Health Center Role in Housing Innovations: Pay for Success Models

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Health Center Role in Housing Innovations: Pay for Success Models for Health Centers

In the last ten years, there has been a growing cross-sector trend toward measuring outcomes to understand successful service interventions that create meaningful social good and a shift away from focusing solely on outputs such as the number of visits or people served. In the business sector, this trend has taken the form of an explosion of impact investing.

This type of financial investments targeted at specific performance outcomes has grown nearly 300% to $11.6 trillion since 2012[1]. In the social services sector, there has been an increasing focus on outcomes or performance-based contracting in which some portion of funding is tied to the achievement of identified outcomes. The growth of this broad outcomes-focused funding environment has given rise to innovative strategies like Pay for Success. Such strategies have been used to scale up a range of proven interventions focused on Social Determinants of Health (SDOH), including access to housing.

Strategies like Pay for Success should be used to implement interventions that are part of an overall effort to build thriving communities in which everyone has the healthcare, food, economic opportunity, education, childcare, civic engagement and outdoor space to be healthy and make meaningful progress in their lives. At the center of this is safe and affordable housing aligned with supportive services. In reality, most communities are far from this ideal. Stark disparities exist for Black, Indigenous, and other People of Color (BIPOC) in particular. Health centers have the responsibility to understand and address systematically racist policies and practices that have led to these disparities. In approaching this work, health centers should lift up and center the voices of people who face intersectional barriers related to extreme poverty, health disparity and disability, and racism and discrimination.

This brief will provide an overview and discuss the benefits of Pay for Success (PFS) funding strategies. It will provide examples from a range of communities, define relevant terms, and give health centers concrete next steps to understand and explore their potential role in implementing a PFS strategy. Specifically, the following will be covered:

[1] https://www.sriconference.com/blog/the-dramatic-growth-of-impact-investing

- **National context for and overview of PFS**
    - PFS is part of a national and international movement to produce both social and financial returns. It often pairs a performance-based contract with an upfront investment that is repaid based upon successful results.
- **How PFS funding strategies can be used to implement interventions to improve outcomes for people experiencing homelessness and housing instability**
    - PFS is a strategy that can bring together diverse stakeholders around a common vision of successful outcomes. It provides the community with an opportunity to scale evidence-based interventions with a high level of quality.
- **Examples from the field including the role of health centers**
    - Health centers can and have played critical roles in PFS initiatives ranging from community convener to service provider.
- **Key components of building PFS initiatives and actions that health centers can take to get started**
    - There are concrete steps that health centers can take to explore the potential of PFS as a strategy to meet SDOH needs. These start with defining the problem to be solved and bringing together multi-sector partners, including persons with lived expertise.

