Strengthening the Housing and Services System: *Recommendations and Strategies for Vermont*

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CSH 30 Years of Supportive Housing Solutions

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ABOUT CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 385,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided more than $1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at www.csh.org.

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EXECUTIVE SUMMARY

The challenge of responding to the homelessness and housing instability and the COVID-19 pandemic have highlighted the need for housing and services to be aligned more effectively in communities across the state. At the request of the Vermont Housing Finance Agency (VHFA) and the Vermont Housing & Conservation Board (VHCB), CSH convened a Steering Committee of leaders across the state to develop solutions. In coordination with the request of the Steering Committee, CSH held focus groups comprising People with Lived Expertise (PLE), shelter and housing providers, and designated agencies to learn about the current state of affairs and ideas for improvement.

The focus groups outlined various issues that make the work more challenging: keeping and maintaining a direct services workforce, housing capacity, and the increasing acuity of behavioral health needs of program participants. The state has many examples of innovation and program models that addressed needs effectively, but few are available statewide and few are the result of system-level coordination across state housing and services departments. None of the models had the capacity to address the current need statewide. The report also outlined the values inherent in the successful models that were considered required for success. Values such as relationship-based, trauma-informed, scalable and sufficient and assertive engagement were all seen as essential to moving forward. The group pressed to assure solutions that had scale and were able to move beyond pilots.

With the new federal resources available from the CARES Act and the American Rescue Plan Act (outlined in Appendix A), and the state's proposed Global Commitment to Health 1115 Medicaid Waiver, Vermont has the opportunity to integrate systems and develop many of these new solutions. The report ends with eight concrete recommendations for moving forward, including aligning workforce solutions to develop across sectors, re-engaging cross sector partnerships and establishing a new statewide supportive services fund. The Steering Committee is hopeful that these recommendations can spur leaders across the state to collaborate to address the complex housing and services needs of the most marginalized members of our communities.

INTRODUCTION

The state of Vermont faces a crisis regarding homelessness and housing instability. The governor and the legislature have responded with new resources and opportunities, and there is a new level of political will at the federal and state level to address this urgent need. At the same time, there are barriers to meeting the needs of the most vulnerable Vermonters. Statewide, systems are stressed beyond capacity, hundreds, if not thousands of social service positions are vacant, emergency efforts are strained, and homeless encampments are forming and growing in a number of communities. The service needs of those individuals, families, and communities are only growing in acuity and complexity. The state is at a crossroads, brought on by the pandemic and the growing inequities in our society. But Vermonters have historically risen to address these types of challenges and build a stronger community rooted in the common good for all.

Both the housing and health care sectors across the state of Vermont are aware of the increasing needs of the state's vulnerable residents and the challenges they face accessing integrated housing and community services. Across the state and across the country, there is also a growing consensus that housing is health care and that no community can improve their population health outcomes without addressing the Social Determinants or Social Drivers of Health (SDOH), and, in particular, housing-related needs. The housing sector has worked for decades to create an environment where everyone can thrive with safe, decent, affordable housing, as well as health care and other services to address needs across the lifespan. CSH considers housing as foundational to SDOH. This understanding of SDOH considers housing stock, housing affordability, and the services needed to keep individuals and families safely and successfully housed. A population health framework includes people experiencing literal homelessness as well as persons experiencing housing instability, those who wish to age in place and those who need prevention services to ensure they

do not become housing unstable or homeless.

In 2016, then-Gov. Peter Shumlin put forth Executive Order #03-16,[1] requiring that 15% of publicly-funded housing development serve households experiencing homelessness. Vermont's affordable and supportive housing sector expanded its efforts to address homelessness and met that call. Since the Executive Order, nonprofit housing organizations embraced and exceeded that goal, with many reporting that 25-50% of the units in their portfolios had been leased to those experiencing homelessness. As housing organizations leased to more households with deep and complex challenges, resident needs increasingly exceeded the levels of services the housing groups or their network of services partners could provide, even with support through local informal networks of service partners.

The gap between service needs and availability has grown as the numbers of individuals and families experiencing homelessness expanded as a result of the COVID-19 pandemic. While extraordinary efforts and coordination at the state, regional and local levels have resulted in more than 1,300 households moving from homelessness to permanent housing, still many more remain temporarily placed in motels or in emergency shelters. As the state continues to grapple with COVID-19, new individuals and families are falling into homelessness and those that remain unhoused typically have deep service needs. As a whole, shelters, housing providers, and service agencies have continued to prioritize addressing the needs of those experiencing homelessness, but consistently struggle with meeting the acuity of the needs of some households and helping them stay stably housed. In performing this work at such scale and speed, there were many more households with deeper needs than existing systems were able to meet. At the local level, many new creative and innovative partnerships between service providers, developers, shelters, and permanent housing agencies housers were developed to address those needs. However, these partnerships, which in some cases born out of crisis, either have not been sustainably supported, or proactively replicated statewide.

In a short-term response, the Vermont Housing Finance Agency (VHFA) and the Vermont Housing & Conservation Board (VHCB) have only recently begun to allow substantial services funds to be financed within housing project budgets, thereby reducing funds dedicated to building housing and decreasing the construction of new affordable housing units. With such an alarming shortage of affordable housing statewide, the use of capital dollars to fund services may not be sustainable. And yet, with no change in this current system of service delivery, the housing finance industry does not have another sustainable strategy of other dedicated services funding. At best, this approach is a short-term workaround strategy and lacks long-term

[1] https://legislature.vermont.gov/statutes/section/03APPENDIX/003/00073

sustainability. At best, this approach is a short-term work around strategy and lacks long term sustainability. At worst, if the strategy remains in place long term due to lack of services and unmet individual and families' needs, the result will be that Vermont will build fewer affordable and supportive housing options than they might otherwise have achieved.

When funding is available, some housing developers and owners are hiring their own services staff or in-house clinicians to address the need. In other cases, without funding or system-level support, difficulties arose that made housing stability and maintaining successful developments challenging. The primary goal is to ensure that persons are able to obtain and maintain housing successfully that will lead to thriving communities.

