Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Theresa Slusher, 360-725-4907, slushtm@dshs.wa.gov* *Organizations Involved: DSHS's Economic Services Administration, Behavioral Health Administration and the Department of Commerce*
Project Title	*Supported Employment and Supportive Housing Infrastructure and Capacity Building – Vulnerable Families, Vulnerable Adults and Opportunity Youth*

Rationale for the Project

Problem statement – why this project is needed.

Vulnerable Families - A cohort of our state's most vulnerable families are leaving the TANF program because of the 60-month program time limit without having obtained employment and/or Social Security Disability income. It is estimated that sixty-four (64) percent of time-limited leavers had a mental illness, 25 percent had an alcohol/drug treatment need, and 23 percent had chronic illness risk scores on par with those of individuals receiving SSI.[i] DSHS ESA, BHA and Building Changes are piloting a Supported Employment (SE) program for TANF-assisted families in Snohomish and Skagit counties. After nine months, the pilot has been successful at supporting 43 out of 99 families in obtaining employment. The SE Pilot partners are already finding the intervention to be highly effective at getting families with behavioral health and substance abuse challenges placed and connected to unsubsidized employed.

Opportunity Youth - Among youth served by DSHS between 2000 and 2012 in South Seattle alone, nearly 8,000 (n=7,769) met the definition of "Opportunity Youth" – 16-24 year olds living in Washington who were neither working nor attending a public school. Based on this we estimate the 2000-2012 statewide population to be at least 16,000 meeting this definition. Opportunity Youth are associated with a number of risk factors. About 1 out of 3 Opportunity Youth have experienced homelessness. A sizable share of Opportunity Youth who have graduated may be out of work or school because of disabilities. Many Opportunity Youth are parents, and a sizable portion of male Opportunity Youth have been incarcerated. Among Opportunity Youth who have dropped out of high school, nearly 1 in 3 have a history of substance abuse disorder, homeless history, have had contact with child welfare, or received Temporary Assistance for Needing Families. Opportunity Youth have experienced more challenges and face more barriers than non-Opportunity Youth graduates.

ABD & HEN Referral Participants – ABD recipients are low-income adults who are age 65 or older, blind, or determined likely to meet federal Supplemental Security Income (SSI) disability criteria. The average monthly ABD program caseload in SFY 2015 was 21,904. The average ABD recipient is approximately 50 years old, male, non-Hispanic white, and never married. Nearly half (48.8%) of all ABD recipients reported mental health related condition(s) as their primary disability. Nearly a third (31.8%) of the total ABD population self-identified as homeless or experiencing housing instability.

HEN Referral recipients are low-income adults who are determined unable to work for at least 90 days due to a physical or mental incapacity and are ineligible for the ABD program. While all HEN Referral recipients are eligible for essential needs items (e.g. toiletries, personal hygiene items), the Department of Commerce determines eligibility for HEN housing assistance through its network of local providers.

In SFY 2015, the HEN Referral program served a monthly average of 8,681 clients. The average HEN Referral recipient is approximately 41 years old, male, non-Hispanic white, and never married. The majority of HEN Referral recipients (65.7%) reported mental health related condition(s) as their primary incapacity. Nearly half of the total population (40.5%) self-identified as homeless or experiencing housing instability.

DSHS understands the impact that Supported Employment (SE) and Supportive Housing (SH) has for vulnerable families, disabled adults and disconnected youth. DSHS would like to ensure that SE and SH are available statewide with the implementation of the Medicaid Demonstration project.

Without engagement, training and creating administrative linkages within the existing systems of care (e.g. DSHS, Commerce, RSAs, BHOs, MCOs, Housing Authorities and Homeless Systems) SE and SH are not likely to be accessible to the most vulnerable in Washington State by Year One of the Demonstration period. DSHS is in good position to ensure that the infrastructure is in place and accessible to vulnerable families, HEN and ABD adults and disconnected youth in Year One of the Medicaid Demonstration period.

Supporting research (evidence-based and promising practices) for the value of the proposed project.

- Individuals receiving supported employment services use fewer health care services and have fewer costly hospitalizations.