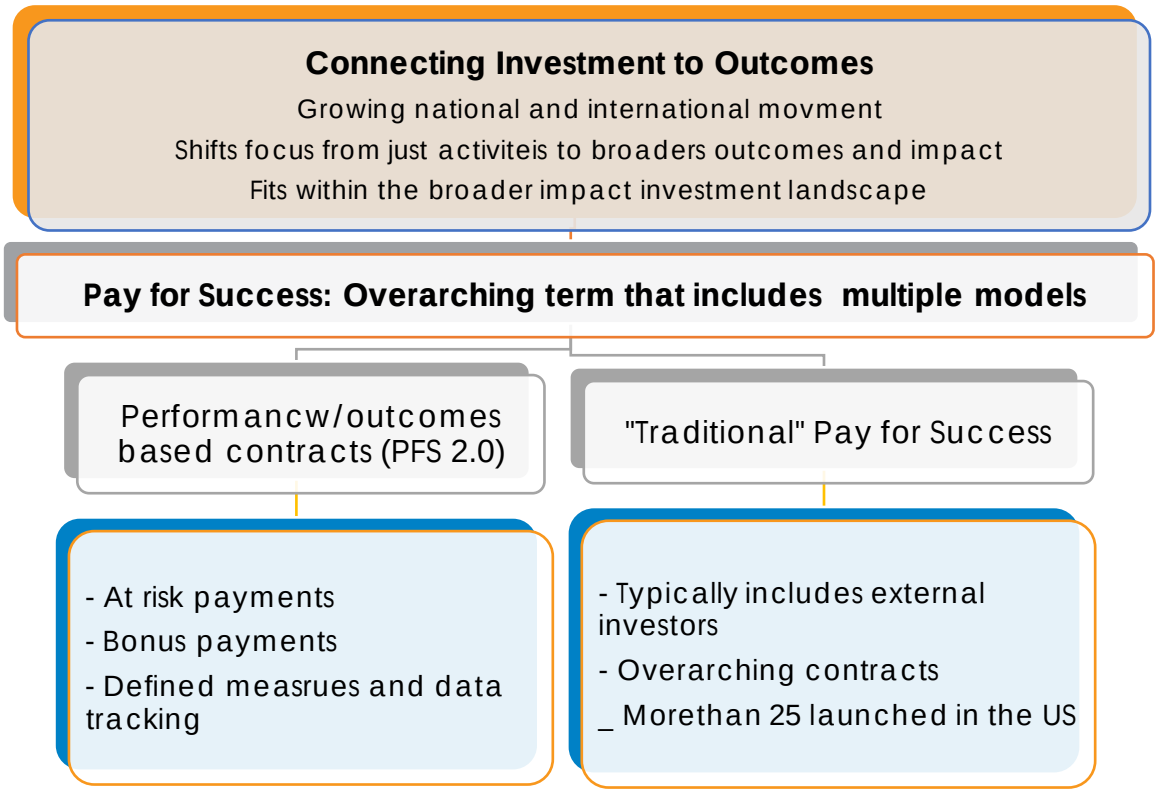
Overview of Pay for Success

Throughout this brief, the term "Pay for Success" is used to refer broadly to types of models and approaches that tie funding to outcomes or performance. This first section will review a number of those models that have been used to fund interventions focused on SDOH. Selecting the best approach for a given initiative is a function of overall goals and available resources as well as the interests of the key stakeholders structuring an initiative.

Impact Investment

Investments that produce measurable social, as well as financial, returns are part of the broader landscape and "double bottom line" approach of impact investment. There is evidence to suggest that a focus on social good can improve financial returns. Impact investment funds with less than $100M in assets under management outperformed similarly sized traditional funds over a six-year period[2]. The Kaiser Permanente Thriving Communities Fund is an example of impact investment focused on SDOH, in this case, housing. The fund is designed to address housing stability and homelessness, among other community needs.

Figure 1: Impact Investment Model



[2] https://thegiin.org/research/publication/introducing-the-impact-investing-benchmark

"Traditional" Pay for Success

Traditional PFS transactions (also called Social Impact Bonds) are a subset of impact investment. PFS refers to the concept of paying for positive social impact rather than paying just for services performed. Under this model, the impact is measured rigorously, and "success payments" are made based on agreed-upon metrics. PFS typically includes performance-based contracting between an entity, often government, paying for the achievement of outcomes (the 'end payer'), and the organizations responsible for implementing a given intervention, often nonprofit organizations. The term "Social Impact Bond" is used less commonly in the United States, as it is not actually a "bond" in the way the term is typically used in financial markets.

PFS is a combination of two different elements: upfront funding provided by impact investors and a performance-based contract, in which most of the payments are made for social outcomes rather than paid on a 'fee-for-service' basis. The mechanics of PFS financing vary, but most structures support PFS programs by providing upfront funding to implement and/or scale an intervention that has been proven to produce desired outcomes, such as improvements in housing stability or reductions in recidivism. 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 the potential for a modest return on investment. In exchange for this upfront payment, investors accept the risk that the intervention may not fully produce the desired outcomes. Roles in Pay for Success Transactions

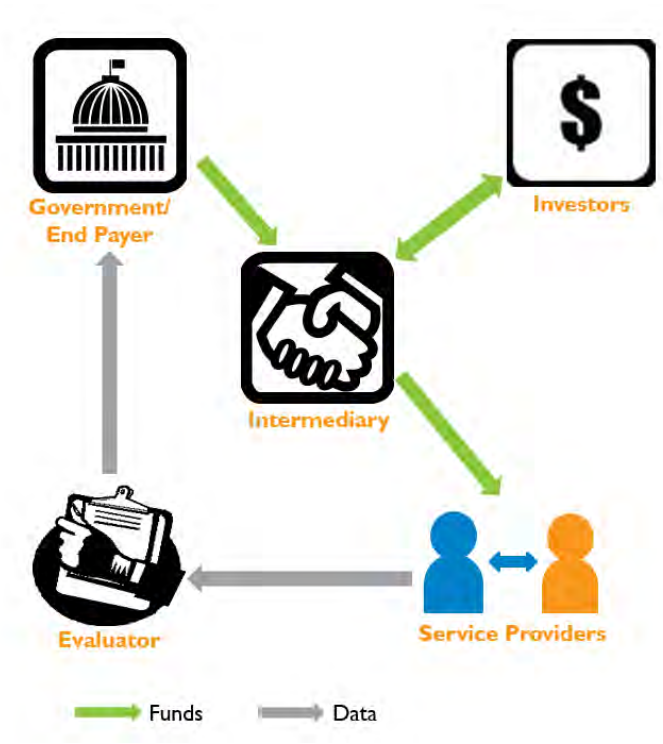
Roles in Pay for Success Transactions

Each PFS transaction leverages the strengths of the community partners. This means that each will fill the core roles in slightly different ways based on what is the best fit for a given community. Health centers are often at the table during these discussions as potential primary and coordinating service providers to help ensure that individuals receive the full range of supportive services they need. The diagram included in this section highlights the roles that many PFS projects include, but it is important to note that there are many variations on this model.