Despite the housing and health care sectors' mutual interest and overlap in serving our most vulnerable community members, the two sectors are not aligned structurally. The health care sector focuses on providing care at the individual level, while housing more commonly considers households, buildings or a communitywide focus. This misalignment begins at the federal level. Public health, health care's community-level arm, has been substantially under-resourced for decades. Service models such as behavioral health care may be available at times of crisis but are not sustained over time with ease of access and long-term engagement strategies. Service needs for people change over a lifetime, and the services systems do not intersect effectively to address those evolving needs. All systems most commonly operate from a scarcity model, intentionally or unintentionally, putting in place barriers to limit access to services and therefore to contain costs.

Leaders in Vermont's affordable and public housing sectors began monthly roundtable discussions in 2020 to address these concerns. Sector leaders found common themes, including a difficult process to access quality supportive services that were flexible and assertive enough to meet resident's needs. Many residents had difficulty connecting with local service organizations due to factors such as transportation issues, limited staffing at agencies or service hours that competed with family and employment demands. Housing leaders indicated that it was common for services to be available to support leasing a new tenant, but in the

event of subsequent crisis or need, were no longer accessible due to overwhelming demand for such services. These conversations grew to include shelter operators and service partners who worked most with affordable housing nonprofits. As the conversation evolved, the COVID-19 pandemic also hit, and with it came an increase in homelessness and limitations on in-person services, with the goal to reduce face-to-face contact and prevent COVID-19 from spreading. Behavioral health challenges and acuity were also reported to rise during this time.

The housing sector partners, led by the VHFA and VHCB, created a Request for Proposals (RFP) for an outside contractor to investigate the issues raised and help develop solutions. A joint RFP was issued in March 2021 requesting recommendations for system improvement and an actionable policy agenda. The Steering Committee engaged a focus groups of providers and People with Lived Expertise (PLE) to hear their experiences and develop recommendations that build upon grassroots and community-level innovation to address evolving challenges.

This report is the result of a collaborative effort initiated by those conversations and most recently has been led by a smaller and more-focused Steering Committee established in the spring of 2021, comprising leaders in the housing and service sectors across Vermont. The report outlines values, recommendations and strategies to address an urgent need for greater integration of housing with services.

CURRENT CONTEXT

Addressing these challenges entails building new collaborations that likely require new resources and funding. In March of 2021, the American Rescue Plan Act (ARPA) was signed into law, providing $1.9 trillion to states, counties and local jurisdictions for COVID-19 relief, including $31.6 billion for housing assistance and services with an additional $9.1 billion set aside specifically for services. Vermont received $2.7 billion in aid from ARPA. Gov. Phil Scott and the state legislature agreed to target significant ARPA funding to the housing sector in order to dramatically increase the production of new rental units, with a focus on those set aside for households experiencing homelessness.[2] Directing ARPA funding to housing development followed substantial appropriations of funds from the CARES Act and other federal sources as well as state funding. The new rental units include rapid re-housing units, permanent housing for individuals experiencing homelessness and affordable/mixed income units. This historic investment in housing is coming at a critical time when the lack of available housing stock is greatly affecting Vermont's ability to address homelessness and improve the well-being of all Vermonters. Furthermore, it highlights the urgent need to strengthen and expand access to

[2] https://governor.vermont.gov/sites/scott/files/documents/Governor%20Scott%20Proposed%20ARPA%20Budget.pdf

necessary services such as behavioral health care, childcare, employment, education and other social supports that will allow those accessing housing to maintain successful tenancies and ultimately thrive in their communities. In order to make this effort a success, housing and homelessness sector leaders will need to rapidly evolve to deal with the demands of these new units and consider creating a new framework for services access and financing. Vermont's Agency of Human Services (AHS), a national leader on Medicaid policy, has supported health and housing systems work in their new Global Commitment to Health 1115 Medicaid Waiver proposal. AHS is seeking to deepen that work in their request for the waiver renewal that is currently being negotiated between the state and federal government.[3] The new waiver request includes a Permanent Supportive Housing pilot program. While a positive development, Vermont's housing community has already proven the effectiveness of PSH and will need to quickly move from pilot programs to scale to achieve the necessary impact.

[3] https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver

INTENDED AUDIENCE

The intended audience for the report is threefold:

1. Housing sector providers and partners to help amplify and clarify their voices and concerns. The report highlights themes heard from focus groups about what is happening on the ground, both since the governor's executive order, as well as in response to the COVID-19 pandemic.

2. Service sector partners who are attempting to meet community needs but have limited resources and capacity to do so.

3. State leaders working to address homelessness, housing insecurity and population health, and who seek to understand differing aspects of these challenges.

STEERING COMMITTEE MEMBERS

- **Jenny Hyslop**, Vermont Housing & Conservation Board
- **Maura Collins**, Vermont Housing Finance Agency
- **Mary Moulton**, Washington County Mental Health
- **Margaret Bozik**, Champlain Housing Trust
- **Josh Davis**, Groundworks Collaborative
- **Elise Shanbacker**, Addison County Community Trust
- **Michael Redmond**, Upper Valley Haven
- **Kevin Loso**, Rutland Housing Authority
- **Molly Dugan**, Cathedral Square- SASH
- **Ian Jakus**, Vermont Housing Conservation Board
- **Bill Schrecker**, Vermont Housing Finance Agency
- **Lindsay Thrall**, Evernorth
- **Jess Graff**, Vermont Coalition to End Homelessness

VALUES AND OTHER ESSENTIAL COMPONENTS OF SUCCESSFUL HOUSING AND SERVICES MODELS

The experience of the housing sector and the voices of Persons with Lived Expertise (PLE) highlight a number of values present in different effective models aligning housing and services nationwide. Those values include:

CHOICE - Individuals and households must have choice in their living situation, their service providers and what services they select.

PERSON-CENTERED - Need is defined by the person, not the program. The program must be flexible enough to address the evolving need or have in place partnerships to support residents when the housing or service programs themselves do not have the right expertise or supports in place. No agency can cover all potential needs, so strategic partnerships are necessary between agencies to complement the resources available with other resources where need may arise.

RELATIONSHIP-BASED - Services depend upon care and respect between those receiving service and those delivering services.

