Improving outcomes for veterans

Feasibility study

Assessing Pay For Success opportunities







Report by Bank of America in partnership with Social Finance

The United States is home to roughly 22 million military veterans: more than 200,000 service members have left the military each year since 2008, and experts project that this figure could increase to as many as 300,000 annually over the next five years. A significant number of these new veterans face unique health, housing and employment challenges that prevent them from productively transitioning to civilian life.

Today, there are many organizations providing services across the country, but too often the most effective programs lack adequate funding. These high-impact service providers need greater and more reliable funding to expand successful programs that can measurably improve the lives of veterans.

Government agencies at the local, state and federal levels also face resource constraints. As a result, they are forced to make difficult decisions about funding programs, often without the benefit of a clear understanding of which programs are most effective. Pay for Success (PFS) programs, sometimes referred to as Social Impact Bonds (SIBs), are a potential source for greater resources. PFS programs provide a funding mechanism through which private and institutional investors can support high-quality service providers with a proven track record and at the same time help drive government resources toward programs that measurably improve the lives of veterans.

Through this first-of-its-kind feasibility study, we have assessed the viability of using PFS financing to expand evidence-based services for veterans in the areas of employment, wellness and housing. This report represents more than 80 interviews with leaders across multiple sectors (military, finance, government, academia, nonprofits and philanthropy) and the screening of more than 70 veteran-serving organizations.

PFS financing represents a unique solution, creating an uncommon partnership in pursuit of common goals. There is great potential for government, nonprofit organizations and private investors to come together to rapidly expand access to effective programs. The report identifies eight promising PFS initiatives, three of which have the potential to be acted upon in the near term. We hope that this new research will generate conversations that lead to action in order to better serve the needs of veterans who have served our nation.

"Through this first-ofits-kind feasibility study, we've assessed the viability of using PFS financing to expand evidence-based services for veterans in the areas of employment, wellness and housing."

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Preface

In May 2014, Social Finance and Bank of America partnered to identify potential Pay For Success (PFS) projects to serve veterans. Social Finance conducted the study with the support and participation of Bank of America. This report represents more than 80 interviews with leaders across multiple sectors (military, finance, government, academia, nonprofits and philanthropy) and the screening of more than 70 veteran-serving organizations. Social Finance also performed the analysis and produced findings and recommendations outlined in this document. We thank these contributors for their generosity and insights (see the Acknowledgements section for a complete list).

The study focused on identifying the programs most ready to scale up via PFS-type funding. Therefore, this report does not represent a comprehensive analysis of veteran service organizations or provide information on all the services considered.

While our work cannot fill this broader need, we hope that by highlighting intervention programs with a strong track record of impact, we can spur a conversation about how to better serve the veterans who have faithfully served our nation.

"we hope that ... we can spur a conversation about how to better serve the veterans who have faithfully served our nation."





Executive summary

Needs of the veteran community

As the public cost of serving veterans rises, more demand is being placed on both government and nonprofit organizations to help veterans and their families live happier and more connected lives.

This has also led to the formation of smaller organizations — without the resources to track what works or the benefit of historical evidence that larger service providers have available — adding to an already fragmented market of services. There is a need to develop greater capacity within these organizations and create collaboration among effective programs.

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A potential solution

Pay For Success (PFS) and Social Impact Bonds (SIBs)¹ offer a solution to mobilizing capital to expand the operations of evidence-based programs. Through PFS, private and institutional investors provide multi-year funding to growth-ready nonprofits operating cost-effective programs that have demonstrated the potential to improve the lives of veterans. If a PFS-financed program achieves successful outcomes, which are defined and agreed upon clearly in advance by all parties to the contract, government repays investors their principal plus a rate of return. If outcomes are not achieved, on the other hand, government is not obligated to repay investors, who are subject to a partial or complete loss of principal.

Key success factors

Bank of America engaged Social Finance to assess the viability of using PFS to expand evidence-based services for veterans in the areas of employment, wellness and housing, by analyzing five key factors: target veteran population, programs and evidence, service providers, economics and metrics, and outcomes for payors.

Through interviews, academic research review and data analytics, Social Finance developed a list of potential PFS initiatives. These initiatives were assessed for PFS readiness and narrowed to three options with the highest potential. These options are outlined in detail in the pages that follow. Summaries of other promising initiatives and recommendations for next steps are also included for field building purposes.