A major national study funded by the Social Security Administration, the Mental Health Treatment Study, estimated that expanding supported employment services to cover 14 percent of people receiving SSI or SSDI due to a psychiatric impairment—or approximately 306,000 people—could result in a savings of $550 million per year.[ii] The average savings due to reductions in hospital use alone was approximately $1,800 per year per person.[iii]
Similar results were demonstrated in a review of data for individuals receiving supported employment in New Hampshire. Over ten years, the average annual cost for an individual receiving supported employment was approximately $16,600 less than the cost of serving individuals who did not receive supported employment and worked minimally.[iv] The authors concluded that this cost reduction was "certainly enough to justify offering supported employment to all persons who use high levels of services and express interest in working."[v]

- Work plays a critical role in improving quality of life and mental health outcomes.[vi]

SE is not only highly successful in getting people with serious mental illness into work, but also results in better clinical and social outcomes. Work helps people with serious mental illnesses become part of the community and helps build an individual's sense of purpose, self-esteem, and self-worth.[vii] Given the importance of work, it is not surprising that SE has been shown to reduce symptoms of a person's mental illness,[viii] and reduce the need for other services.[ix]

- Stable, supportive housing is a platform for health, especially for those with mental illness.

The Corporation for Supportive Housing has compiled evidence to show that supportive housing has positive effects on housing stability, employment, mental and physical health, and school attendancex. Studies in six different states and cities found that supportive housing results in tenants' decreased use of homeless shelters, hospitals, emergency rooms, jails and prisons.xi

Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.

- **Increase and strengthen coverage of low income individuals.**

This project will meet this federal objective by creating more access to stable employment and stable housing for vulnerable families, disabled adults and disconnected youth. Both of these programs address domains that top the list of the Social Determinants of Health. Families who either do not qualify for TANF or have already reached their 60-month time limit could benefit from safety net programs like these. Those with mental illness and substance abuse issues, it may be the last stop to homelessness and a total disconnect from other safety net programs like primary health and mental health care. Families, disabled adults and disconnected youth approaching DSHS Community Services Offices for basic food can be reengaged and referred to Supported Employment and Supportive Housing appropriate for those with complex behavioral health needs.

- **Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.**

Employment and stable housing create a platform for better health. This infrastructure building project is aimed at strengthening the safety net by connecting systems to offer coordinated access, enrollment and support in

maintaining SE and SH for vulnerable families, disabled adults and disconnected youth. SE and SH programs are evidence-based best practices important to make available to vulnerable households experiencing behavioral health and/or substance use challenges.

This federal objective for Medicaid can best be achieved by helping ACHs weave together the systems of care to be able to administratively deliver SE and SH benefits targeted to the most vulnerable in the state. DSHS is in a good position to perform this infrastructure-building work. With over 30,000 households on TANF and 1 million people on food assistance, DSHS's Economic Services Administration makes sense as a convener of this effort to strengthen networks available to serve Medicaid and low-income populations.

Effective networks require program development, case management protocols, eligibility guidelines, technology and data systems development and program measures and evaluation standards. The SE services will require trained clinical behavioral health staff at Behavioral Health Organizations (BHOs) across the state. DSHS will coordinate with BHA to ensure the training is made available statewide as a way to build capacity for Supported Employment. DSHS will also coordinate with the Department of Commerce, its statewide grantees, Housing Authorities and BHOs to let them know of our client population in need of SE and SH, create capacity for housing providers to utilize Medicaid and invite them to partner in the access, referral and coordination of our related systems of care. Housing Authorities and Homeless Systems providers are not typically Medicaid licensed providers and will need to build that capacity or form partnership with providers that do. This will allow housing providers to provide supportive services to those with serious mental illness and substance abuse, those they normally would screen out for lack of capacity to work with those with serious needs. Throughout the project, DSHS proposes to engage, inform and provide updates to the Accountable Communities of Health.

- **Improve health outcomes for Medicaid and low-income populations.**

As stated before, because of the public savings associated, a national study recommended "*offering supported employment to all persons who use high levels of services and express interest in working.*" Employment and housing are a platform for better health. This infrastructure building project is aimed at strengthening the safety net by connecting systems to offer coordinated access to SE and SH for vulnerable families, HEN and ABD adults and disconnected youth.

