherine Eckl	Alvarado Parkway Institute	Program Administrator	Target population, health care systems
Amy Thompson	County HHSA	Assistant Director of Finance	County Health and Human Services budgeting
Pam Mokler	Care First	Vice President	Medi Cal / Managed Care
Noah Solomon	Care First		Medi Cal / Managed Care
Leslie Levinson	SDHC	VP of Finance	SDHC budgeting and finance

APPENDIX B: Center for Health Care Strategies Data Request Memo:

M E M O R A N D U M

TO: SAN DIEGO PAY FOR SUCCESS TEAM
FROM: CAITLIN THOMAS-HENKEL, CHCS
SUBJECT: SAN DIEGO HOUSING COMMISSION: HEALTH PLAN DATA REQUEST
DATE: APRIL 24, 2016
CC: STEPHANIE MERCIER, CSH

This brief is in response to San Diego's request for information to assist in the identification of people that frequent the health care, corrections and systems of care for the San Diego Housing Commission's Pay for Success program

Inclusion Criteria.
Adult Medi-Cal members with no less than 4 months of Medicaid eligibility in a 12 month period, residing in San Diego County.

Three years of de identified member-level data including: aggregate paid claims by category of service, hospital admissions per year, ED visits per year, and identified high risk conditions, for members that meet some or all of the criteria, as noted, by major service categories listed below:

- Costs ≥$20,000 in last 12 months or predicted to have high costs (required);
- ≥2 inpatient stays and/or ≥6 ED visits in last 6 months (required);
- Polypharmacy ≥5 outpatient medications (optional); and
- Diagnosis of ≥2 chronic conditions (severe mental illness or emotional disturbance, asthma, diabetes, etc.); or one chronic condition and is at risk of developing a second (optional).

Exclusion Criteria:
- Age ≥ 18;
- costs for long term/residential/rehab care/ nursing home stays;
- other disease specific (e.g., rare diseases, brain injury, obstetrics/ gynecological, cancers);
- eligible for Medicare.

SAN DIEGO HOUSING COMMISSION

Homeless Housing Innovations Department

Contents

INTERVENTION SUMMARY DRAFT #1

Overview

The San Diego Housing Commission (SDHC) was awarded a technical assistance grant by the Corporation for Supportive Housing (CSH) in April of 2015 to develop organizational and community-wide capacity to utilize the Pay for Success (PFS) model as a mechanism to develop supportive housing for vulnerable populations. PFS, also known as Social Impact Bonds, is a form of social impact investing that provides tremendous opportunities to diversify and expand investments in supportive housing. It also provides an excellent opportunity for government to reform how it invests and allocates public resources, with greater emphasis on paying for results.

Leadership Team

The project leadership team is comprised of representatives from SDHC, the County of San Diego, St. Vincent de Paul Villages, Inc. and the University of California, San Diego. We anticipate receiving TA from CSH, and their partners, Third Sector Capital and the Center for Health Care Strategies, Inc., through the end of March, 2016. The majority of assistance will focus on helping us complete a Feasibility Assessment. Our end goal is to design and implement a pilot project using the PFS model that will serve 100-150 chronic homeless super users of public resources.

Purpose of Working Group

The group's goal is designing an intervention for permanently housing and offering holistic services for individuals who are high utilizers of the current health care system of care in the city of San Diego. This working group is a reoccurring meeting.

Focus Group

In order to see what is truly working (or not working) on the ground level when engaging and housing homeless high utilizers we asked that key individuals attend a one-time focus group. In this small (5-10 people max) focus group, we were able to learn from the attendee's years of experience and strategic ability to triage care for a high need populations. The focus group's goal is to collect what the current areas of improvement are (What's missing now?) and note various best practices across their fields of expertise. Their knowledge was rolled into the working group that was tasked with actual design of an intervention model for permanently housing and offering holistic services for folks who are high utilizers of the current health care system of care in the city of San Diego.