Findings: three promising options

Option 1 Employment and wellness services – Individualized Placement and Support (IPS)

Veterans between the ages of 18 to 34 experience unemployment rates higher than the civilian unemployment rates for the same age groups.² A PFS project could provide Individualized Placement and Support (IPS) to veterans between the ages of 18 and 40, who are unemployed and have a mental health diagnosis (such as depression, Post Traumatic Stress or PTS). PFS can facilitate the scale-up of an evidence-based model focused on rapid employment and mental health support.

Option 2 Chronic disease management – Transitional Care Model (TCM)

The fastest growing segment of healthcare spending for veterans comes from those with four or more chronic diseases, including diabetes, chronic obstructive pulmonary disease, heart conditions, renal failure, dementia and stroke.³ A PFS demonstration project could provide home-based transitional care to prevent hospital readmissions for veterans over the age of 65 diagnosed with one or more chronic diseases. A demonstration will help to build a robust evidence base of improving health outcomes for veterans, to support scale-up via PFS.

Option 3 Housing support for female veterans/transitional housing – Permanent Supportive Housing (PSH)

Female veterans represent a high percentage of the homeless population, and are becoming homeless in increasing rates, even as overall veteran homelessness is decreasing. Current estimates of female veteran homelessness range from approximately 4,000 to 11,000.4 A PFS initiative could develop and test a regional hub concept to drastically reduce or eradicate homelessness for female veterans not currently served by VA programming, including those with dependents and those diagnosed with military sexual trauma (MST) or suffering domestic violence.

Conclusion

We have identified three strong opportunities where PFS could play a role in the near term in scaling up effective programs for veterans, and we are excited by the potential for government, veteran-serving organizations and private-impact investors to come together to expand effective veteran programs and evidence base in wellness, employment and housing.



Pay For Success feasibility assessment

Benefits to veterans, government and investors

What is PFS?

Pay For Success (PFS) is an innovative financing mechanism designed to raise private-sector capital to expand effective social service programs. Social Impact Bonds (SIBs) are a way to finance Pay For Success contracts, which allow government to pay only for results. If a program funded through PFS achieves successful outcomes, which are defined and agreed upon in advance by all parties to the contract, government repays investors their principal plus a rate of return based on the program's success. If outcomes are not achieved, on the other hand, government is not obligated to repay investors.

PFS is one tool within the wider impact-investing market, which offers the potential to draw large sums of private capital to the effort of solving complex social problems. By leveraging a new source of capital to fund social services, impact-investing tools like PFS provide an opportunity to accelerate progress on longstanding issues by scaling up effective programs to reach many more people in need than would be possible through grant or government dollars alone.



PFS has the potential to curtail substantial public-sector spending and transform how governments allocate scarce taxpayer dollars while increasing veterans' capacity to maintain employment, housing and a healthy lifestyle. By facilitating positive transitions for returning service members, for instance, PFS may reduce expenses incurred by the VA as well as Medicaid, TRICARE, unemployment and general public assistance. Similarly, preventing veteran homelessness may create cost savings from both reduced reliance on public homeless shelters and better health outcomes. Specifically, PFS can:

- encourage public policy decisions that reallocate funding to programs that work and foster data-driven decision making because of their emphasis on metrics and outcomes assessment,
- direct funds to programs with demonstrable track records, relying on rigorous evaluation to determine investor payments and incorporate performance management over the life of the investment,
- support prevention and early intervention programs for veterans that present a robust economic proposition,
- provide a way to bridge the timing and financing gaps between the costs of required interventions and realized benefits.





Assessment methodology

The project team explored the viability of multiple potential projects by analyzing five key dimensions:

- Population segmentation Analysis of the veteran population across workforce development, wellness and housing issue areas and identification of specific subpopulations with definable needs substantially greater than baseline population outcomes.
- Program and evidence assessment Exploration of programs
 currently available to these subpopulations and assessment of the need
 for additional services. Review of studies and formal program evaluations
 of programs to assess efficacy (such as randomized control trials.)
- Provider and geographic review Qualitative screening of leading service providers delivering select evidence-based programs, including initial review of: data collection practices, operational capacity to expand to new geographies with high concentrated need and ability and interest in participating in a PFS financing.
- Economic analysis and metrics definition Calculation of the costs of an intervention per individual and comparison to its associated short- and long-term benefits (cost savings and other societal benefits). Construction of a preliminary financial model to assess whether SIB financing might be financially viable based on appropriate outcome metrics.
- Payor assessment Identification of potential payors of outcomes based on savings accrual to specific agencies or institutions.

The feasibility study drew on interviews with more than 80 stakeholders in the field and screenings of more than 70 organizations for their potential fit with a PFS project. From an initial list of twenty potential initiatives, eight were identified as promising based on SIB criteria—and three were identified as potentially PFS-ready. These are outlined in detail on the following pages.