- **End Payer:** Government agency, or other "payer" such as a school district or hospital, defines the desired outcomes and pays back the upfront funding once the

outcomes are achieved. This entity plays a primary role in deciding whether to sustain or scale up the intervention based on its level of success.

- **Investors:** Provide the upfront capital to finance the intervention. Investors expect measurable social and the potential for financial returns. They may be local trusts, health insurers, foundations or large national banks.



- **Intermediary or Project Manager:** Facilitates the flow of funds and data for the project. They are charged with supporting overall project success for all stakeholders. Intermediaries facilitate transactions, particularly during the project's structuring and implementation.
- **Service Providers:** Deliver the services that are part of the targeted intervention. For supportive housing, this may include transition supports, rental assistance, as well as ongoing tenancy and clinical supports. Multiple providers are especially useful when the population to be served has diverse needs. Service providers delivering under a PFS contract usually have a strong track record of collecting data and using outcomes information to improve service quality.
- **Population:** Includes individuals, families or organizations being served by PFS program interventions.
- **Independent Third-Party Evaluator:** Assesses performance data, conducts evaluation on intervention outcomes, and verifies the extent to which agreed-upon outcomes are achieved in order to determine government payments.

Variations on the PFS Model

Outcomes-Based Contracting (PFS 2.0)

Increasingly, the PFS model has evolved to be inclusive of outcomes-based contracting (OBC) approaches that are not necessarily financed through an upfront payment from third-party investors with an expectation of repayment. In this "PFS 2.0" model, many of the PFS hallmarks are included such as a contract that clearly defines outcome measures tied to payment and ongoing performance management. However, government and/or philanthropy may provide funding directly, up-front or pay as you go, without an

expectation for repayment. Providers may still have a portion of their funding at risk based on performance; and have the potential to receive bonus payments. The project's success forms the basis through which to determine if ongoing investment in the intervention should be sustained or increased.

Value Based Payment Models

Value Based Payment (VBP) models (currently operating in the healthcare sector) have some commonalities with the PFS approaches described above. In general, VBPs describe a shift in the traditional reimbursement of healthcare activities from the basis of volume or services (fee for service) to alternative payment models. In traditional payment models, hospitals are reimbursed by each admission or Emergency Room visit. This payment model has received longstanding criticism because it incentivizes volume over quality of services. In response, the Centers for Medicare and Medicaid Services (CMS) has paved the way for VBP models in healthcare. In a VBP approach, providers might receive an increase or decrease in their baseline payment based upon performance on a measure like reducing emergency room visits for individuals with chronic illness. CMS has created an Alternative Payment model framework for payers and providers to build towards more comprehensive Value Based Payment structures[3]. For more information on what VBP and PFS models can learn from each other, please see Value Lessons from PFS for Medicaid's VBP.

Flexible Funding Pools

PFS approaches are a powerful tool for cross-sector stakeholders to come together to clearly define a problem and design an evidence-based solution. Implementing a solution requires identifying and aligning multiple sources of funding. Often led by funders such as government, publicly funded health systems or philanthropy, this strategy presents an opportunity for funders to streamline the process of disbursing funds through joint Requests for Proposals (RFPs), contracting and coordinated requirements. The Flexible Funding Pool is an example currently being implemented in several communities. Flexible Funding Pools:

- Combine funding from multiple sources (government, foundation, private)
- Typically focus on streamlining and filling gaps in the existing system(s)
- Include cross-sector partners and governance
- Function like grants in that funders are not typically repaid
- May distribute funds to social service agencies via performance-based contracts
- Are usually associated with robust data tracking or evaluation to demonstrate results

Although Flexible Funding Pools are not always paired with performance-based contracts, there are examples, such as the Indianapolis Housing to Recovery Fund (details provided

[3] http://hcp-lan.org/workproducts/apm-factsheet.pdf

below), that do take this approach. Additional Flexible Funding Pool examples may be found here: Los Angeles Flexible Housing Subsidy Pool, Chicago Flexible Housing Pool.

Comparing Traditional Contracts, OBCs, and PFS

To recap, the following chart compares traditional service contracts, OBCs, and PFS, identifying the key aspects of each as well as high-level benefits and challenges.