Focus Group ***Key*** Findings Included:

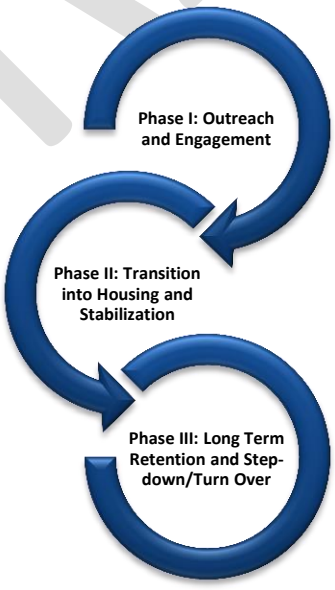
Street Outreach

a. Having a centralized system is helpful to connect clients with multiple agencies
b. Non-clinical and "Health Navigators" are necessary to help clinical staff because they provide important help to clients that clinical staff might not have time to complete
c. Motivational interviewing can get stuff done
d. Mental stabilization becomes an issue when a

	client cannot stabilize and gets lost in the system or never even gets inputted e. LEAD – Law Enforcement Assisted Diversion; peer-based system and uses a more intensive approach than motivational interviewing that has been used in Seattle and New Mexico
Availability	a. 24/7 Staffing/service access design
Approach	a. Stay true to Housing First; it almost seems like it is always said but roadblocks still constantly exist
Emergency Rooms/Hospitals	a. Case management must be available, but need to constantly watch for duplications b. Need to educate clients on how to get help they need and at correct level of care that is needed for their state of health
Internal Collaborative Structure required	a. Reentry becomes difficult for people who have been arrested and even more so for people who have sexual offenses as part of their record b. After Crisis need to be able to access supports/coordinate to get person back to housing. (i.e. hospitalization/5150/ etc)

Working Group Design Summary

Phases of the Intervention, Figure 1



Overall, the design is heavy and most costly in the front end during the first phase. Most of this phase is used for coordination, relationship building and strategy built between multiple key players to ensure long term stability is achieved.

	Phase 1: Outreach & Engagement	Phase 2: Transition into Housing & Stabilization	Phase 3: Long Term Retention & Step-Down/Turn Over
Core Services & Key Design Elements	• Evidence Based and Best Practices: a. ACT model/ACT-like model - Psych - Nurse/psych nurse - Med management - Financial- rep payees - Housing First Model - Harm Reduction - Trauma Informed Care Modality - Motivational Interviewing - Flexible model to adapt to clients. b. Crisis appointment slots- MOU with medical/MH providers c. Call line 24/7 (emergencies and loneliness were discussed) d. Low Barrier e. Peer model/social design f. Mobile care/ case management (meet client where they are) g. EMT/ER Diversion Program Alignment	*Includes same components as Phase 1*	*Includes same components as Phase 1* • Add a step down process for those who increase ability for self-sufficiency. a. Empower the clientele if they improve b. Allow the services team in serve more over time. c. Possibly transition to Medical Case Management Service supports for this lower level of need.
Key Players	• Core Street Outreach Team Homeless • Social Service Providers (ACT Team model/ like model) • Law Enforcement, EMS and Specialty Teams (i.e. HOT, PERT) • Mental health/AOD providers and Medical Providers (i.e. BHS/ Managed Care SW, Clinics etc.)	• Includes same key players as Phase 1 but focus is on the strong relationship/coordination of care between clientele and core program services team. (I.e. ACT Team) • As needed, the other key players may offer supports/ triage. (i.e. crisis, use of jail as an	• Includes same key players as Phase 1-2 but focus is on the strong relationship/coordination of care between clientele and core program services team to continue LT stability as well as the potential to transition care coordination to a Medical CM for lower