TRAUMA-INFORMED - Homelessness and housing instability is traumatic and any staff directly supporting persons with experience of homelessness must take a trauma-informed approach. Staff members too often are experiencing primary or secondary trauma as well, and the agencies themselves must also take that trauma-informed approach to operations.

COORDINATION OF SERVICES - Navigating services, particularly in a rural state such as Vermont, can be challenging. The onus of navigating services should fall on agencies that may offer integrated services, or on collaborations between agencies to offer integrated programs from the individual or households' perspective. The burden must not lie with the household to navigate these complex systems.

SCALABLE AND SUFFICIENT - Services must be intensive enough and caseloads must be low enough so that staff have the time needed to spend with those they serve. Staff must also be qualified to address the complex needs of residents. Staff compensation and program funding are often an issue where programs do not have intensive enough services budgets to pay staff adequate salaries. The resulting effect is that staff turnover is high and too frequently, staff do not have the right level of experience, qualifications and support. Services must be responsive to the cyclical nature of crisis, recognizing that tenants may experience prolonged periods of stability, interrupted by periods of high needs for support.

FLEXIBLE - Services models and staffing patterns need to be flexible enough to address community need. Services should fit residents' availability and concerns and will need to be scheduled beyond regular business hours.

ASSERTIVE ENGAGEMENT - Service models commonly are office based and require persons to attend appointments, ask for assistance and follow all requests from services providers. Many persons will need long-term engagement to fulfill these requirements, and some may never be able to fulfill them, but still should have access to housing and services. Service models need to be operated and financed in a manner that these possibilities operate structurally within our systems. Relying exclusively on office-based voluntary services that require sobriety and complete compliance from the individual cannot be the only services options in our communities.

IDENTIFIED NEEDS

In partnership with the established Steering Committee, CSH undertook a qualitative analytical approach, conducting focus groups with five categories of stakeholders, including housing providers, shelter operators, service providers, Designated Agencies, and individuals with lived experience of homelessness. A comprehensive review of Vermont's Global Commitment to Health 1115 Waiver was also conducted to identify opportunities relating to expansion of services under the Medicaid 1115 waiver for increased tenancy supports[4]. While each stakeholder group represented their unique perspective and needs within the system, there was significant overlap of general themes. These themes centered on the following topics:

TABLE 1
IDENTIFIED THEMES

Cross-Systems Alignment	• Regional disparities in collaboration and services access with housing and shelter providers • Desire and need for more coordination and uniformity statewide. Promising models should be expanded • Data integration statewide
Barriers attributed to low housing stock	• Need for an equitable response to the housing crisis • Local NIMBY-ism that creates local, powerful opposition to new housing stock • Inability to access affordable and supportive housing as needed
Behavioral health acuity and support	• Desire for more community-based vs. office-based support and services • Need for financing models that support clinicians in community non-office based settings • The need for increased parity between Developmental and Behavioral Health (Mental Health and Substance Abuse) IDD/MH services. • Housing and homelessness agencies needing 'someone to call' when service recipients' behavioral health needs are too acute. There is a significant unmet need for an intervention for a person whose needs are not acute enough for an involuntary commitment, but are too acute for housing or shelter providers to address
Workforce Needs	• Workforce shortages across sectors. including behavioral and mental health care sectors • Licensure requirements affecting hiring pools • Need for flexible funding and billing capacity to support hiring • Workforce housing needs affecting hiring capacity

[4] https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver

As themes were identified by focus group participants, the impact was evident on multiple levels. On the individual level, the PLE group was clear that access to person-centered services was often difficult to come by. Multiple participants told stories of fragmented, difficult-to-access care that did not respond to their needs and life circumstances. Persons told stories of needing a particular medication, but only being able to access primary care and not psychiatric care. Participants also told stories of trying to access care in emergency departments, because agencies were not accessible via public transportation, or calling ambulances because they could not access care in any other way.

Focus groups of housing and shelter program leaders shared stories of severe, acute behavioral health crises for their residents, but no access to care or consultations support. Program leaders across housing and Designated Agencies discussed the lack of housing stock and affordable housing for program participants and even for direct services staff. Many participants highlighted solutions, such as the Supports and Services at Home (SASH) model or the Pathways Vermont model. Each of the promising models had limitations such as not being available statewide (Pathways) or having age restrictions (SASH). Other examples included small collaborations between local partner, trying to address community needs with no new funding, guidance, or support. The chart below lists each of the themes heard within the focus groups. Themes listed in the chart on the following page are categorized according to how the issue raised intersects with these following four levels of consideration:

- Individuals Level - Can families and individuals access the housing and services they need to thrive?
- Program Level - Can agencies sustainably operate and maintain programs to meet individual, family and community needs?
- Regional Level - How do solutions differ across regions, urban, suburban, and rural areas across the state?
- State Level - What solutions are best adopted at the state level?

Since the Steering Committee's overall goal was to better address needs at the individual and community level, solutions may need to be developed at multiple levels, including the state and regional level. At this moment, CSH believes that many of the ideas that would advance positive change are bubbling up from the grassroots level and require broader regional or state understanding and support. In our experience, many of the best ideas come from listening to PLE and the programs that serve them. The chart lists themes raised and places each issue in that framework. As is common with many states, Vermont has well-developed single-issue agencies or departments, but many of the challenges our communities face today cross sectors. The chart highlights the challenges at the individual and program level and solutions that need a broader regional and state approach.

TABLE 2

CONSIDERATIONS ON INTERVENTIONS BASED UPON IDENTIFIED THEMES FROM FOCUS GROUPS

THEME	Defining the Challenges		Building toward Solutions	
	Individual	Program	Regional	State
Cross-Systems Alignment	Individuals cannot access needed services and supports for a life in the community.	Supporting residents and communities is challenging when the services needs of some residents are greater than what the housing agencies can support.	Some local promising solutions, based upon personal networks and relationships but not easily replicable throughout the state. Barriers need to be more clearly understood and addressed.	For a statewide approach, need high-level state engagement from various state agencies that address these needs.
Behavioral health acuity and support, including substance use.	Individual is unable to remain living in the community and cycles between homelessness, jail and hospitals due to increasing acuity of needs. Individual is re-traumatized repeatedly.	Program cannot effectively serve persons with high acuity behavioral health needs. Traumatization for individual, staff and community neighbors.	Designated Agencies (DAs) are helping as they are able, but outreach and engagement are not activities for which there is a reimbursement for these agencies. The cost of doing the work is not paid for.	Need for support, collaboration and model development to address need.