	Traditional Service Contracts / Grants	Outcomes-Based Contracts (PFS 2.0)	Traditional PFS
Payment Structures	Payments based on *activities/eligible expenses* according to contract/grant conditions	Payments based on achievement of *outcomes and/or performance* standards	Payments based on *achievement of outcomes*
Parties Involved	Funder and service provider	Funder and service provider, may also have an evaluator	End payer, investors, intermediary, third-party evaluator, service provider
Evaluation and Performance Management	Funder driven and compliance oriented, focused on spend down, eligible expenses, and accurate reporting	Outcomes oriented. Benefits from a collaborative approach to define success and manage performance	Outcomes oriented. Collaborative structure to define success, metrics, and manage performance towards outcomes. Rigorous evaluation often required, typically using an independent evaluator
Benefits	Well known, accepted, financial predictability	Focus on outcomes, clear expectations, flexibility to service provider, reduced risk to government	Focus on outcomes, clear expectations, flexibility for service provider, reduced risk to government, engages nontraditional partners
Challenges	Focus on compliance, eligible expenses/activities and not on outcomes, performance typically an indirect factor or after thought	Service provider capacity, less financial predictability, more complex	Service provider capacity, less financial predictability, stringent evaluation, complex transactions, requires significant stakeholder education

Using PSFs to Meet SDOH Needs

PFS initiatives have grown in number, with more than 25 transactions implemented in the United States and over 160 transactions globally[4]. Many of these transactions are explicitly focused on health or SDOH including projects with a focus on supportive housing, home visiting, and substance use support. In order to implement any sort of outcomes focused investment, there needs to be evidence available to provide at least a sense of what outcomes could be achieved. The robust evidence base for interventions like supportive housing and Nurse Family Partnership are reasons that there have been multiple PFS projects focused on them.

In the case of supportive housing, dozens of studies across the country over the last 20 years have repeatedly proven that it is 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[5]. 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[6] and one that consistently helps people with disabilities achieve their desired goals. The research[7] clearly shows that Supportive Housing results in:

1. Reductions in hospitalizations, emergency department usage, and in some cases, reduced health costs for persons with complex co-occurring disorders including chronic health conditions, mental illness, and substance abuse disorders;
2. Reductions in criminal justice interactions among persons with histories of justice involvement
3. Improved health and mental health when comparing the period before and after individuals enter supportive housing; and
4. 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] https://socialfinance.org/social-impact-bonds/

[5] Rog, D., Marshall, T., Dougherty, R., et al. (2013). Permanent supportive housing: Assessing the evidence. *Psychiatric Services.*

Retrieved from http://ps.psychiatryonline.org/article.aspx?articleid=1790640

[6] Permanent Supportive Housing Evidence-Based Toolkit. Using Multimedia. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/usingmultimedia-psh.pdf

[7] https://www.csh.org/wp-content/uploads/2018/07/CSH-supportive-housing-outcomes-healthcare_Final.pdf

Benefit of PFS

There are many reasons that a community or organization might choose to pursue PFS funding strategies, which provide the opportunity to:

- ✓ **Develop collaborative cross-sector partnerships.** PFS initiatives have been described as an "admissions ticket" that serves as a concrete opportunity for new partners, ranging from hospital systems to housing developers, to come together and define a shared vision of success. They provide an avenue for stakeholders to move away from a scarcity mindset and toward planning for how services should be delivered; and possibly redeploying resources to improve outcomes. Health centers should be at the table leading and supporting such discussions.
- ✓ **Design interventions to maximize outcomes for individuals and families.** Oftentimes providers are stuck in a cycle of doing the best they can with what they have. PFS initiatives break this cycle by encouraging stakeholders to come together and design a service model that will maximize outcomes. People with lived expertise in the relevant service model and/or who are Black, Indigenous and People of Color (BIPOC) should play a lead role in this process. Putting the desired change for the populations to be served and communities' front and center ensures that all parties are driving toward these shared goals and working collaboratively to ensure success.
- ✓ **Provide flexibility to service providers to tailor services to individuals.** Providing individualized services is what makes interventions like supportive housing effective. Contracts that pay for services based on outcomes can allow service providers to focus on what will work best for the client, and not just what might be an eligible expense.
- ✓ **Use funding more efficiently and effectively.** When structured and managed well, PFS initiatives allow funders to pay more for what works, and less for what does not. PFS initiatives can support efforts to shift spending away from avoidable crisis care such as jail or emergency rooms and toward appropriate supportive and preventive care like housing or substance use treatment.
- ✓ **Scale up what works.** PFS strategies can be used to expand an existing initiative or to put a new one into place. In either case, the goal is to make the intervention available to a significant number of new individuals. The focus on tying at least some portion of payments to specific outcomes that have value to the payer can help to provide justification to implement the initiative. Further evidence generated through the results and/or evaluation of the initiative can support sustaining or further scaling the initiative.
- ✓ **Real time learning and problem solving.** The structures that support many PFS initiatives involve regular meetings of stakeholders to review performance. Unlike traditional grant funded programs that might wait a year or more to review results, outcomes-based initiatives meet frequently (bi-weekly in comes cases) to review progress toward outcomes and to solve problems in real time. Some of the solutions developed through this structure have led to broader system improvements, allowing the whole community to benefit from the learnings.