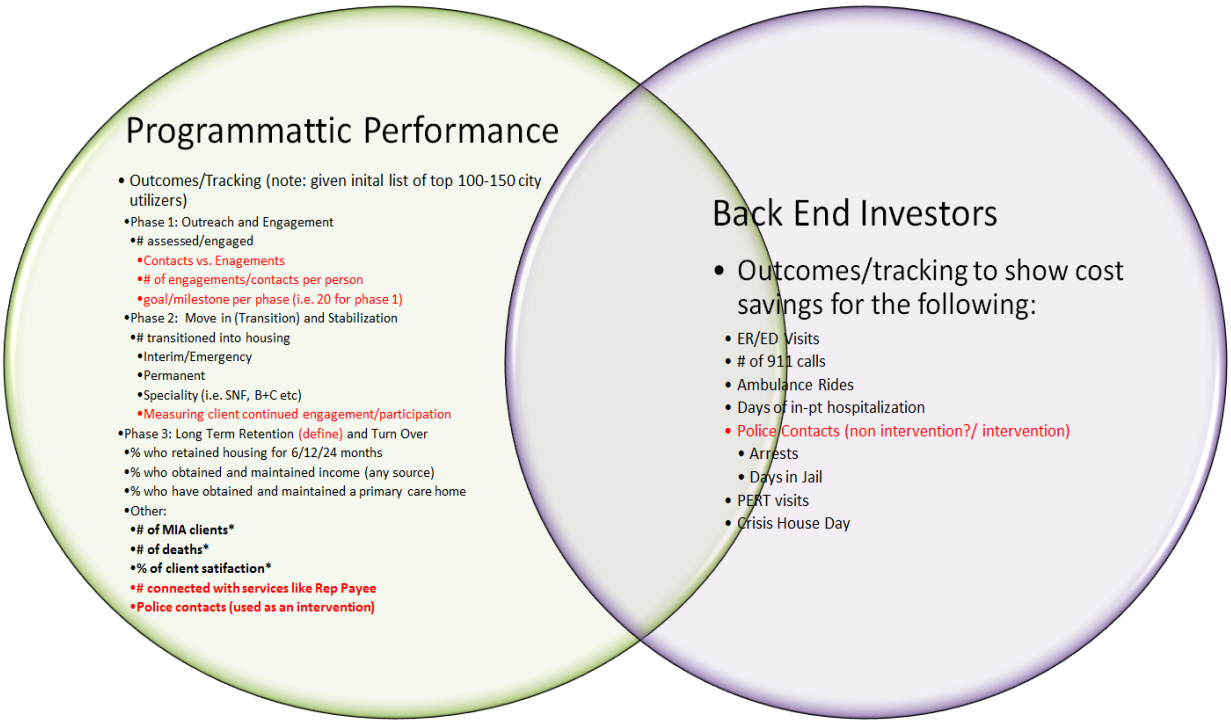
	• Coordinated access to open beds (i.e. respite, SNF, interim/ ES, etc.)	intervention)	level of supports as deemed clinically appropriate.
Staffing Elements & Program Best Practices	• Staff retention was discussed as a key element to create consistency for clientele • Consistent messaging • Use of diversion programming when possible and appropriate • Core trainings/ components: a. Cross trained across such things as benefits, community resources, health care access, housing 101 etc. b. Clear understanding of harm reduction and housing first c. Trauma informed care (TIC) d. Motivational Interviewing e. Critical Time Intervention f. Solution Focused g. SMART goals (i.e. clearly defined goals)		
Key Resources	• Trained/paid peers to offer supports for transition to being housed • MOUs with additional resources/ providers: a. Health/Psych crisis appointment slots (i.e. SVdP has these predefined slots for easy crisis intervention and coordination) b. Day Centers and Senior Centers c. Food Access (i.e. flex line item in budget/ access to meal programs/ resources) d. Benefits Coordination (i.e. SSI/SSDI, SOARS aka HOPE, health/ VA benefits etc) • Flex funds Examples: a. Client was encourage to come on site to FHCSD and was granted access to TV in waiting room as a point of motivation to stay engaged/ come in for services b. Coffee "To make a house a home"- need access to ways to fill the empty unit with items/move in kits		
Program Data (see figure 2, pg. 8)	**Programmatic Performance** Outcomes/Tracking (note: given initial list of top 100-150 city utilizers) •# assessed/engaged ***(Define Contacts vs. Engagements)*** •# of engagements/contacts per person •Goal/milestone per phase (i.e. 20 for phase 1) to keep momentum occurring even when other phases have reached capacity. **Other:**	**Programmatic Performance** •# transitioned into housing ○ Interim/Emergency ○ Permanent ○ Specialty (i.e. SNF, B+C etc.) •Measuring client Success: ○ ***"Success" will vary for each client.*** ○ Continued engagement/ participation in services ○ Established	**Programmatic Performance** •% who retained housing for 6—12--24 months •% who obtained and maintained income (any source) •% who have obtained and maintained a primary care home **Other:** •# of MIA clients •# of deaths •% of client satisfaction* •# connected with services like Rep Payee