Workforce Needs	Needed services cannot be accessed because agencies cannot pay enough to hire. Additional barriers such as need for specialized trained staff, were noted as well.	Programs cannot serve the community without staff.	Counties and state need deeper understanding of the workforce issues in different regions across the state. Then solutions can be developed from that data and understanding.	Using better data, and a statewide process to consider workforce shortages, develop solutions that address needs.
Barriers attributed to low housing stock	Individual is unable to access community housing and household remains homeless or unstably housed.	Programs have difficulty developing new housing and recruiting staff who can afford to live in the communities where they work.	Acknowledge the diverse housing needs of regions across the state.	The State Housing Council can prioritize the challenges raised in the report.

MODELS RECOMMENDED BY FOCUS GROUP PARTICIPANTS

Focus group participants, particularly PLE of homelessness, highlighted a number of models across the state that were working. The primary issue noted was that the models were not as widely available as needed, a fundamental capacity issue. The alignment of housing and services at the provider level, such as in the SASH and Pathways examples, was the most common example of what is working. Where the housing sector had funding for services, or even support for partnerships with local health care entities, those programs were viewed as more effective and easier to navigate for the PLE. These in-house services roles may address residents' needs and/or also refer to community service agencies, such as Designated Agencies. The Steering Committee felt strongly that effective models will include active collaboration between the services and housing sectors at the individual or household, program and system level. Persons' needs change over time and this fact has to be built into these multiple levels of cross-sector collaboration.

A common theme was insufficient capacity, meaning not enough people were able to access these quality services. Models vary in their reach, definition, costs and impact. The analysis highlights these models, what is known about them,

and where learnings are needed regarding these models.

- **Pathways Vermont (PVT)** – An evidence-based Housing First model that provides immediate access to permanent supportive housing to individuals who are homeless and who have co-occurring mental health and substance use challenges.[5] General guiding principles for PVT included
- eliminating barriers to housing access and retention,
- fostering a sense of home,
- facilitating community integration and minimizing stigma,
- utilizing a harm-reduction approach, and
- adhering to consumer choice and providing individualized consumer-driven services that promote recovery.
    - There is strong recognition that fidelity to the model is essential to optimal outcomes. Model Fidelity is defined as the degree to which a program is implemented as intended. Pathways Vermont maintains a validated Fidelity Scale Index[6] to track and measure the components of a program to ensure the program and therefore its outcomes can be attributed to the original model.

- **Support and Services at Home (SASH)** - SASH coordinates the resources of social-service agencies, community health providers and public and nonprofit housing organizations to support Vermonters who choose to live independently at home. Individualized, on-site support is provided by a wellness nurse and a SASH care coordinator as well as population-based support using evidence-based practices and data-informed planning from standardized health and wellness assessments. SASH is based out of 140 affordable-housing communities throughout Vermont that serve residents in those properties as well as people in the surrounding community.[7] Key findings from a multiyear independent evaluation of SASH include:
    - Medicare claims data showed that, among the site-based SASH participants, growth in annual Medicare expenditures was slower by an estimated $1,100 per-beneficiary per year and for those in

[5] Tsemberis, Sam, and Ronda F. Eisenberg. "Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities." *Psychiatric services* 51.4 (2000): 487-493.
[6] https://housingfirsttoolkit.ca/wp-content/uploads/Pathways_Housing_First_ICM_Fidelity_Scale_2013.pdf
[7] https://aspe.hhs.gov/reports/support-services-home-sash-evaluation-highlights-first-four-years-research-summary

urban panels, growth was slowed up to $1,450 per beneficiary per year as compared to a similar cohort of HUD-assisted residents without access to SASH. Slower rates of growth in Medicare spending were evident in hospital, emergency department and specialty physician costs.[8]

- SASH participants and wellness nurses were able to identify health issues early before those issues progressed to more serious incidents.
    - SASH participants reported having significantly less difficulty with common medication management tasks compared to Medicare beneficiaries who were not in the SASH program, according to survey results from the SASH independent evaluation.[9]
    - The SASH program has been successful in helping participants remain in their homes, both in terms of aging in place as their health and functional needs increase and in helping participants avoid eviction. SASH staff help ensure that participants have the services and resources needed to be safe in their apartments and uphold their tenancy obligations.
    - In a pilot of an embedded mental health clinician at two SASH sites, data from participant survey results and hospital admission and discharge data (Patient Ping) show reduced stigma around seeking mental health supports, increase access to mental health support and reductions in emergency room visits by those accessing pilot services.[10]

- **Assertive Community Treatment (ACT)** - ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or case-management program that provides referrals to mental health, housing or other services but provides them directly at the individual level.[11] Pathways Vermont is the only agency in the state offering ACT services, and those services are not available in more rural areas due to lack of population density. Vermont has Community Response Teams (CRT) that offer many but not all traditional ACT services. Housing and shelter providers who were not familiar with the model were interested in learning how to access this intensive level of service for some of their residents.

- **Family Supportive Housing** - The Family Supportive Housing (FSH) Program provides intensive case management and service coordination to homeless families with children, following evidence-based practice for housing families with complex needs and multiple systems' involvement. The program's goal is to

[8] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190066/SASH5.pdf
[9] https://aspe.hhs.gov/reports/support-services-home-sash-evaluation-evaluation-first-four-years-0
[10] Personal Communication, Molly Dugan, Cathedral Square, Director of Policy and Strategic Initiatives
[11] Bond, Gary R, and Robert E Drake. "The critical ingredients of assertive community treatment." *World psychiatry : official journal of the World Psychiatric Association (WPA)* vol. 14,2 (2015): 240-2. doi:10.1002/wps.20234

reduce the incidence and duration of homelessness through supports for families as they transition to and sustain permanent housing over time.[12]

- **Embedded Clinicians/Outreach Services** – This approach, while lacking a formalized definition or evidence-base, refers to the programmatic approach of embedding or placing a mental health clinician or service within a program, shelter or housing project that delivers low-barrier mental health or crisis intervention services. The benefit of such an approach is the removal of barriers that would otherwise limit an individuals' ability to access services. Furthermore, such an approach is favored by programs as it allows trained professionals to address often complex mental health needs or crises that are often beyond the training and capacity of shelter staff such as case managers or peers. Some housing agencies are partnering with their local Designated Agencies for these supports while others are fundraising and hiring.