KEY COMPONENTS OF DESIGNING A PFS INITIATIVE

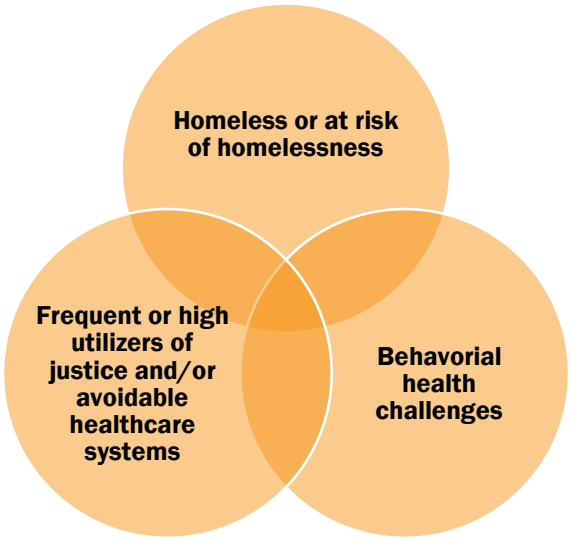
Although the key components of PFS are discussed more fully in the "Moving to Action" section below, this section highlights two components in which health centers have an especially critical role to play.

Identifying the Population of Focus

Any PFS initiative should always start with "who;" identifying a group of individuals or families who are not having success in the current system and whose outcomes could be improved through an evidence-based intervention. This population identification should include consideration of disparities and inequities within the current system by race, ethnicity, gender identity or expression, sexual orientation, family composition or other factors. For effective and long-lasting interventions, it is important to incorporate work to understand and address systematically racist policies and practices that have led to stark disparities for Black, Indigenous, and other People of Color (BIPOC) in particular.

Defining a population of focus for a PFS project is typically a multi-stage process comprised of three core components 1) describing the population to be served at a high level; 2) using data to establish specific threshold criteria to determine eligibility, and then; 3) prioritizing eligible individuals from within that group to be offered the intervention.

For example, PFS projects focused on supportive housing have generally focused on individuals who are experiencing homelessness and who are the highest utilizers of crisis systems such as justice, detox, emergency transport and health care. These individuals often cycle between homelessness, institutions such as nursing homes, incarceration, and emergency hospital stays, creating avoidable costs to these systems and a poor quality of life. They cycle through crisis care systems rather than accessing appropriate primary and preventive care in the community such as that provided by health centers.



In this example, a given community might start with a high-level understanding of their population of focus as noted in the Venn Diagram in Figure 1. They would further refine their understanding through discussion and review of available data.

Figure 1: Proposed High Level Population of Focus for Pay for Success

In discussing a potential population of focus, it is important to understand what information is already available about the group(s) being considered. Health centers track a wealth of information that may be helpful in defining the characteristics of a particular population. Some of this data such as chronic conditions may be tracked in the Uniform Data System (UDS). Information on health utilization such as emergency room visit can be tracked using ICD-10 codes. SDOH screening tools, such as the PRAPARE tool[8]. may also include helpful details such as those related to housing instability, food insecurity, and access to healthcare or perceived level of health. These data could be used to identify a group of individuals who could benefit from a particular intervention.

Defining and Measuring Success in PFS

Along with identifying a potential group of beneficiaries, another fundamental step in building a PFS initiative is developing a shared vision of success across all project stakeholders. This process of defining success should include people with lived expertise with the challenges, organizations and/or programs that are relevant to your initiative. As you develop your vision for success, you will also begin to think about how you will know if your project has achieved this level of success. Although each PFS initiative has unique features in terms of its geographic focus, population served, and service design, using all available national and local data to understand what kind of outcomes can be expected helps to align stakeholders around a shared vision for success.

This section includes examples of measures from existing PFS projects to illustrate how this has looked in other communities. As of April 2021, five PFS transactions nationally with supportive housing as the targeted intervention have moved into implementation. These five projects all focus on connecting persons with histories of homelessness and with significant utilization of the criminal justice and/or healthcare systems to supportive housing. In PFS projects, desired outcomes are identified as those that will form the basis for success payments. Examples of these "payment triggers" from these implemented supportive housing PFS projects are summarized in Figure 3.