For other promising initiatives which are not yet PFS-ready, we have included brief summaries as well as our recommendations for how other actors in the veterans space might engage to move them forward. For these initiatives, philanthropic support could: build capacity and evidence at both the service provider and field levels to prove the efficacy of programs for veterans; support organizations providing services that create hard-to-measure or longer term outcomes for veterans; and build a national coordinated service provider network.

Key findings

Opportunity 1: Employment and wellness services

Unemployment is a costly and difficult problem among a subset of veterans. The average unemployment rate for veterans of the Iraq and Afghanistan wars in 2013 was 9.0% (versus 7.2% in the US overall).⁵ Additionally, age is a significant factor in determining the employment outcomes of this population: veterans between the ages of 18 to 24 and 25 to 34 experience unemployment rates significantly higher than the civilian unemployment rates for those age groups⁶ (Table 1).⁷ While some of these differences are the result of utilization of the GI Bill, a RAND report concluded that younger veterans are positioned to be excellent employees and contributors to the workforce — but that recent separation from employment (exiting the military) requires specific education and support while they search for new employment.⁸

Table 1

Veteran and non-veteran unemployment rates by age group					
Age	Total population	Veteran unemployment rate	Non-veteran unemployment rate	Difference (veteran – non-veteran)	
18 to 24 years	215,000	21.4%	14.3%	7.1%	
25 to 34 years	1,750,000	9.1%	7.3%	1.8%	
35 to 44 years	2,344,000	6.0%	5.9%	0.1%	
45 to 54 years	3,407,000	5.6%	5.6%	0.0%	
55 to 64 years	4,367,000	6.4%	5.2%	1.2%	
65 years and over	9,315,000	5.9%	5.1%	0.8%	

Note: Unemployment rate by 2013 annual average

Finding jobs for transitioning veterans is especially important because persistent unemployment is often linked to negative health conditions, including depression, which exacerbate pre-existing mental health conditions. A 2013 Gallup poll found that unemployed Americans were nearly twice as likely to be treated for depression compared to the general public.⁹



Supporting both employment and wellness services is a promising PFS opportunity for unemployed veterans with a mental health diagnosis. Individualized Placement and Support (IPS), a program that delivers rapid employment services and wrap-around therapeutic support, is supported by proven evidence of success, including a randomized control trial with veterans. In addition, outcomes generated by the IPS program directly link to government savings (such as lower unemployment payments) as well as societal value (such as better employment rates). IPS has successfully been implemented at scale in the civilian population, and given the recent success treating veterans, a network of VA Medical Centers and VA Community Outpatient Clinics have expressed interest in offering the program.

Target population: A specific population with a significant need is post-9/11 veterans between the ages of 18 and 40, with a discharge rank of E4 to E7, who are both unemployed and have a mental health diagnosis. Service members between the ranks of E4 and E7 represent 55% of active duty discharges between 1990 and 2013 (Table 2)¹⁰; these veterans tend to face significant barriers upon transition to civilian life, but possess a high school diploma or equivalent certificate and typically have developed a professional skill that could be translated to the civilian economy.

Table 2

Active military separations by military grade (1990 – 2013)					
Military grade	Military separations	Percent of all military separations E0 – E9			
EO	8,450	<1%			
E1	721,833	12%			
E2	438,323	7%			
E3	712,684	12%			
E4	1,613,857	27%			
E5	870,015	15%			
E6	447,415	8%			
E7	318,429	5%			
E8	125,800	2%			
E9	51,570	1%			
Total E4 – E7	3,249,716	55%			
Total all military grades	5,910,380	100%			

IPS has a proven evidence base serving civilians with serious mental illness (such as bi-polar disorder, schizophrenia or major depressive diagnosis). The program shows statistically significant impact across age, race, gender and geography. While IPS could be effective for a broad population of veterans, a focus on unemployed post-9/11 veterans suffering from PTS may yield the greatest impact. Studies with veterans suggest that individuals with PTS may have a stronger recovery trajectory and employment outcomes than individuals with other diagnoses. Moreover, the VA estimates that PTS is the third most common service-related disability for veterans receiving compensation, with more than 150,000 veterans seeking treatment at the VA each year. 12

Program: IPS is a supported employment model for individuals with severe and persistent mental illnesses based on eight core principles:

- Focus on competitive employment, meaning permanent jobs in the open market rather than transitional or 'sheltered' work
- 2 Open eligibility to all clients regardless of mental diagnosis
- Integration of mental health and employment services, for example out-patient clinical visits
- 4 Attention to client needs
- 5 Personalized counseling
- 6 Rapid job search
- 7 Individualized job development
- 8 Unlimited and ongoing support

"... individuals with PTS may have a stronger recovery trajectory and employment outcomes than individuals with other diagnoses."