- **Place-Based or Portfolio-Based Models for Services Combined with Housing** - This approach aligns housing financing with a housing-based services coordinator who can continually engage residents, connect residents with community services as appropriate and otherwise support the whole development. This model of a site or portfolio-based services coordinator allows for the long-term engagement needed for many residents with complex needs and complex lives. The model is common in HUD 202 Supportive Housing program, and the model has been found to be successful serving many distinct populations.[13] Champlain Housing Trust has an example in their project called Susan's Place. Larger affordable housing providers may have a single-service coordinator across multiple smaller properties for a portfolio or scattered site approach. With new housing financing and VHCB and VHFA allowing services funding to be included in new projects, the state will have a few examples of this model that can be studied for best practices and impact.

- **Drop-In Centers** - This approach offers a low-barrier option for persons who may not wish formal treatment, housing or services, but do wish assistance with basic needs such as food, clothing and shelter. This trauma-informed approach offers assistance with basic needs and the opportunity for engagement with staff who can gradually offer additional assistance as well.

- **Psychiatric Consultation Model** - This approach offers specialized, highly trained staff as a way to support multiple agencies with consult and training.

When considering a model or service delivery approach for vulnerable populations, it is imperative to examine internal/external factors that could impact

[12] https://dcf.vermont.gov/sites/dcf/files/OEO/Docs/FSH-AR-SFY2019.pdf
[13] https://www.hud.gov/program_offices/housing/mfh/progdesc/eld202

its effectiveness or appropriate application. Table 3 (see below) examines those variables of influence on each of the identified models/approaches. This includes capacity, both at the program and levels of scale, financing origins and considerations, methods of delivery, evidence-base and tools for fidelity measurement and what data systems and tracking are in place to learn about impact. Examining each model/approach through this lens ensures a uniform approach to assessment and implementation of all models. No one model is the ultimate solution for service delivery enhancement, but rather this presents a menu of options each with their own opportunities and challenges.

Table 3:
Variables of Influence in Bringing to Capacity

	Capacity	Financing	Delivery System	Definition and Evidence-Base	Fidelity to Model	Impact and Data Tracking
Pathways	Not available in all regions of the state or to all groups that focus group participants would like to see have access to the services.	Medicaid and state contracts.	Single provider.	Well-defined and high evidence-base.	Multi-point fidelity index that is recognized by third party evaluators.[14]	Commonly tracks housing stability and acute behavioral healthcare admissions.
SASH®	Limited by cap on persons served due to budget constraints. Some waitlists statewide. Population and funding limitations.	Services funded by OneCare, DAIL, DVHA, VDH, and Philanthropy.	Managed statewide by Cathedral Square and implemented locally by 22 nonprofit and local Housing Authorities.[15]	Well-defined and high evidence-base within its VT implementation.	Comprehensive training curriculum, quality assurance review process is in place. Recognized by third party evaluators.[16]	SASH has a statewide single data management tracking systems that is used by all agencies operating SASH called Population Health Logistics (PHL).
Assertive Community Treatment (ACT)	Narrow entry criteria as determined by Depart. of Mental Health.	Department of Vermont Health Access and Department of Mental Health.	Not Available outside of Pathways Modified ACT model, but developing in Brattleboro.	Well-defined and high evidence base.	Validated Fidelity Scale.	Commonly tracks Housing stability.

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969120/
[15] https://sashvt.org/admin/
[16] https://aspe.hhs.gov/reports/support-services-home-sash-evaluation-highlights-first-four-years-research-summary

Family Supported Housing	Limited capacity, and unclear if analysis exists to quantify need throughout the state.	Office of Economic Opportunity (OEO)	Community Non-Profit Agencies	Well defined and high evidence base17	Some program variation by region of the state	Commonly tracks housing and family stability
Embedded Clinicians/ Outreach Services	Successful examples across the states with significant variations in the model.	Variable- Most are partnerships between local DA and housing providers. SASH example is partially funded through OneCare Vermont.	Housing sectors receives funding in some places, in other places DAs stretch themselves to address need.	Promising practice but differs place to place so defining is challenging. Limited evidence base. Would require mutually agreed upon standards and definitions of practice.	Informal approach, no validation or fidelity measure.	Limited history of data tracking. Suggested outcomes include housing stability and connections to longer term Behavioral Health Supports
Placed or Portfolio Based Models of Services Combined with Housing	Successful examples nationally and across the state. Again, capacity is too limited to address need	Examples include HUD 202 for older adults, HUD 811 for those with disabilities. VHCB and VHFA have used this financing model on occasion.	Services funds bundled with current and new housing operating and developing funds.	Basic definition of the service is well understood nationally. Who is the right population and for how long is less understood.	Informal approach, no validation or fidelity measure.	Good history of Pre/Post impact studies, limited stronger designed studies in place. For HUD 202, housing metrics are well defined.
Drop-In center	Successful examples across the states with significant variations in the model.	Various funding sources	Not centralized	Promising practice but limited evidence base. Commonly used nationwide.	Informal approach, no validation or fidelity measure.	Limited history of data tracking.
Psychiatric Consult Model				Promising practice but limited evidence base.	Informal approach, no validation or fidelity measure.	Limited history of data tracking.

[17] https://dcf.vermont.gov/benefits/fsh/manual

The issues raised by the focus groups are similar to those many communities across the country are facing. Some can be addressed by the efforts of a single sector, such as increased housing stock. While housing stock is a complex issue, it is one that fits squarely within the expertise and oversight of VHCB and VHFA to address. Other issues will require state and local collaboration across agencies and departments. Other industries, funding and cross sector collaboration and community partners will be needed to address effectively.