	•# of MIA clients •# of deaths •% of client satisfaction* •# connected with services like Rep Payee •Police contacts (used as an intervention)	Service Relationships: ▪ Medical / MH Home ○ Financial: ▪ Benefits and other income ▪ Rep Payee **Other:** •# of MIA clients •# of deaths •% of client satisfaction* •# connected with services like Rep Payee •Police contacts (used as an intervention)	•Police contacts (used as an intervention)
Investor Data	**<u>Back End Investors</u>** ***Note, since these are typically negotiated by the investor these are merely suggestions.*** Outcomes/tracking to show cost savings for the following: • ER/ED Visits • # of 911 calls • Ambulance Rides • Use of Diversion • Days of in-pt hospitalization • Police Contacts ○ Nonintervention ○ Intervention • Arrests • Days in Jail • PERT visits • Crisis House Day		
Data Management	**Secure data base(s)** ○ Community Information Exchange (CIE) ▪ Use for alerts ▪ Pick up/ look ups ○ Homeless Management Information Exchange (HMIS) Service Point ▪ Case Plans ▪ CAHP placement tracking ▪ Able to see across some programs where clients accessed services Secure Method and work flow for easy coordination with Managed Care and other related professionals not on the other database systems.		
Quality Assurance	**Database and Privacy QA** • Predefine Security protocols • Ensure the least amount of duplicated work since there is a need for multiple systems. • Clearly define privacy practices and workflows. • HMIS		

	○ Run ART Report APR 0625 ○ Ideally less than 10% errors/missing data elements at all times • Hard Copy Files ○ Storage ▪ Locked cabinet and Locked door ○ File Content Check List ○ Internal Audit procedures ▪ By Front Line Staff ▪ Quarterly by Management ▪ Annually by funding sources (including HMIS) • **Clientele and Provider QA** ○ Annually ▪ Survey and feedback form ○ Formal Grievance Process and Accessible Form • **Program QA** ○ Use both Client and provider survey and feedback ○ Use outcomes as a guide to where workflow and programmatic design could improve. (i.e. low engagement rates could indicate that the approach to engage needs improvement) ○ Overall, data driven and client-centric model to drive workflow and program improvements ongoing
Analysis	**Internal** ○ Basic program review effectiveness, delivery, and overall effectiveness. Monitor in conjunction with QA. **External** 3rd Party Review ○ Educational Institution ○ Qualitative and or quantitative data review ○ HealthCare or BHS Institutions
Capacity Building	**Things to consider:** 1. Collaborations: ○ Improving service delivery model/ Evolution and Flexibility ○ Informed Decision making/Strategy ○ Leveraging existing resources/ Financial ○ In-Kind Versus Fee for Service (save on costs here) ○ Database ○ Client services ○ Key staffing 2. Clientele Sustainability and Housing Subsidy 3. "Step Down" Process 4. Additional funding/ layered funding.

Data

Simplified Performance Discussion Handout, Figure 2



Intervention Working Group Participants
(Participant= attended 1 or more meeting *or* emailed in feedback based on minutes)

Name	Agency
April Joy (AJ) Galka, Facilitator	**San Diego Housing Commission**
Angela Orias , Intern	**San Diego Housing Commission**
Anne Marie Jensen	**San Diego Fire Department**
Aurora Kiviat	**Health and Human Services Agency**
Chuck Kaye	**San Diego Police Department**
Denise Johnson (PFS Data and Financial Working Group updates)	**San Diego Housing Commission**
Ellen Birrell	**Family Health Centers of San Diego**
Herb Johnson	**San Diego Rescue Mission**
J. Wes Morris	**San Diego Police Department**
Marc Stevenson	**Father Joe's Villages (Project 25)**
Neil Greco	**People Assisting the Homeless (PATH Recuperative Bed Program)**
Shelly Tregembo	**Health and Human Services (BHS)**
Susan Bower	**Health and Human Services**