It is important to note that all of these projects also measure and evaluate outcomes that go beyond those used to trigger payments. In many cases, the level of data or evidence for these additional outcomes is not deemed strong enough to be used as a basis for payment, but project stakeholders desire to learn more in order to consider the use of new metrics as the basis for future projects.

[8] https://www.nachc.org/research-and-data/prapare/

Figure 3: Summary of Payment Triggers for PFS Projects with Supportive Housing

Location	Payment Triggers
State of Massachusetts	• One year of stable housing and each day spent in stable housing after one year
Santa Clara Co., CA	• 3, 6, 9 and 12 months of continuous tenancy and for each month after the first year of stable tenancy
Denver, Colorado	• One year of stable housing and each day spent in stable housing after one year • Percent reduction in jail days against a control group
Los Angeles, California	• 6 and 12 months of continuous stable housing • Number of rearrests during a two-year period
Anchorage, Alaska	• Housing stability measured at the one-month mark and at intervals between 6 and 24 months

Figure four highlights Pay for Success initiatives with interventions focused on improving health and SDOH that may be of interest to health centers.

Figure 4[9]: Summary of Payment Triggers for PFS Projects with a Health Focus

Location	Payment Triggers
South Carolina Nurse Family Partnership	• Reduction in preterm births; • Reduction in childhood hospitalization and emergency department use due to injury; • Increase in healthy spacing between births; • Increase in number of first-time moms served in high-poverty ZIP codes
Santa Clara County Partners in Wellness	• Reduction in clients' utilization of costly emergency, inpatient, and contracted psychiatric services and jail days
Michigan Strong Beginnings	• Reduction in preterm births • Reduction in rapid repeat pregnancies
Maternal, Infant, and Early Childhood Home Visiting Outcomes Rate Card Pilot	• Full-term birth (babies born 37 weeks or later) • Safe children (no instances of child maltreatment or injury)

[9] Information taken from "Pay for Success: The First 25 A Comparative Analysis of the First 25 Pay for Success Projects in the United States" by the Nonprofit Finance Fund. Available at https://nff.org/report/pay-success-first-25

PFS IN ACTION: EXAMPLES FROM THE FIELD

This next section looks more closely at several PFS initiatives focused on SDOH, with health centers as key partners and three different approaches to outcomes-based funding and contracting.

Denver Social Impact Bond

Overview	• **A PFS initiative launched in 2016 and completed its 5-year term in 2020. The City of Denver has committed to funding a project continuation to sustain the cohort in supportive housing through performance-based contracts in 2021 and beyond.** • **Designed to provide supportive housing to 250 individuals who are frequent users of the city's emergency services including police, jail, courts and emergency rooms**
Project Partners	• Payer: City of Denver • Intermediary: CSH and Enterprise Community Partners • Service Providers: Colorado Coalition for the Homeless and Mental Health Center of Denver • Evaluator: Urban Institute • Investors: The Denver Foundation, The Piton Foundation, The Ben and Lucy Ana Walton Fund of the Walton Family Foundation, Laura and John Arnold Foundation, Living Cities Blended Catalyst Fund LLC, Nonprofit Finance Fund, The Colorado Health Foundation, and The Northern Trust Company
Population to be Served	• Population identified based upon the work of the Denver Crime Prevention and Control Commission (CPCC), now called the Department of Behavioral Health Strategies. • CPCC calculated that in the four years prior to the start of the SIB, a group of 250 high-utilizers cost taxpayers upwards of $7.3 million per year on average. • Based on this data, the population targeted were individuals who had at least eight arrests over 3 years and were identified as transient at the time of arrest.
Investment and Repayment	• Upfront funding was provided by eight investors as noted in "project partners" • Repayments based upon success are made by the City and County of Denver
Targeted Outcomes	• Housing stability for a minimum of 12 months and reductions in jail days as compared to a control group. • The project evaluation also includes extensive information on health-related outcomes although these are not directly attached to payment.

Intervention Design	• The initiative delivered supportive housing with a Housing First approach and a service delivery model of modified Assertive Community Treatment (ACT). Services included tenancy support services, crisis intervention, substance use counseling, mental health treatment, peer support, skills building, connection to primary care, and various other services.
Health Center Involvement	• Two services providers connected to the Denver SIB provided supportive housing using the model described above: o Colorado Coalition for the Homeless (CCH) is a Federally Qualified Health Center and Healthcare for the Homeless Provider. o The Mental Health Center of Denver is a community behavioral health and Medicaid managed care provider.
Results	• Final results revealed sustained housing stability and reductions in crisis care services and reincarceration. Of those who were housed through the program, 86 percent of participants remained in stable housing at one year. In the three years after being randomized into the evaluation, people referred to supportive housing had an average of eight fewer police contacts and four fewer arrests than those who received usual services. • Based on preliminary results, the City of Denver has already expanded the initiative to house an additional 75 people through a direct outcomes-based contract with CCH.
Lessons Learned	• Assuring housing availability as part of the defined intervention can be challenging. In the case of the Denver SIB, two housing developments that were to provide the majority of the housing for persons entering the SIB were delayed. However, all of the project partners worked together to develop a revised enrollment schedule that still allowed the cumulative targets to be met.