EMBARKING ON CROSS-SECTOR SOLUTIONS WITH PARTNERS

BEST PRACTICES IN PARTNERSHIPS

Highlighting the collaboration needed, other themes raised in the focus groups clearly require consistent cross-sector partnership activities such as cross-sector planning teams' collaboration, data sharing, partnerships and likely braided funding opportunities. Addressing themes such as workforce across industries, behavioral health acuity and the need for more supportive housing capacity will necessitate regular consistent cross sector planning and development efforts. Best practices in partnerships note the following processes found in successful partnerships:

SHARED PURPOSE

Shared purpose is the time and process for cross-sector leaders to come together and define the problem and how they jointly will address the problem with clearly defined goals and objectives. The process is time consuming and needs funding for neutral facilitation and to cover costs of staff and program recipients to participate. In this process, participants learn enough of each other's language to communicate effectively. Participants build the networks, relationship, understanding and trust needed to level set between groups. The evolving team develops common language, definitions, measurements and cross-sector goals and processes to guide them as they work together. That jointly developed shared purpose becomes a touchstone throughout the next steps of the process. Commonly, the first step to develop a cross-sector planning team is developing shared purpose for that team.

SHARED DATA

Defining the problem is done most objectively through data. Information needed for stakeholders captures the prevalence of the issue, capacity to address and quantifiable gaps. This data can be used to prioritize funding, projects and solutions. Most commonly, this means data sharing and building upon current existing structures. Some states are developing data warehouses for collaborating across sectors. Other states are collaborating with local universities to build an integrated data system. One key factor is building on existing structures in each sector to lessen time and effort needed to create joint data systems as well as improving workforce efficiency by reducing duplicated efforts. Whatever the most expeditious model for Vermont, the goal is to have a system that tracks key information across sectors, so that accountability and defining progress is jointly held by the cross-sector team. From the provider perspective, data systems need to be easy to access, easy to use and place as little burden as possible on the direct care staff that use them on a regular basis. The process needs to include training for staff on not

just the "how" but the "why" of these systems and allow for rapid cycle quality improvement.

SHARED FINANCING

Once the issue is clearly defined and jointly understood by a cross-sector planning team, then a discussion of solutions and financing of solutions can begin. Shared financing commonly involves flexibility around timelines and project design while building upon the unique expertise and funding requirements of each sector. Supportive housing commonly builds upon cross-sector teams in which the affordable housing partners are there to fund housing, while Medicaid, behavioral health, aging or intellectual disabilities funding can be accessed for services. The cross-sector planning team may develop a joint Request for Proposals that blends funds at the state level, while ensuring that the regulations and requirements for each unique funding stream is respected and made clear from the start. Shared financing also commonly means shared reporting to ensure compliance with federal or state regulations.

SHARED GOVERNANCE

Shared governance includes shared oversight, shared data reporting and shared communications around project impact. Once shared financing has been decided upon, the cross-sector planning team needs to ensure that each sectors' funding, implementation, oversight and reporting priorities are all considered as the projects move forward and grow. The goal is not only single joint projects, but developing the cross-sector level of trust and engagement that, as new challenges occur, the team can continue to respond in an integrated manner.

UPCOMING OPPORTUNITIES

Global Commitment to Health/ 1115 Medicaid Waiver

Vermont has an opportunity with proposed new Global Commitment to Health 1115 Waiver to further their goals of improved population health. The draft waiver includes a pilot for Permanent Supportive Housing, but will not address many of the issues raised in these focus groups. While this project will support those served by the pilot, this will not bring about scale, or access to the crisis and assertive engagement services, that the focus groups were requesting for their shelter and housing developments. As of fall 2021, the state and the federal Centers for Medicaid & Medicare Services (CMS) are in negotiations around the waiver and the comments below reflect the pending version of the waiver renewal, dated 6/29/21. That waiver is in negotiations between the state and CMS and has not been approved at this time.

The Global Commitment to Health waiver includes a pilot for Permanent Supportive Housing that is likely to only be approved for housing-related services, if CMS follows precedent.[18] Therefore, to implement, the project will need access to affordable housing opportunities. State leaders in the health care and housing sectors should begin collaborating immediately to ensure that priorities, populations, referral systems, data and timeframes are aligned to ensure success of the pilot.

The waiver also includes funding for a variety of public health, population health and other investments to improve the health of all Vermonters. The housing sector has developed solutions for a number of vulnerable populations that could be scaled with cross-sector support.

[18] https://www.csh.org/resources/policy-brief-summary-of-state-actions-on-medicaid-housing-services/

The housing sector should be included in the planning, implementation, impact and outcome stages of effort as soon as possible. Those discussions should include the perspective of state leadership, housing providers and PLE. Only then can shared purpose and stronger collaborations be developed.

Finally, in response to the pandemic and the resulting challenges to our communities, significant state and federal funds have been committed to respond to the housing crisis. New funding resources are highlighted in Appendix A.

FINAL RECOMMENDATIONS

The fundamental challenge in the state is that the housing and public services sectors are not consistently aligned:

- At the state, regional or many local levels
- In regards to populations, policies, priorities or data systems

Both sectors are facing workforce challenges, capacity strains and high acuity needs leading to frequent crisis situations. The solutions Vermont needs will only be achieved by a new level of collaboration between the housing and public services sector and funding to support the collaboration. The recommendations below, coming from the challenges outlined by the focus groups, begin to chart a part forward to create the structures needed to facilitate that new level of collaboration. The sectors are aligned on values, and the goals of a healthy Vermont, where all residents thrive. New federal funding and the new Global Commitment to Health 1115 Waiver all offer opportunities for the sectors to align systems of care for ease of access and equitable response.

