ANCHORED HOME
PAY FOR SUCCESS
PERMANENT SUPPORTIVE HOUSING
PROJECT

MARCH 7, 2019
REDUCING RECIDIVISM & REENTRY CONFERENCE
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Engage Plan Implement AGNEW ::BECK

ALASKA'S UNIQUE CONTEXT- CRIMINAL JUSTICE

- HIGHEST VIOLENT CRIME RATE IN THE NATION AND VIOLENT CRIME RATES ARE AT A 10-YEAR HIGH
- VIOLENT CRIME RATE IS 2.6 TIMES HIGHER THAN THE RATE OF ARRESTS FOR VIOLENT CRIME
- 42% OF ALASKA INMATES HAVE MENTAL ILLNESSES, 20% WITH SERIOUS AND PERSISTENT MENTAL ILLNESS
- ALASKA HAS ONE OF THE HIGHEST PRETRIAL INCARCERATION RATES IN THE COUNTRY (OVER 300 PER 100,000 PEOPLE)
- ALASKA LACKS STATEWIDE EFFORTS TO PROVIDE LAW ENFORCEMENT TRAINING ON BEHAVIORAL HEALTH
- 63% OF PEOPLE RELEASED FROM ALASKA PRISONS ARE REINCARCERATED WITHIN THREE YEARS OF RELEASE

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ALASKA'S UNIQUE CONTEXT

- **Behavioral Health Workforce**
- Alaska has the most severe behavioral health workforce shortage in the nation, with 1,200 people for every behavioral health care provider
- **Medicaid**
- Alaska tops the nation in per person expenditures on adult Medicaid beneficiaries, 3rd highest for people with disabilities, and 2nd for all beneficiaries

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CHALLENGES AND OPPORTUNITIES

- Law enforcement capacity stretched thin with responding to behavioral health and social challenges (e.g. homelessness)
- Alaska prison over-represented with pretrial detainees, recidivists, people with mental illnesses and co-occurring disorders
- Health care delivery and spending oriented towards acute care and hospitalizations rather than prevention, behavioral health, and care management

- **Alaska has opportunities to make more efficient use of its public resources to increase public safety and improve public health.**

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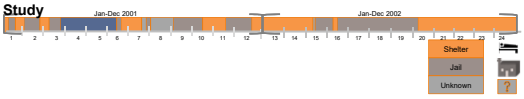
KEY STRATEGY: IDENTIFY AND PURSUE ALTERNATIVES FOR MULTI-SYSTEM INVOLVED PEOPLE

- There is a subset of individuals caught on a revolving door to multiple service systems and who consume a disproportionate amount of public resources.
- These individuals have complex health and social needs that exceed the capacity of any one system to address.
- Their experience brings to light areas of agency and policy fragmentation.

Frequent User Case Study



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PAY FOR SUCCESS PERMANENT SUPPORTIVE HOUSING PROJECT

An outcomes-based contract paid on the basis of improved housing stability, reduced justice involvement, and better health outcomes for the highly vulnerable multi system involved homeless – through a significant expansion of high-quality Permanent Supportive Housing

HUD/DOJ grant awarded	Feasibility study	Project design, contracting, and structuring	Implementation
$1.3 million Pay for Success Demonstration Grant *(November 2016)*	***Completed by Agnew::Beck*** *(May 2018)*	***Support from national experts Social Finance & Corporation for Supportive Housing*** *(summer 2018)* ***Engaging wide coalition of nonprofits, foundations, policymakers, community leaders, businesses, and researchers***	***Pilot to launch*** *(2019)* ***Pay for Success scale-up*** *(2020-2022)*

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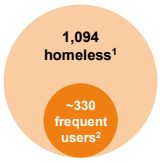
MULTI SYSTEM INVOLVED FREQUENT UTILIZERS IN ANCHORAGE



Approximately 1,100 people experience homelessness, and **an estimated 300-400 are adult "frequent users" of public services** who cycle in and out of jail, shelters, emergency rooms, and other intensive social services

Failing to meet their housing and service needs **creates dispersed costs** which fall upon cities, boroughs, state, and Federal government, local businesses, and the homeless themselves

Dispersed costs have created **roadblocks to collective action**, causing community stakeholders to manage, rather than solve, this complex issue