Reference Materials

- **Community Information Exchange (CIE- database**)
  - http://ciesandiego.org/
  - http://www.livewellsd.org/content/livewell/home/all-articles/partners/partner-home/community-information-exchange.html
  - http://www.sdgrantmakers.org/Portals/0/PastPrograms/2014-12-11%20CIE%20Presentation.pdf
- **Corporation for Supportive Housing (TA for this project)**
  - Pay For Success (grant)
    - http://www.csh.org/pfs
  - Health and Housing Partnerships
    - http://www.csh.org/wp-content/uploads/2015/12/CSH-Health-Housing-Partnerships-Guide.pdf
- **Health and Human Services (current metrics and initiatives)**
  - www.healthypeople.gov
  - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.html
- **HMIS (Homeless- database)**
  - http://www.bowmansystems.com/software/servicepoint (basics)
  - https://www.acgov.org/cda/hcd/documents/ServicePointManual.pdf (for system visuals)
  - https://prezi.com/15wyefhdi7rw/hmis-servicepoint-new-user-training/ (video)
- **Project 25 Materials (reviewed for metrics and areas of success)**
  - SDHC Presentation, June 2012
    - http://www.sdhc.org/uploadedFiles/Media_Center/PowerPoint_Presentations/FINAL.6.6.12%20Keith's%20NACo%20Presentation.pdf
  - St. Vincent de Paul Village Presentation, December 2014
    - http://caph.org/wp-content/uploads/2014/12/Whole-Person-Care_Housing_Kuntz_StevensonProject-25_PPT.pdf
  - Point Loma
    - http://www.pointloma.edu/sites/default/files/filemanager/fbei-project-25-final.pdf

APPENDIX D: Pay for Success Program Summary for Molina:

PAY FOR SUCCESS

Scaling Housing First for Super Utilizers

The San Diego Housing Commission (SDHC) and key local partners, including The County of San Diego, are working together to explore the feasibility of scaling supportive housing through Pay for Success. In 2015, SDHC was awarded Technical Assistance support and funding by CSH to evaluate the key components of a Pay for Success financing mechanism to improve access to supportive housing for vulnerable populations experiencing homelessness in San Diego, including super utilizers of the healthcare and/or criminal justice systems.

CSH is a national nonprofit that advances housing as a platform to improve lives, maximize public sector resources and build healthy communities. It works to assure that housing solutions are accessibly to more people in more places. With over 25 years of experience in the supportive housing sector, CSH partners with government, community organizations, foundations and financial institutions. Partners for the Technical Assistance provided to SDHC include the Center for Health Care Strategies and Third Sector Capital Partners.

Working together, partners will determine whether a Pay for Success funding mechanism is an appropriate way to scale supportive housing by:

- Defining the target population of interest to stakeholders using homelessness, health, and criminal justice metrics
- Quantifying cost savings and cost avoidance for the target population using supportive housing statistics
- Costing the service using real service provision, housing, data collection and evaluation costs
- Determining the best financing mechanism, including leveraging existing resources
- Designing Pay for Success outcome metrics and payment mechanisms, if appropriate
- Developing a financial model to use in conversation with social investors, if appropriate

HOMELESSNESS AS A HEALTHCARE AND CRIMINAL JUSTICE PROBLEM

In San Diego, a small group of individuals plays a significant role in the escalating costs for medical services, correctional services, and other emergency systems. These "super utilizers" have complex needs and ricochet between incarceration, hospitalization, detoxification services, and homelessness. The San Diego 2014 Point in Time count survey identified 1,248 adults experiencing chronic homelessness in the region. Additionally, in November, 2014 through the 25 Cities initiatives using the Vulnerability Index Prioritization Decision Assistance Tool (VI-SPDAT), 2,369 individuals experiencing homelessness were screened in downtown San Diego. Of these individuals 62% identified as chronically homeless, 57% reported having a serious medical condition, and 75% of the individuals screened identified as having a mental health disorder.