"An RCT study showed that IPS participants were significantly more likely to gain competitive employment ..." The IPS Specialist is at the heart of the IPS program. The IPS Specialist is responsible for up to 25 participants at any given time, and his or her duties include: evaluation of mental health and professional interest, rapid job search, time-unlimited case management and follow-along support, community network building, job opportunity identification, rehabilitation team communication and supervision, ongoing professional development for case managers and veterans and feedback sessions focused on implementation and fidelity to implementing agencies.¹³ At the national level, among other support tools, IPS trainers provide: on-site visits, online training, face-to-face workshops at the Dartmouth IPS Supported Employment Center and bi-monthly calls with state leaders, trainers and IPS team leaders. Each IPS site is evaluated on a 125-point fidelity scale that assesses: Staffing (caseload size, employment specialists, and vocational generalists); Organizational Qualities (collaboration between employment specialist and mental health specialists; execution of zero exclusion criteria, and focus on competitive employment); and Services (individualized job searches, diversity of employers and job types, and ongoing work-based assessments).14

Evidence: IPS has been evaluated with 22 randomized control trials (RCTs) for the non-veteran population, which showed statistically significant impacts on both employment and wellness outcomes for those with mental health diagnoses, including schizophrenia, bi-polar disorder and major depression. Additional studies on unemployed veterans with PTS have had similarly impressive results. An RCT conducted between 2006 and 2010 at the Tuscaloosa VA Medical Center on veterans with a mental health diagnosis showed that IPS participants were significantly more likely to gain competitive employment than the control group — those receiving the VA's traditional Vocational Rehabilitation services. 15 While only 28% of those receiving traditional VA services were employed 12 months after the start of treatment, 76% of those in the IPS treatment group were employed. The IPS group also earned \$6,600 more in annual income. Both outcomes were statistically significant at the highest levels (a p-value of less than .001).16 Another RCT is in progress with 500 veterans across 12 VA Medical Sites; enrollment began in January 2014 and service provision will last for one year, with 18 months of follow-up observation.¹⁷



Economics: Savings generated by IPS can be evaluated on 3 metrics: utilization of unemployment benefits, reduced usage of healthcare services and public sector benefit through increased earnings. The IPS RCT with veterans at the Tuscaloosa VA Medical Center established outcomes relevant to unemployment benefits and increased earnings. The reduction in healthcare services is supported by two studies with civilians showing health care savings over one- and five-year timeframes.^{18, 19}

Estimates of economic impact based on unemployment benefit savings and one-year health savings indicate a Return on Investment (ROI) 20 of 1.6. Including greater tax revenues from increased lifetime earnings 21 and five-year healthcare savings 22 increases the ROI to more than 4.

Payor: The primary outcomes studied for IPS focus on time to and duration of competitive employment. These employment outcomes generate savings to government in three ways. First, by decreasing the time for which one is eligible for, and reliant on, unemployment benefits, agencies realize deferred costs. Specifically for veteran services: Unemployment Compensation for Ex-servicemembers (UCX) is an unemployment insurance program administered by state governments and reimbursed by the Department of Defense. Reduced benefits distributed via this vehicle could generate savings for the Department of Defense.²³ Second, because IPS has been linked to reduced healthcare utilization (over one year and over five years), a lessened burden of health provision via agencies that serve veterans—the VHA operated by the VA for veteran service members, and TRICARE operated by the Department of Defense for retired service members and their families—could serve as a source of savings. Finally, in the long-term, veterans receiving IPS services are likely to generate increased tax revenue from enhanced lifetime earnings generating greater economic return to State governments.





Opportunity 2: Chronic disease management

Serving individuals with chronic disease is a growing burden on society. According to the Robert Wood Johnson Foundation, in 2010, 84% of healthcare spending in the United States was associated with individuals with chronic conditions.²⁴ The one-third of Medicaid beneficiaries without multiple conditions generated Medicare costs of approximately \$20 billion; beneficiaries with at least six chronic conditions had Medicare costs of more than \$140 billion.²⁵

Research on the veteran population indicates that aging veterans are no exception to the rising expenditures associated with chronic disease. The fastest growing segment of healthcare spending for veterans between 2000 and 2008 came from expenditures supporting individuals diagnosed with four or more chronic diseases, including: diabetes, chronic obstructive pulmonary disease, heart conditions, renal failure, dementia and stroke. The veterans studied contributed to a more than 40% increase in annual spending.²⁶

Due to high treatment costs, preventing costly clinical care for veterans with chronic disease is a potentially investment-ready option. The Transitional Care Model (TCM) has a strong evidence base and appears to generate robust cost avoidance by preventing hospital readmissions after an inpatient stay.