- **Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.**

Having SE delivered as a partnership between DSHS CSOs, BHOs and housing transforms service delivery networks in a way that allows greater access to effective services by creating multiple front doors and accomplishes goals of both systems which include addressing mental health and substance use through an employment lens. This allows behavioral health care, social services, basic needs provision and employment services to be integrated and delivered in a manner that is mindful of the whole person.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- ☐ Accelerate transition to value-based payment
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

- ✓ Health Systems Capacity Building
- ✓ Care Delivery Redesign
- ✓ Population Health Improvement – prevention activities

Describe:

- ***Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g.,***

persons discharged from local jail facilities with serious mental illness and or substance use disorders).

All Regions in the state would be impacted by this project and the target populations are 1) adults in families applying for or already receiving benefits from DSHS Community Service Offices across the state that have a mental health diagnosis and/or substance abuse issue, 2) adults with a disability or chronic, severe medical condition, and 3) disconnected youth.

- ***Relationship to Washington's Medicaid Transformation goals.***

Evidence shows that employment and stable housing promote health and result in the use of fewer health care services and costly hospitalizations. Providing a means for those with mental health and substance abuse issues to find and maintain employment and stable housing will yield savings in the short-term and in the long-term, thus impacting the Medicaid Transformation goals of reducing avoidable use of intensive services and in preventing the deterioration of mental health, addiction and physical health conditions.

Redesigning care delivery on a statewide level is a big task. This project will redesign access to employment (earned income) for a particularly vulnerable group of individuals with multiple barriers and access to housing, and be coordinated with respect for the whole person and their need to also be mentally and physically cared for. SE and SH both operate on the philosophy that when housing and meaningful work come first, health and mental wellness will follow. DSHS proposes that this whole-person and whole family approach will transform systems of care and transform lives.

- ***Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.***

The goals of this project would be to develop system infrastructure to support the expansion of a SE Pilot statewide and to work with Commerce to build capacity for SH statewide. The current SE pilot has a placement rate of 43% after nine months of operation.[xii] Given that the target population includes TANF parents with severe mental health and/or substance abuse issues, 43% placement rate is considered to be a highly successful outcome. To the goal of improving health equity and reducing health disparities, engaging families with mental health and substance abuse issues in supported employment reduces isolation and improves the symptoms of their conditions that left untreated are exacerbated. These unique Supported Employment Programs that integrate clinical behavioral health create opportunities to address mental health and substance abuse issues in the context of finding and maintaining work. Without Supported Employment, those who can find and maintain employment and navigate healthcare systems without assistance get better and those who are unable to get worse.

Supportive Housing offers stability to people with severe mental illness and/or substance abuse and provides a platform for regular primary and behavioral health care, reducing the use of expensive hospital, emergency room and inpatient services. Housing creates opportunities and support to access primary and preventative care, reducing health inequities and disparities.

- ***Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.***

This project links to Initiative 3 which addresses Supported Employment and Supportive Housing. This proposal is to provide the critical infrastructure improvements and coordination necessary to be ready to deliver the SE and SH benefits in Year One of the Medicaid Demonstration period.

- ***Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.***

Project partners include DSHS ESA, DSHS BHA, Commerce, ACHs, RSAs, BHOs, MCOs, Housing Authorities, Homeless Systems. Other potential partners depending on target population would include public schools, law enforcement and youth organizations. Certainly when SE and SH programs are ready to launch, employers, property owners and rental managers become key partners to engage.

Core Investment Components

Describe:

- ***Proposed activities and cost estimates ("order of magnitude") for the project.***

Within DSHS, ESA:
Program Development to include: analysis to prepare request legislation to create regulatory framework and IT changes as needed, outreach and engagement to ACHs, outreach, engagement and training RSAs, MCOs, BHOs, Housing Authorities and Homeless Systems which will lead to the development contractual relationships or MOUS, develop case management protocols and procedures, develop program eligibility, IT, program evaluation, and other activities.

Order of magnitude would be the equivalent of 1 FTE.