Indianapolis Housing to Recovery Fund

Overview	• **The Indianapolis Housing to Recovery (HTR) Fund is a flexible funding pool primarily dedicated to funding supportive services delivered as part of supportive housing.** • **Funds are made available via outcomes-based contracts.**
Project Partners	• Planning Partners: Central Indiana Community Foundation, City of Indianapolis, Blue Print Council, Coalition of Homeless Intervention and Prevention, CSH • Service Providers: Horizon House, Adult & Child Health

Population to be Served	• Individuals experiencing homelessness referred from the City's homelessness Coordinated Entry System • Projects may further prioritize individuals who have a pattern of homelessness and history of high-cost utilization of crisis services or health or behavioral health challenges as well as frequent interaction with the criminal justice system.
Target Outcomes	• Year 1 outcomes are focused on the one-year housing stability rate as well as access to insurance and health care utilization. • Future year outcomes are expected to include reductions in justice interaction and avoidable use of emergency room services.
Intervention Design	• Supportive housing using a Housing First approach with robust and flexible supportive services. • Supportive services include but are not limited to outreach/in reach, engagement, housing navigation, care coordination, integration of behavioral health, integration of primary care/medical home, vocational support, community support, education support and tenancy/housing support.
Health Center Involvement	• The HTR Fund is still actively raising funds but made its first two awards in 2020. o Adult & Child Health received an award to support their Assertive Community Treatment initiative. Adult & Child Health is a community mental health center and Health Center Look Alike that offers primary care and behavioral health services. o Horizon House received an award to provide tenancy-support services. They collaborate closely with multiple local health centers to connect tenants to primary and behavioral health services.
Results	• The initiative is still in its first year of implementation, but has successfully raised more than $2 million and convened a broad range of community partners. • The project also engaged an in-depth system analysis to identify opportunities to streamline and improve service delivery across multiple community providers.
Lessons Learned	• The HTR fund is focused on catalyzing system transformation. This makes it especially important that the HTR Fund planning committee coordinate closely across related efforts in Indianapolis and the State of Indiana. Members of the HTR Fund planning committee are intentional about bringing knowledge of other related community efforts to meetings to ensure alignment.

Anchorage Home for Good

Overview	• **A PFS initiative providing 150 units of supportive housing to individuals who are experiencing homelessness and who are high utilizers of public services.** • **Pilot launched in 2019, full initiative in 2020.**
Project Partners	• Project Managers: Municipality of Anchorage, Social Finance, Inc., United Way of Anchorage • Funders: Alaska Community Foundation, Alaska Mental Health Trust Authority, Municipality of Anchorage, Rasmuson Foundation, Premera Blue Cross, Providence Alaska • Service Providers: Alaska Behavioral Health, Southcentral Foundation
Population to be Served	• Individuals residing in Anchorage who are persistently homeless, who have interacted with the justice system and utilized emergency services.
Investment and Repayment	• Upfront philanthropic funding provided by Alaska Mental Health Trust Authority, Premera Blue Cross, Providence Alaska Foundation, and Rasmuson Foundation • Outcomes based funding provided by the Municipality of Anchorage will sustain services after spending the initial philanthropic funding.
Intervention Design	• Supportive housing comprised of affordable housing and wraparound supportive services • Supportive housing delivered with a Housing First approach, and other best practices such as harm reduction and trauma-informed care
Health Center Involvement	• Two services providers are connected to Anchorage Home for Good: o South Central Foundation (SCF) is an Alaska Native-owned, nonprofit health care organization and Federally Qualified Health Center serving Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Borough and 55 rural villages in the Anchorage Service Unit. o Alaska Behavioral Health is a community behavioral health provider serving children and adults with a wide range of mental health challenges.
Target Outcomes	• Housing stability measured at the one-month mark and at intervals between 6 and 24 months. • Additional outcomes not connected to payment will be reviewed related to interactions with public services such as the police department, emergency transport and shelter.