Target population: E0 – E9 pre-9/11 veterans over the age of 65, diagnosed with chronic disease. The Veteran's Health Administration (VHA) estimates that the number of veterans aged 85 and older tripled between 2007 and 2011.²⁷ According to the US Census Bureau, the veteran population will increase from 33% to 57% of all Americans over the age of 85 between 2000 and 2020.²⁸

Program: Community based strategies for managing chronic disease have been shown to reduce hospitalizations and days in care — both costly drivers of healthcare expenditure. The TCM coordinates care for patients entering a hospital for major procedures, then continuing into home-based care. The model provides comprehensive assessment, individualized plans and oversight to reduce the cost and number of hospital readmissions.

Individuals are evaluated within 24 hours of admission to a hospital and assessed for risk of readmission. Eligible patients are then enrolled into the TCM service, whereupon a Transitional Care Nurse (TCN) visits the patient, develops a care plan and visits with the patient after transition from hospital to home. The TCN conducts a comprehensive assessment of a patient's and caregiver's goals and needs, and collaborates with physicians, including the primary care provider. The TCN also initiates home visits and phone calls. Home visits can include working with a patient on prescription adherence and preventing falls (such as ensuring that electrical cords will not trip a patient prone to falls). The average length of TCM is 30 days following a patient's return home.²⁹

The VA has implemented variants of TCM at two centers: the Transitional Care Partners Program at the Durham VA Medical Center and the Coordinated-Transitional Care Program (C-TraC) in Madison, Wisconsin.

Evidence: TCM has been the focus of multiple NIH-funded clinical trials (three randomized control trials and one comparative effectiveness study). Additionally, translational studies of the clinical and economic effects of the TCM in clinical practice have been supported by multiple foundations. The first was an RCT of 363 elderly hospital patients with a variety of conditions in two hospitals in Philadelphia, carried out from 1992 to 1996. The second involved 239 elderly hospital patients with heart failure in six Philadelphia hospitals, carried out from 1997 to 2001. All individuals in the study were 65 years of age or older, at-risk for poor post-discharge outcomes (due to age, multiple recent hospitalizations, multiple chronic health problems, or functional impairment).³⁰



Study one showed a 22% reduction in the likelihood of rehospitalization or death, a 34% reduction in average rehospitalizations per patient and a 38% reduction in days hospitalized during the year (5 days vs. 8 days).³¹ Study two showed even greater reductions of 45%, 52% and 63% respectively.

Net savings per patient exceeded \$4,000 for both evaluations. While veterans were not the direct focus of either RCT, the populations studied included veterans and the demographics reflect the health status of the elderly veteran community.

Because of presumed economic impact, the VA is exploring home-based treatment of chronic disease. In one instance, the VA hospital in Madison Wisconsin drew on the work of a TCM to implement Coordinated Transitional Care (C-TraC), a telephone-based care coordination program, utilizing core TCM strategies. Evaluation found that patients receiving the protocol were less likely to be rehospitalized than a baseline comparison, which saved more than \$1,000 per patient net of programmatic costs.³²

Economics: While the TCM team is studying secondary outcomes and their impact on healthcare utilization (such as self-sufficiency and transition to palliative care), initial ROI calculations focus on the immediate and quantifiable reduction in healthcare costs—reductions in rehospitalizations and number of days hospitalized. Based on one-year savings from these reductions, preliminary calculations indicate a return on investment of 1.6.

Payor: The healthcare payors that serve veterans — the VHA operated by the VA for veteran service members and TRICARE operated by the Department of Defense for retired service members and their families — are potential payors of outcomes for a chronic disease management initiative. Private insurers are beginning to pay for preventative programs and palliative care (Aetna is currently partnering with TCM), setting the precedent for insurance-based care payment.

"Evaluation found that patients receiving the protocol were less likely to be rehospitalized than a baseline comparison, which saved more than \$1,000 per patient net of programmatic costs."





Opportunity 3: Housing support for homeless female veterans

Veteran homelessness has been consistently dropping since 2010, largely due to concerted efforts on the part of the VA and others. Collaboration between the Housing and Urban Development Department (HUD) and the VA supported the development of the Veterans Affairs Supportive Housing (HUD–VASH) program that has awarded almost 60,000 vouchers for public housing and wellness services — reducing homelessness and proving the efficacy of permanent supportive housing programs. Other effective programs include Supportive Services for Veteran Families and the Grant Per Diem Program. These housing initiatives, combined with basic physical health care, substance abuse care, mental health counseling and personal development, have resulted in a reduction of homeless veterans by 70% since 2005.