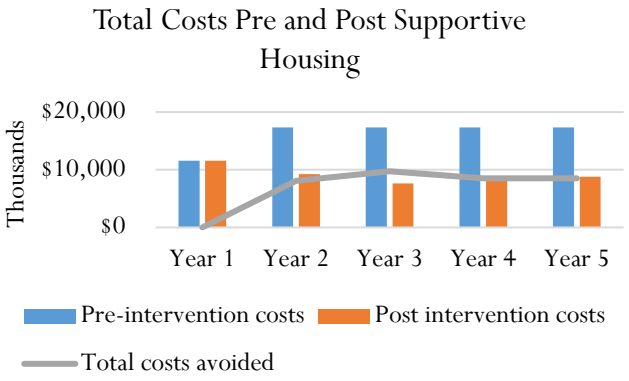
The system is producing poor outcomes for this population at a high cost to the community.

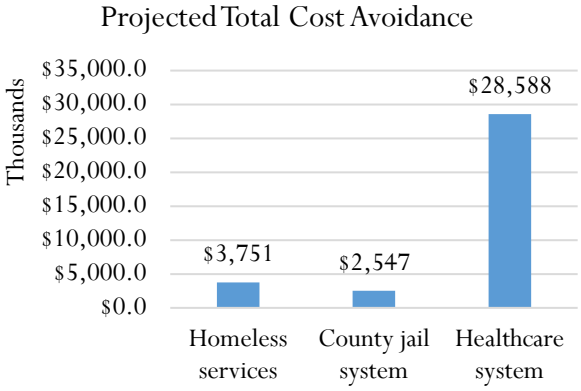
SUPPORTIVE HOUSING: AN EVIDENCE-BASED SOLUTION

Local delivery of supportive housing is proven to be very effective: 95% of those it serves do not return to homelessness. At a national level, at least 85% of supportive housing residents remain stably housed after one year.

San Diego has already has proven cost-savings to health systems, especially among individuals experiencing homelessness who were "frequent utilizers" of emergency rooms and inpatient hospital services before Project 25 housed and provided service to them. According to data from the 2015 Project 25 final report, "frequent utilizer" participants in supportive housing decreased emergency room visits by 78 percent, and inpatient hospitalization visits decreased by 68 percent. Criminal Justice interactions decreased significantly as well for the target population with the supportive housing intervention; the number of arrests for frequent utilizers decreased by 78 percent and the number of jail bed days for participants was decreased by 62 percent.

Preliminary analysis based on data from Project 25, identifies significant potential cost avoidance if this target population is connected with the intervention of supportive housing, particularly through costs that could be avoided by reducing unnecessary usage of the emergency room and preventable hospitalizations. This analysis continues to be refined as we narrow in on an anticipated target population for a potential PFS initiative and the relevant status quo costs through comprehensive data matching and analysis.





Scaling supportive housing will address inappropriate healthcare usage and reduce recidivism among this high need, vulnerable population

Opportunity: Pay for Success Contracting to Better Address Outcomes

Pay for Success (PFS) is a contracting model that reduces risk to the public sector and sometimes leverages private, socially motivated investment in service provision. It pairs up performance based contracts to the resources needed to scale an intervention with repayment from public funders only if the intervention achieves agreed upon success metrics.

Success metrics for other supportive housing PFS projects include:

- 12 months in stable housing
- Reduced number of jail days
- Reduced emergency shelter days

Paying for outcomes when they are achieved enables partners to unlock additional sources of funding for supportive housing

Anticipated Beneficiaries

The anticipated beneficiaries in San Diego County & City include:

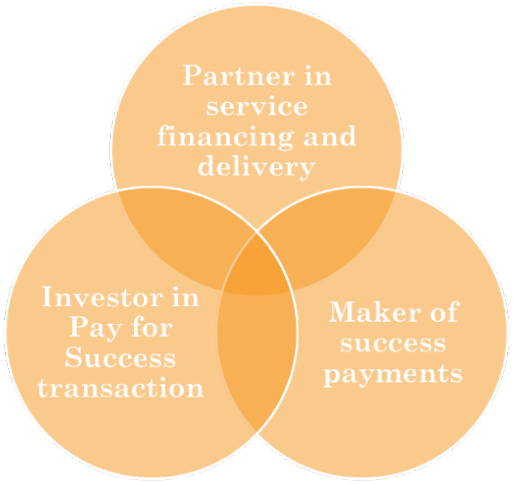
- Local hospitals and MCOs: Reduced pressure from inappropriate emergency usage and avoidable hospitalization
- The County of San Diego Criminal Justice Services: Reduced jail days, arrests and police time
- The City & County of San Diego Crisis services: Reduced emergency detoxification service usage, EMS transports, shelter usage