Cost of the status quo (per person, per year)[3]

Emergency Services	*Department of Corrections*	*Health Payors*	*Total*
$5,400 *Includes police, fire, Anchorage Safety Center*	**$8,277** *Includes cost of prison / recidivism*	**$33,243** *Includes emergency, inpatient, outpatient services*	**$47,413**

1. Anchorage HMIS, 2018 Point-In-Time Count. 2. Agnew::Beck, "Pay for Success Feasibility Study," May 2018. The target population includes individuals with 2+ releases from 9/2014-9/2017, and at least 1 within the most recent year; 3+ encounters with homeless services 1/2015-1/2018; and an estimated Vulnerability Index – Service Prioritization Decision Assistance Tool (Vi-SPDAT) of 9 or above. 3. Ibid.

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TARGET POPULATION IDENTIFICATION

- 2 or more releases from prison in the past 3 years, at least one in the past 12 months **AND**
- Meet definition of "chronically homeless" OR Homeless at least once in each of the last 3 years OR Homeless for at least 12 months cumulatively in the last three years **AND**
- History of high-cost utilization of crisis services (fire and police emergency services, emergency rooms, hospitals) OR Has significant health or behavioral health challenges

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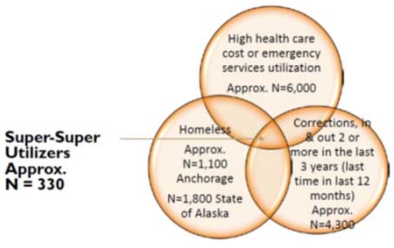
TARGET POPULATION



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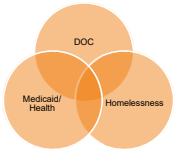
DATA SHARING AND INTEGRATION IS CRITICAL

Identify multi-system high utilizers



Develop and track outcome measures

Housing Stability & Health

Recidivism

Hospitalizations

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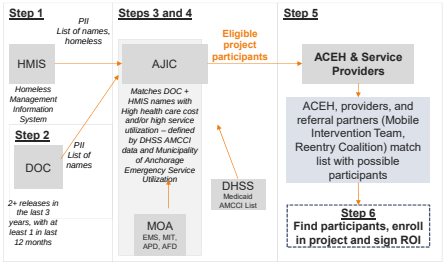
PROPOSED DATA INTEGRATION PROCESS TO ESTABLISH LIST OF ELIGIBLE PARTICIPANTS



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ADOPTING A MULTI-SYSTEM APPROACH FOR TARGET POPULATION ENGAGEMENT

- **Routinely screening for housing status in health and justice settings –** Use validated tool for assessing housing status within hospitals, prisons, LE contacts, Consider using ICD 10 Z59 codes
- **Data "flagging" –** Creating flags within shared data systems or across multiple data systems for target population members or sharing client lists with frequented locations and outreach teams
- **Police-homeless outreach teams** – Law enforcement agencies partner with homeless services providers to identify target population members
- **Prison/hospital in-reach** – Service providers engage target population members in prisons or hospitals prior to their release
- **Court liaisons –** Designating staff in courts to identify target population members and inform case review and adjudication

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SUPPORTIVE HOUSING: AN EVIDENCE-BASED INTERVENTION

- 85-90% of participants achieve **housing stability** and avoid returns to homelessness
- Improved **mental health** outcomes, **addiction recovery**, less use of opioids and hard drugs
- Improvements in **chronic health conditions**
- Fewer **emergency department visits** and inpatient **hospitalizations**
- Cost offsets in **Medicaid** and other publicly funded services
- Reductions in **recidivism** to jail and prison

Permanent: Not time limited; not transitional

Affordable: Tenants pay no more than 30% of their income for rent

Independent: Resident holds lease with normal rights and responsibilities

HOUSING

Targeted: Based on populations served

Flexible: Responsive to residents' needs

Voluntary: Sobriety is not a condition of residency

Housing First Model

Independent: Focus is on housing stability

SERVICES

PERMANENT SUPPORTIVE HOUSING RESULTS

"Study after study has shown that supportive housing not only resolves homelessness and increases housing stability, but also improves health and lowers public costs by reducing the use of publicly-funded crisis services, including shelters, hospitals, psychiatric centers, jails, and prisons."