- ***Best estimate (or ballpark if unknown) for:***
  - **How many people you expect to serve, on a monthly or annual basis, when fully implemented.**

Vulnerable Families
The TANF Leavers study identified over a two-year period, an ***average*** of:
169 adults leaving per month with a mental illness
67 adults leaving per month with alcohol or drug treatment needs
61 adults leaving per month with a probable chronic illness
The homeless rate was 20% for time-limited Leavers in the study.

Adults Receiving HEN and ABD
Average monthly ABD caseload in FY 2015 was 21,904. In a snapshot for the month of June 2015, 48% have a mental disability.
Average monthly HEN caseload in FY 2015 was 8,681 clients. In the month of June 65.7% have a mental disability.

Opportunity Youth
Among youth served by DSHS between 2000 and 2012 in South Seattle alone, nearly 8,000 (n=7,769) met the definition of "Opportunity Youth" – 16-24 year olds living in Washington who were neither working nor attending a public school. Based on this we estimate the 2000-2012 statewide population to be at least 16,000 meeting this definition.

TANF caseload with Teen (16, 17, 18 years of age) Head of Household 642 monthly average per year.

  - **How much you expect the program to cost per person served, on a monthly or annual basis.**

The costs for the SE Pilot are about $3,400 per placement into a job. Many more are served than get placement and need retention support, so the cost is averaged out over those who drop out of the program as well. These costs are only the costs associated with the BHO. Developing a statewide program and partnership among BHOs, DSHS CSOs, MCOs, Housing Authorities and homeless providers will likely mean additional costs that may or may not be Medicaid eligible, requiring other additional resources to implement.
Supported Housing costs are projected to be $600 per the HCA Medicaid Waiver application.
SE and SH expenditures from Medicaid Demonstration funding would leverage around $700 per month in rental assistance and an average of $511 per month in basic food and $521 cash assistance.

- ***How long it will take to fully implement the project within a region where you expect it will have to be phased in.***

Once infrastructure investments have been made and implemented, implementing the delivery of new SE programs in every Region of the state are expected to take three to six months in Year One of the Medicaid Demonstration period.

- ***The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI***

timeline.

Studies have been cited in this proposal that have demonstrated ROI by providing SE and SH to high-utilizers of Medicaid services. The SE Pilot which began in April of 2015 includes and RDA component that might be able to include a Medicaid ROI analysis.

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Wherever possible describe:

- ***Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application http://www.hca.wa.gov/hw/Documents/waiverappl.pdf pages 46-47.***

Employment measures are being tracked for mental health consumers through the 1519/5732 performance measure work. A performance baseline was identified, but a new baseline can be established for the Medicaid Demonstration period that would be appropriate for supported employment in particular.

Similar measures are likely to be available and established for housing stability and/or incidence of homelessness as well. The statewide annual Point-in-Time Homeless Count provides a one day count of those who meet the chronically homeless definition.

***If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?**

See above. This proposal includes data analysis to establish a baseline as part of the project.

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[i] TANF Caseload Decline, The Well-Being of Parents and Children Leaving WorkFirst in WA State (April 2015)

[ii] WILLIAM D. FREY ET AL., WESTAT, MENTAL HEALTH TREATMENT STUDY, FINAL REPORT EX-11 (July 2011).

[iii] Id. at EX-10, 8-13.

[iv] Id.

[v] Id.

[vi] Sandra Moll et al., *Supported Employment: Evidence for a Best Practice Model in Psychosocial Rehabilitation*, 70 Canadian Journal of Occupational Therapy 298, 298 (Dec. 2003).

[vii] Campbell, supra note 9, at 373-75.

[viii] *Id. See also* Morris D. Bell et al., *Clinical Benefits of Paid Work in Schizophreni*a, 22 Schizophrenia Bulletin 57 (1996) and Laura Blankertz and Susan Robinson*, Adding a Vocational Focus to Mental Health Rehabilitation*, 47 Psychiatric Services 1216 (1996).

[ix] Campbell, supra note 9, at 373-75.

[x] http://www.csh.org/supportive-housing-facts/evidence/#sthash.QbfHDf7t.dpuf

[xi] http://www.csh.org/supportive-housing-facts/evidence/#sthash.QbfHDf7t.dpuf

[xii] Snohomish and Skagit counties SE Pilot data through December 2015.