"Estimates of total female veteran homelessness range from 4,000 to almost 11,000 individuals."

However, female veterans are overrepresented within the homeless population and are becoming homeless in increasing rates, even as overall veteran homelessness is decreasing. Female veterans are nearly twice as likely to become homeless than their civilian counterparts.³³ Estimates of total female veteran homelessness range from 4,000 to almost 11,000 individuals.³⁴

Programs that assist the homeless (like permanent supportive housing and transitional housing with wellness supports) have a strong evidence of effectiveness and could lead to significant savings. While evaluation focused on female veterans has not been conducted, the strength of research on housing programs generally indicates that a housing initiative to support female veterans is a potentially investment ready opportunity for a PES initiative.

Target population: A specific population with a significant need is post-9/11 female veterans not sufficiently served by VA programming (such as those with dependents or diagnosed with mental illness not broadly treated). Current VA systems often fail to adequately support female veterans with dependents and those struggling with Military Sexual Trauma (MST) or domestic violence. In 2012, a VA Task Force on Women Veterans found that not all of our systems are equipped to address the comprehensive needs of women veterans or to provide certain services and benefits for which women veterans have a greater need relative to their male counterparts. Many women veterans still do not know about or think they are eligible for services. Some gender-based health disparities continue to exist.³⁵

While female veterans are as likely as their male counterparts to face depression, mental illness and substance abuse that contribute to homelessness, Military Sexual Trauma (MST) and domestic violence appear to be driving some portion of the increase in female homelessness. The National Institute of Health studied female veterans and found that nearly one-third



of female veterans experienced rape, one-third experienced physical assault and 16% experienced both rape and physical assault.³⁶ One in four female veterans under the of age 50 reports having been the victim of domestic violence in the past year. Women who experience domestic violence are at risk for developing substance abuse disorder, mental health disorders and other health problems.³⁷ These negative life outcomes tend to compound, adding urgency to the need to serve needy female veterans.

Program: Any program for female veteran homelessness must overcome two challenges. First, traditional veterans services are geared towards men. Second, because there are comparatively few homeless female veterans, any specialized program operating on a local basis would be too small and too costly to sustain itself financially.

Any program for female veterans must provide customized, gender-specific support. In a continuum of care, providers screen participants to understand their specific needs, then provide customized services with varying levels of intensity based on those needs. For instance, women could be referred to various specialists and forms of therapy specific to diagnoses such as depression, PTS, substance abuse and MST. Medical, psychiatric, physical therapy and vocational rehab would all be offered as well. Participants could then be 'stepped down' in intensity of services as they stabilize and progress so that intensive services are reserved for only a small percentage. Providing a continuum of care specifically intended for women veterans — made up of the strongest programs in housing, mental health and case management — should generate strong results in terms of housing stability.

The challenge of scale can be addressed by creating a regional hub for female veteran homelessness, accepting referrals from multiple states to maintain sufficient scale. Ultimately, a national network of regional referral networks could radically reduce female veteran homelessness. Women veterans would be screened locally, a needs assessment conducted and then a referral made to the regional hub if appropriate. At the hub, a dedicated Case Manager and a mentor would be assigned to each participant, who would then triage the woman based on needs and make an assignment to a level of care including clinical mental health support and housing support appropriate to the situation.

Evidence: Multiple RCTs have been conducted on efficacy of permanent supportive housing and housing vouchers. In 2003, Rosenheck focused specifically on veterans and found that veterans leveraging HUD-VASH³⁸ — a federal program that supplies vouchers for housing — had 16% more days housed than the case-management-only group and 25% more days housed than the standard care group. HUD-VASH veterans also experienced 35% and 36% fewer days homeless than each of the control groups.³⁹

Additional research on the mental health component is deep. Clinical supports for victims of military sexual trauma are similar to the Cognitive Behavioral Therapy for PTS diagnosis—a counseling technique that has been studied extensively. At least 44 studies have evaluated CBT and validated that CBT reduces symptoms and disability due to mental health disorders for at least 5-10 years post-treatment. Moreover, research components of CBT, specifically exposure therapy, had success in reducing PTS symptoms in civilians that have experienced sexual trauma. This preliminary research indicates that CBT techniques, applied to veterans who have experienced sexual trauma will have positive outcomes.⁴⁰

This approach would be grounded in specific programs with strong evidence, but we do not know of evidence supporting a comprehensive continuum of care for homeless female veterans.