Results	• The initiative is still in its first year of implementation and is enrolling new participants each month. • At the conclusion of the one-year pilot, 19 of 21 people remained stably housed. Pilot participants experienced 85% fewer arrests, 85% fewer Safety Center intakes, 63% fewer stays in shelter, and 44% fewer emergency medical service trips.[10]

[10] https://www.liveunitedanc.org/wp-content/uploads/HFG-press-reslease-10-1.pdf

MOVING TO ACTION: KEY COMPONENTS OF BUILDING A PFS INITIATIVE FOR HEALTH CENTERS

Health centers can play a critically important role as a catalyst to bring together stakeholders to discuss opportunities to use a PFS strategy to improve results for a particular population of focus. The steps below can guide these efforts. This list is not exhaustive, but is meant to represent some of the key stages and questions as you approach outcomes-based funding:

#	Component	Activities, Considerations and Decision Points
1.	**Define the need.**	Develop an overview that focuses on the need for a particular intervention like supportive housing in the community and/or with a focus on a specific population (e.g. older adults, youth, and justice-involved individuals). Potential activities include: • Conducting focus groups and outreach with local stakeholders from relevant sectors such as homelessness response, healthcare, justice, child welfare, housing, and/or other key sectors, as applicable. • Engaging persons with lived expertise through partnerships with local organizations, direct outreach, and/or focus groups. This could include a focus on current patients. • Using health center and other publicly available data to assess existing need, racial disparities and gaps in services.
2.	**Establish a multi-sector planning group.**	• Determine the membership of the planning group, including but not limited to: service providers, housing providers, funders, culturally specific organizations; individuals with lived expertise of multi-system involvement and/or who have been disproportionately affected by systemic inequities; and Black, Indigenous and People of Color (BIPOC) led organizations and individuals. • The planning group should include individuals who: o Have direct access to data sets regarding the proposed population to be served o Have direct access to the proposed population to be served o Are a service provider to the proposed population to be served o Have a role or interest in making payments based on the proposed outcomes • Discuss roles and responsibilities of the members of the planning group with a focus on creating opportunities to empower culturally specific organizations and people with lived expertise to lead this work.

#	Component	Activities, Considerations and Decision Points
3.	**Define the population to be served and develop a shared vision for success.**	The planning group should consider: • Which vulnerable population is of greatest interest to the core leadership team/broader community for an outcomes-focused initiative? • What are the key demographics and characteristics of this population group? • How will this initiative address racial disparities in the community and promote racial equity? • What would success look like for this group of individuals? How will you know if this success is achieved? • How and to what extent will these be achieved by connecting the members of the population to be served to the targeted intervention?
4.	**Design the Intervention**	The planning group should work through the key components of designing the intervention including answering the following questions: • How will you address the need that you identified in your community? • How are the people who will be most impacted by this initiative leading and/or involved in this design process? What support do they need to meaningfully participate? • What are the key features of your initiative? What program needs to be put in place for your initiative to work? What specific policy needs to be developed or changed? • What partners do you need to collaborate with in order for your initiative to be successful? • What research, emerging evidence, or examples lead you to think that your initiative will achieve your desired impact?

5.	**Develop the Contracting Process and Structure**	As discussed throughout this brief, there are different PFS structures that can be used. Project stakeholders should consider:
		• How will the project be funded and contracted?
		• Will an outcomes-based contract be used?
		• Is there a desire to use a PFS financing structure that would bring in upfront working capital via third-party investors? Which investors would be interested?
		• How will providers be selected?
		  ▪ How will the process be fair, open, and transparent?
		  ▪ What factors will be considered?

6.	**Collaborate to Manage Performance**	• What stakeholders will be involved and with what frequency? • What capacity is needed to manage performance and conduct evaluation? • What support will be provided to service providers to achieve target outcomes?

Conclusion

PFS is a powerful strategy to implement or scale initiatives focused on meeting health and SDOH needs. As core providers of community-based healthcare, health centers are well positioned to play a critical role in catalyzing and supporting PFS efforts focused on building thriving communities. Such efforts can bring new collaborations and funding to invest in proven solutions that improve health for individuals and families. The process of developing a PFS initiative is also a valuable opportunity to elevate the voices of persons with lived expertise and to intentionally design solutions that will promote racial equity. Health centers should take the opportunity to convene multi-sector conversations and explore how PFS can be a tool to meet needs in their communities.

About CSH

CSH, the Corporation for Supportive Housing, is the national leader in supportive housing, focusing it on person-centered growth, recovery, and success that contributes to the health and wellbeing of the entire community. Our greatest asset is our team. From our Board of Directors to staff, we work every day to build healthier people and communities. Through our consulting, training, policy, and lending, we advance innovation and help create quality supportive housing. Our hub offices drive initiatives in 48 states and more than 300 communities, where CSH investments create thousands of homes and generate billions of dollars in economic activity.

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