"Supportive Housing." Homelessness Statistics by State | United States Interagency Council on Homelessness (USICH). August 15, 2018. Accessed September 13, 2018. https://www.usich.gov/solutions/housing/supportive-housing/.

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"THE CULHANE REPORT"

Change with PSH Intervention

Indicator	Change in Days per person per year	% Change	Change in Cost person per year	% Change
Inpatient Psychiatric Hospital	-28.2	-49%	-$6,162	-49%
Non-Medicaid Inpatient Hospital	-3.5	-21%	-$1,322	-21%
Medicaid Inpatient Hospital	-8.6	-24%	-$2,825	-24%
Outpatient Medicaid	47.2	76%	$1,983	76%
VA hospital	-1.9	-24%	-444	-24%

New York City, 1989 – 1974 679 people, "case-control" method
Homeless vs supportive housing
2 years before; + 2 years after

Source: Culhane, Dennis, Stephen Metraux and Trevor Hadley. "Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing." Housing Policy Debate (2002).

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"THE RAND REPORT"

Change with PSH Intervention

Indicator	Change in Days per person per year	% Change	Change in Cost person per year	% Change
Emergency Room	-1.38	-68%	-$1,636	-66%
Inpatient	-5.17	-77%	-$19,111	-76%
Outpatient	-2.7	-25%	-$1,611	-23%
Mental Health Inpatient	-0.01	-2%	-$2,369	-90%
Mental Health Outpatient	-1.83	-25%	-$343	-24%

Los Angeles, 2010 – 2015, 890 people
Pre-post Permanent Supportive Housing
1 year before, 1 year after

Source: Hunter, Sarah B., Melody Harvey, Brian Briscombe, and Matthew Cefalu, Evaluation of Housing for Health Permanent Supportive Housing Program. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR1694.html.

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FUSE (FREQUENT UTILIZER SERVICE ENHANCEMENT)- NYC

Change with PSH Intervention

Indicator	Change in Days per person per year	% Change	Change in Cost person per year	% Change
Incarcerated	-19.2	-40%	-$29,208	-76%

NYC
Pre-post Permanent Supportive Housing
2 years before, 2 years after

Source: Angela Aidala and colleagues. (2014) "Frequent User Service Enhancement II Evaluation Report." Columbia University

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"RETURNING HOME"- OHIO

Change with PSH Intervention

Indicator	Change in Days per person per year	% Change	Change in Cost person per year	% Change
Rearrested		-40%		
Reincarcerated		-60%		

Ohio
Quasi Experimental
244 people, "case-control" method
Homeless vs supportive housing

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DENVER

Change with PSH Intervention

Indicator	Change in Days per person per year	% Change	Change in Cost person per year	% Change
Emergency Room	-1.21	-34%	-$902.00	-34%
Inpatient	-4.37	-81%	-$3,422.50	-66%
Outpatient	0.05	1%	$446.95	51%

Denver, 2004 - 2008
19, pre/post intervention
Housing First + Assertive Community Treatment
2 years pre and post intervention

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

JUNEAU HOUSING FIRST STUDY

Change with PSH Intervention

Indicator	Change in Days per person per year	% Change	Change in Cost person per year	% Change
Emergency Room				-65%
Sleep Off Center				-99.4%
Juneau Police Calls				-72%

Juneau 2018
pre/post intervention
Housing First + Intensive Case Management
6 months pre and post intervention

Source: Brocious, Heidi and Morgan Erisman, Juneau Housing First 6 Month Pre/Post Service Utilization

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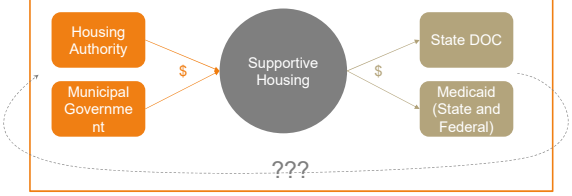
SUPPORTIVE HOUSING SUFFERS FROM THE "WRONG POCKETS PROBLEM"

- The "wrong pockets" problem is when one entity bears the costs of an intervention that results in other entities' benefits or savings:
  - Interagency
  - Intergovernmental
- Pay for Success Funding Model is designed to address this