1. **Address Workforce Needs:** A common theme from multiple stakeholders and stakeholder groups was the inability of agencies to hire and fill needed positions at all levels of staff. These stakeholders need to be a part of a statewide process to address workforce issues throughout the state. Housing, social services and health care sector partners would all benefit from a statewide plan to address staff shortages and to support recruitment and retention. These efforts should include:
    a. Data and information efforts around what type of positions are vacant for long periods and what strategies can be brought to bear to address these vacancies.
    b. Needs-based budgeting for the nonprofit sector so that rates of public sector payments match the cost of delivering services, especially in today's existing job market. These efforts should be informed by a labor market analysis to determine wages needed to fill positions.

c. Align state efforts across departments. Consider building upon work already done by Vermont's Rural Health Task Force Workforce Subcommittee.[19]

2. **Cross Sector Collaboration:** Support cross-sector collaboration either through an existing body or new creation/merger of existing efforts to examine opportunities, expand partnerships and create structure for efforts around housing and services. An important outcome associated with this effort would be a reinvigorated effort for the final year of the state's Plan to Prevent and End Homelessness[20] and use this group to develop the plan for the future. Cross-sector participation needs to include strong AHS participation (such as Department of Vermont Health Access [DVHA], Green Mountain Care Board [GMCB] and OneCare Vermont), as well as the designated agencies.
    - High-level representation with access and decision-making authority regarding resources is critical to ensure the group can develop the cross-sector projects, systems and scale needed to address the challenges heard from the focus groups in this process.
    - Subgroups of the committee focused upon
        - Policy alignment between partners
        - Data integration efforts
        - Needed models statewide including:
            - Developing financing strategies for proven models that need scale such as SASH and Pathways
            - Development of pilot programs based upon innovations learned from the COVID-19 pandemic. Models listed above such as embedded clinicians, drop-in centers or consult models
            - Determine capacity building needs for community providers. This could be Medicaid billing expertise for the housing and homeless industry to housing financing and development expertise for the Designated Agencies or other community social services agencies.
    - Consider other state-level meetings where this agenda fits to cut down on meetings.

3. **Build on the opportunity of the PSH Pilot within the Global Commitment to Health Medicaid Waiver:** Create a formal engagement process for the housing sector within the state Global Commitment to Health Medicaid Waiver,

[19] https://gmcboard.vermont.gov/sites/gmcb/files/documents/Rural%20Health%20Services%20Report-%20Workforce%20White%20Paper%20FINAL%201.23.20.pdf

[20] https://legislature.vermont.gov/Documents/2018/WorkGroups/House%20Appropriations/Other%20Presentations/Housing%20Supports/W~Angus%20Chaney,%20Director%20of%20Housing,%20Agency%20of%20Human%20Services~VT%20Plan%20to%20Prevent%20and%20End%20Homelessness%202018-2022~4-12-2018.pdf

including the Permanent Supportive Housing pilot design and implementation. This process also needs to include and support People with Lived Expertise at the table through all stages of the process. This should include an assessment of whether and how soon it is possible to move from pilot to scale and what capacity building support is needed for state partners, regions and, in particular, the provider community who will have to execute at scale.

4. **Innovation HUB:** Housing providers have stepped up to deliver community services during the pandemic in unique ways. Create a startup fund, either state funded or by partnering with philanthropy, for agencies that wish to explore new ways of delivering services, including entering the Medicaid billing space for community services but do not have the startup funds to make that transition. The HUB could fund providers to expand and measure the impact of current community models and support the training and technical assistance needed at the community level to create the next SASH, a homegrown model that can be expanded across the state and/or across the nation, just as SASH has succeeded in serving older adults and adults with disabilities across Vermont and beyond.

5. **Provider Capacity Building:** Agencies commonly tend to receive funding from one primary sector, either health care, behavioral health or housing and homelessness services. To venture into partnerships or development in another sector, agencies need capacity building to educate them regarding the other sector and build internal development capacity. State and local-based philanthropy should develop funding and a process to support agencies that actively participate in cross-sector efforts.

6. **Create a state-based supportive services fund aligned with housing:** Portland's Supportive Services Fund could be considered as model of such a fund. This fund could be used to expand capacity for programs that are proven models. The services funded would be focused on housing retention similar to state Medicaid benefits in New Hampshire[21] and Minnesota[22]. The new funds matched to new housing development would ensure that housing funds be used primarily to create the new affordable units that the state desperately needs. This fund could be used to expand capacity for family PSH, SASH or Pathways or to fund placed-based services in other new developments. Prior to COVID-19, CSH has modeled the cost of these services as costing between $7,000-8,000 a year, per person served. These costs may be increased at this time, in order to retain direct services staff, so that annual number may need to be increased from these earlier estimates.

[21] https://www.dhhs.nh.gov/ombp/medicaid/documents/draft-1915i.pdf
[22] https://mn.gov/dhs/partners-and-providers/policies-procedures/housing-and-homelessness/housing-stabilization-services/housing-stabilization-services.jsp

7. **Strengthen opportunities for collaboration:** Opportunities include considering a joint RFP process or other similar coordination efforts among funders of housing and services to increase supportive housing capacity in the state using the developed supportive services funds described above: Currently the burden for blending and braiding funding lies at the community agency level. This recommendations shifts that burden to state systems to ensure that new supportive housing is developed with the level of services supports needed by those currently served by affordable housing developers in the state.

8. **Use ARPA resources to jointly align housing and services sector activities:** The state quickly developed plans for services based upon American Rescue Plan Act opportunities including the state's SAMHSA and HCBS funding opportunities. The details of these funds and plans as publicly available are included in Appendix A. For future opportunities, the housing and homelessness sector should be move involved in this process, with a particular spotlight on including people with lived expertise. A process needs to be developed to engage the housing and homelessness sector partners in a variety of health care and services funding efforts including:

    a. Mental Health Block Grant funds managed by Vermont's Department of Mental Health (DMH)
    b. Substance Abuse Block Grant funds managed by Vermont's Division of Alcohol and Drug Abuse Programs (ADAP).
    c. Home and Community Based services managed by Vermont's Disabilities, Aging and Independent Living (DAIL) Department
    d. Aging Services managed by Vermont's Disabilities, Aging and Independent Living (DAIL) Department
    e. Intellectual or Developmental Disabilities services led by Vermont's Developmental Disabilities Services Division (DDSD)

CONCLUSION / NEXT STEPS

Vermont is building upon its impressive history of addressing community needs. Vermonters stepped up to the challenge of the COVID-19 pandemic and had one of the strongest state responses nationwide. Those efforts have led to better understanding of where gaps to address community needs remain. This report, drawing on focus groups of people with lived expertise, housing providers, shelter operators, service providers, and Designated Agencies all agree that there are local innovations that can be scaled with a stronger, more coordinated state response. All agree that while heroic local efforts have occurred, more coordination between sectors needs to be easier to achieve. Many of the focus group

members cited a few sector-specific challenges such as lack of affordable housing and housing stock. But more of the solutions cited required a cross-sector approach including aligning housing and services, the need for long-term engagement for persons with high behavioral health needs, and the need for increased capacity in family supportive housing. Groups talked passionately about informal partnerships between housing and services agencies that made all the difference at the start of and during the ongoing COVID-19 pandemic. With the Agency for Human Services (AHS) Global Commitment to Health Waiver now submitted to CMS, the state is poised to align systems to improve the health and housing stability of all Vermonters.