Economics: The ROI calculation for a PFS project focused on female veterans leverages reduced reliance on county level services and the reduced public support of the children of homeless women. County level savings include reduced healthcare costs (ER, inpatient and outpatient), food stamps, vouchers, probation and sheriff's department costs. Savings per child include reduced placement in foster care after a woman becomes homeless and assume one child per homeless female veteran.⁴¹ Based on these assumptions and rough program cost estimates, we project a preliminary ROI of approximately 0.96. By including increased public revenue from women's earnings, as well as savings beyond one year, the ROI would turn positive, but these savings need further research.

While the return on one dollar invested may not generate immediate cost savings, investing in homeless female veterans is critical work. Should a payor of outcomes be willing to pay for the positive societal benefits generated by connecting homeless women with homes, jobs, family support, and health care, there is a potential to amplify the ROI by adding quantified value for these societal benefits.

Payor: Safety net services utilized by homeless female veterans (housing, welfare, child services) are incurred at the county and state level. A payor of outcomes interested in direct fiscal savings for this model would likely need to be local (county). However, given the VA commitment to ending homelessness, the agency might be willing to pay for societal benefits not directly tied to budgetary savings.

"Any intervention for female veterans must provide customized, gender-specific supports."





Additional opportunities

In researching the projects described above, we identified other programs that are compelling, but may not be as ripe for investment due to gaps in evidence, capacity of providers, or other elements necessary for PFS financing to be successful. We would encourage government and philanthropy to consider support for the following initiatives to bring these programs to more veterans, or build capacity for a PFS initiative.

Workforce: certification, credentialing or licensure (employment training)

Summary: Programs providing certification, credentials or licensure (CCL) are strong candidates for a demonstration project to develop the evidence base of efficacy and depth of economic benefits of employing veterans in skilled labor positions. Established providers with the capacity to both absorb scale capital and to provide professional training in high-need occupations are operating nationally, but for a successful PFS project, measurement and assessments would need to move from focus on short-term outputs (such



as placement rates and pre- and post-program income data) to outcomes (such as increased tax revenue from higher lifetime earnings) and these outcomes would need to be validated through a formal impact evaluation. Output and utilization metrics, such as number employed, could be incorporated into program design, but would not directly influence savings.

Program: CCL programs are likely most impactful when they target unemployed and transitioning post-9/11 veterans between the ages of 18 to 34, because this population has outsized unemployment incidence when compared to both civilians and veterans from other eras. Some examples of service providers are national programs working in workforce development for civilians, industry-specific training and placement programs (for example: software developers, logistics specialists and construction trades) and veteran-specific programs.

Key objectives for a demonstration project: explore a provider's ability to scale, identify limiting factors to a provider's ability to scale, assess the economic impact (cost benefit analysis) of a program and identify opportunities to work with the Department of Defense to expand programs within transition infrastructure. For a PFS project to be launched, external evaluation of outcomes and economic evaluation would need to be measured and quantified and a government payor would need to be secured.

"Educational support will be most effective when delivered to post-9/11 veterans eligible for the GI Bill—which provides cash payments for tuition and living expenses while they pursue postsecondary education."

Workforce: education continuum support

Summary: Assistance for degree-seeking veterans offers a promising option for a demonstration project to build the evidence base around a single program (such as direct campus-based educational support) or a new combination of programs (such as direct campus-based educational support plus personalized coaching or counseling) to increase completion. Degree completion as a metric is attractive, but tends to push out any hard economic savings beyond a typical investor-friendly time horizon. For a successful PFS project, evaluation of the economic benefits of a postsecondary degree need to be quantified, as the accrual of savings would likely occur outside of an investor-friendly time frame and investors and government partners would need to consider pricing based on value.

Program: Educational support will be most effective when delivered to post-9/11 veterans eligible for the GI Bill — which provides cash payments for tuition and living expenses while they pursue post-secondary education. Programming should focus on veterans with lower degree completion rates, or those veterans without a post-secondary degree, for whom a degree will likely have the greatest economic impact. Two tracks offer the most promising programs and could likely be combined for increased impact:

- 1 Educational Transition Programs are multi-week, residential programs focused on study habits, counseling to select courses/academic paths and connections to additional resources and benefits as needed.
- 2 Continuous Academic and Wellness Counseling provide individualized advice on managing the rigors of an academic setting.