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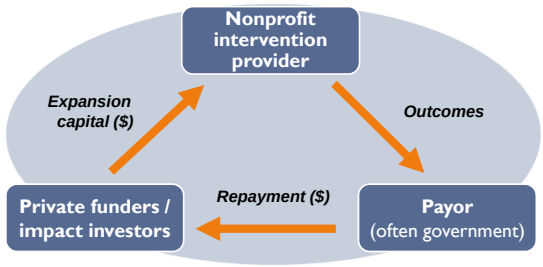
WHAT IS PAY FOR SUCCESS FINANCING?



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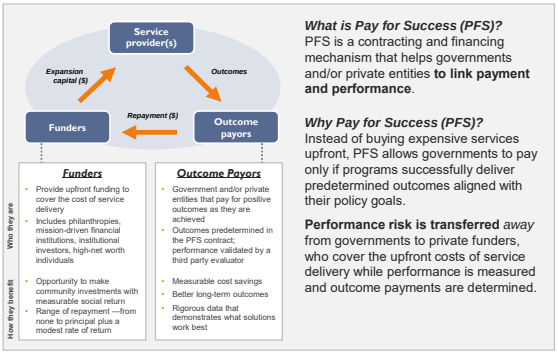
TO OVERCOME THE DISPERSED BENEFITS OF PSH, PAY FOR SUCCESS (PFS) OFFERS A MECHANISM TO POOL FUNDING AND TRANSFER RISK



What is Pay for Success (PFS)?
PFS is a contracting and financing mechanism that helps governments and/or private entities **to link payment and performance**.

Why Pay for Success (PFS)?
Instead of buying expensive services upfront, PFS allows governments to pay only if programs successfully deliver predetermined outcomes aligned with their policy goals.

Performance risk is transferred *away* from governments to private funders, who cover the upfront costs of service delivery while performance is measured and outcome payments are determined.

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WHY WOULD OUTCOME PAYORS CHOOSE A PFS APPROACH?

1. ***Pay for Success enables government to pay for what works—transferring the financial performance risk to upfront funders.***
   Human and social service programs **do not always work as well as we predict**.
   Although it is evidence-based, the effect of PSH **varies based on the local context.**
   Payors get **better value for their money through PFS** because they limit the downside if the intervention does not achieve the intended impact and maximize the value of that intervention if it does.
2. ***PFS helps overcome barriers to commitment, which is especially important for a complex issue like homelessness.***
   Funding is based on outcomes, so there **is mutual interest in and accountability for measuring outcomes** carefully.
   Roles, responsibilities, activities, and funding obligations are **defined in contracts**—so outcome payors are **deeply engaged in the consequences of changing priorities.**
3. ***At the end of PFS contracts, outcome payors have a very clear idea of what they got for their money.***
   If they achieved policy goals, they should **continue to fund the intervention directly**.
   If they did not, they can **re-purpose the money** they would have spent to **try a new approach.**

- 1. A 2007 meta-analysis of 5 RCTs found the effect size of PSH on the reduction in days homeless ranged from 30% to 65%. Dr. Craig Coldwell et al., "The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness: A Meta-Analysis," *Am J Psychiatry* 2007; 164:393–399.

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PROJECT TIMELINE

HUD/DOJ grant awarded December 2016

Phase 0 Project Development	Phase 1 PFS PSH Expansion	Phase 2 Sustainable PSH
2018-2019	*2019-2022*	*2023 and beyond*
✓ Pay for Success feasibility study PSH capacity-building PFS transaction structuring • Project design • Evaluation • Legal and contracting • Economic model • Financing and capital raise • Operations planning **Results: Executed PFS Agreement and completed capital raise**	**Year 1:** 45 PSH units **Year 2-4:** increase units as funding permits *Year 1: Philanthropic funding kick-starts PSH* *Years 2-4: PFS Funding Mechanism* • Funders provide upfront capital for PSH expansion and services • Outcome payors commit money to an outcome fund, make payments based on outcomes achieved	Outcomes payors will sustain the PSH units in Phase 2 to the extent that this intervention is successful in producing desired outcomes

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QUESTIONS?

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