The recommendations offer a variety of strategies to build upon these findings. The fundamental finding is of a strong culture of communitywide commitment to the health and well-being of all Vermont's residents. The report recommendations include interventions at the policy, program, process and funding level to build upon the strengths of this culture and the networks fostered by the culture. CSH recommends that the voice of communities be central to this dialogue and a process be developed for those on the ground to be at the table for all stages of decision-making and system transformation.

The report responds to lessons learned from on the ground housing and services providers throughout the pandemic. While there is much promise in local collaboration, state leadership is needed to allow systems statewide to more effectively collaborate and integrate housing and services locally. The report also includes recommendations that can build upon the values, knowledge and commitment of individuals, programs and systems statewide to improve the health and well-being of all of Vermont's population. CSH looks forward to the future that Vermont's communities, leaders and residents will build together to achieve a global commitment to health and well-being for all.

Appendix A

New Housing and Services Funding post-2020

CARES ACT Funds (March 2020 passage)

Table 4: CPD FY2020 CARES Act Formula Grants						
NAME	**04/02/2020 CDBG-CV1**	**05/22/2020 CDBG-CV2**	**09/11/2020 CDBG-CV3 Part A**	**05/22/2020 CDBG-CV3 Part B**	**04/02/2020 ESG-CV1**	**06/09/2020 ESG-CV2**
Burlington	$450,256	$0	$293,349	$0	$0	$0
Vermont Non-entitlement	$4,256,840	$2,031,600	$2,591,853	$0	$2,334,607	$4,424,450

- Community Development Block Grant- $5 billion nationally; this longstanding, flexible formula grant funding program is used to help low-income communities address housing and community challenges.
- Emergency Solutions Grant- $4 billion nationally; this longstanding formula grant funding program can be used for solutions related to ending homelessness, including shelter
- Vermont's share of these funds is summarized above from the federal Department of Housing and Urban Development's website[23]. Vermont's total for the housing sector, via the CARES Act, is $16.3 million.

FY21 Federal Budget (December 2020 passage)

- Emergency Rental Assistance Program- $21.5 billion nationally. This was a new program to states for rental assistance for persons whose income was impacted by COVID-19 and therefore who were at risk of losing their housing. Vermont received $200 million via this program[24].
- Mental Health and Substance Abuse COVID Supplemental Awards- These were awards to states in addition to their standard Mental Health and Substance Abuse Block grant awards. Nationally, this was $4.25 billion in additional funding.[25]

American Rescue Plan Act Funds or APRA (March 2021 passage)

- Emergency Housing Vouchers- $5 billion nationally. These are Housing Choice vouchers to assist low-income individuals to pay for housing on the community rental market. The Vermont State Housing Authority received 99 vouchers via this program.[26]
- Homelessness Assistance and Supportive Services Program- (HASSP)- $5 billion total nationally. Vermont received over $11 million dollars both in an allocation to Burlington and to the state.[27]
- Health Centers- Health centers across the country received over $6 billion nationally to support operations during the COVID-19 pandemic as well as for community efforts

[23] https://www.hud.gov/program_offices/comm_planning/budget/fy20
[24] https://home.treasury.gov/system/files/136/Emergency-Rental-Assistance-Payments-to-States-and-Eligible-Units-of-Local-Government.pdf
[25] https://www.samhsa.gov/sites/default/files/covid19-programs-funded-samhsa-fy21.pdf
[26] https://www.hud.gov/EHV
[27] https://www.hud.gov/sites/dfiles/CPD/documents/HOME-ARP.pdf

around the COVID-19 response. Eleven Health Centers across the state of Vermont received over $33 million. These funds were also extremely flexible.[28]

- Home and Community Based Services (HCBS) - Vermont projects to receive an additional $161 million in funds, due to the one-year increase in the Federal Medical Assistance Percentage, commonly called the "FMAP bump".[29] The Agency of Human Services has proposed to use these funds to address the Social Drivers of Health (SDOH) including:
  - Promote health equity
  - Offer grants to HCBS providers to allow funds to address SDOH needs of the people they serve
  - Design Value Based Payment (VBP) options that address SDOH
  - Support policy development and implementation costs to advance SDOH screening tools

The plan must be approved by the federal Centers for Medicare & Medicaid Services and as of December, 2021has not been approved.

- Mental Health and Substance Abuse
  - Community Based Planning grants for Mobile Crisis Intervention Services.[30] $15 million is available nationally and state applications were due 8/13/21. As of 9/8/21, awards have not been made.
  - The Mental Health Services Block Grant (MHBG) received an additional $1.5 billion nationally with Vermont's Agency of Human Services receiving an additional $2.4 million in funding.[31]
  - The Substance Abuse Block Grant (SABG) also received an additional $1.5 billion nationally with Vermont's Agency of Human Services receiving an additional $5.2 million in funding.[32]

Both Mental Health and Substance Use agencies were required to create plans and submit to SAMHSA, but plans were not required to be publicly available. SAMHSA received $420 million to expand the Certified Community Behavioral Health Clinic (CCBHCs) model, based upon the Federally Qualified Health Center model. Clara Martin Center in Orange County is the only CCBHC in the state, per the National Council.[33]

[28] https://bphc.hrsa.gov/program-opportunities/american-rescue-plan/awards/vt
[29] https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/21-039-Vermont-HCBS-FMAP-Proposal.pdf
[30] https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html
[31] https://www.samhsa.gov/grants/block-grants/mhbg-american-rescue-plan
[32] https://www.samhsa.gov/grants/block-grants/sabg-american-rescue-plan
[33] https://www.thenationalcouncil.org/ccbhc-success-center/ccbhc-locator/

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