Directional estimates of such programs indicate that participants' persistence in school was nearly 10% higher at six months and 15% greater at 24 months. Also, graduation rates for program participants are 4% greater than the control group (statistically significant at .1 level).⁴²

Key objectives for a demonstration: test the new, combined program model, advance capacity to collect data, identify scale limiting factors and conduct robust economic impact assessment (cost-benefit modeling). For a PFS project to be launched, external evaluation of outcomes and economic evaluation would need to be measured and quantified and a government payor would need to be secured.

Workforce: job placement

Summary: Job placement employment programs focus on resume building, professional skills development and matching veterans with employment opportunities immediately following transition. Such programs represent an opportunity for a demonstration project to build the evidence base for future PFS. These initiatives have a direct link to economic impact, such as increased employment and reduced unemployment benefit utilization, but evaluating and attributing outcomes to workshops and job fairs is challenging as none have undergone a rigorous randomized control trial. While organizations implementing these programs have shown an ability to work within existing USO and VA infrastructures to reach veterans early in their transition process, a robust evidence base of long-term impact does not exist.

Program: The most effective job placement programs focus on post-9/11 veterans and their families and work to engage active duty service members before they transition to the civilian life. These programs may offer transitional workshops that focus on action planning for a job search process, job fairs, employer workshops, or work summits held on or within a short distance from military installations. Best in class programming pairs these strategies with personalized support and corporate engagement to match veterans with employers.

Key objectives for a demonstration: evaluate the link between placement and economic impact via a rigorous evaluation, develop data tracking capacity to understand program costs and impact, evaluate outcomes beyond employment placement and create infrastructural supports to work directly with the Department of Defense as service members transition out of the military.



"An estimated 275,000 to 1,000,000 men and women are military caregivers ..."

Wellness: caregiver and network support

Summary: A military caregiver is a friend or family member who assists and manages the care of a service member or veteran with a service-related disability. An estimated 275,000 to 1,000,000 men and women are military caregivers, though there is significant variation in the definition of 'caregiver.' Currently, very few service providers focus on caregivers and even fewer are designed around the specific problems and demographics of post-9/11 caregivers. While caregivers provide critical support to disabled veterans and maintaining caregivers could save costs for health care systems, further philanthropy and/or fee-for-service field building is required to develop robust programs and develop evidence.

Program: Programs that focus on developing networks for caregivers of post-9/11 veterans are gaining traction, but the "intervention" is typically informal network building — and does not always include data collection or evaluation of impact. Some work is being done to administer group therapy to military families, but these organizations are typically small, academic and focused on conducting research rather than scale.

Key objectives for philanthropic support: identify organizations with strong strategy and program design, evaluate link to economics, understand costs of programs, assess outcomes data and tracking capacity.



Wellness: mental health support

Summary: Veterans suffer mental health disorders at higher rates than the general population. Evidence-based programs, including Cognitive Behavioral Therapy (CBT) have been shown effective in addressing mental health disorders, but questions remain around the economics of implementing these programs and the ability to scale services in a PFS context. Expanding wellness supports to needy veterans in this sub-population will likely require philanthropy and/or fee-for-service models to accelerate policy change and practice.

Program: Mental health support for post-9/11 veterans with a diagnosis of serious mental illness like PTS will service the neediest veterans. For post-9/11 veterans, mental health disorders occur at five times the rate of civilians and at a 50% higher rate than pre-9/11 veterans. Specifically, 18–34 year old veterans, those who have experienced combat, those with multiple deployments and female veterans, have a higher rate of mental health incidence than the comparable veteran population. Cognitive Behavioral Therapy (CBT) has been identified as an evidence-based and effective treatment for PTS. The most common variants of CBT are exposure therapy, cognitive processing therapy and stress inoculation training. CBT can be used to treat anxiety disorders, depression, chronic low back pain, PTS and depression. Providers implementing CBT are typically focused on academic research, rather than scale provision of services. Often, CBT is included as part of a broader program offering (rather than stand-alone programs), making evaluation of impact difficult.

Key objectives for philanthropic support: identify organizations with strong strategy and program design, evaluate link to economics, understand costs of programs and assess outcomes data and tracking capacity. Build CBT into other programs (such as on-campus supports and supported employment) to increase effectiveness and build a link to economics for potential payors.





Conclusion

Through this research, we set out to assess the applicability of the PFS concept to the needs of veterans. We have identified three strong opportunities where PFS could play a role in the near term in scaling up effective programs for veterans. There are also several additional opportunities with strong programs and a natural link to PFS that could become PFS-ready in the near term with the infusion of philanthropic or other funding to build evidence and capacity required for PFS.

We are excited at the potential for government, veteranserving organizations and private impact investors to come together to rapidly expand veterans' access to effective programs in wellness, employment and housing.



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Organization	Name
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