Most importantly, supportive housing transforms the lives of individuals housed and produces:

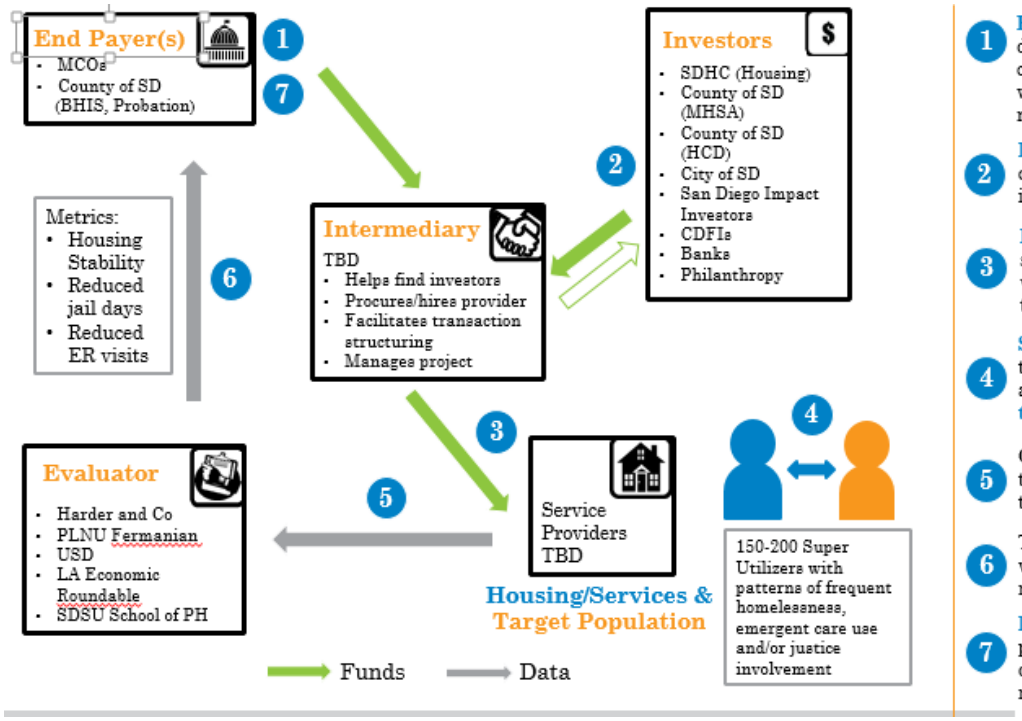
- Empowerment over housing and other life choices
- Respect and dignity for homeless individuals

Potential Role for Molina

Molina is a key partner in supportive housing efforts in San Diego and an important stakeholder in a potential PFS transaction. As outlined in the graphic below, there are at least three key roles that Molina could explore as part of a potential PFS transaction. We look forward to discussing these roles and where there may be potential alignment in terms of your interests.


Partner in service financing and delivery
Investor in Pay for Success transaction
Maker of success payments

Additional Information: Example of a Potential Pay for Success Model in San Diego



1. **End Payer** partners to develop PFS effort that connects a proven intervention with a target population in need of services.
2. **Investors** provide the upfront capital to finance the intervention.
3. **Intermediary** provides the service provider(s) with the working capital to implement the intervention.
4. **Service providers** deliver the transition supports, rental assistance, and services to the **target population.**
5. Outcomes and costs are tracked and provided to the third-party **evaluator**.
6. The **evaluator** determines whether the agreed upon metrics have been achieved.
7. **End Payer** makes success payments the intermediary for distribution if outcomes are met.