Emergency Housing Vouchers: Pairing Services and EHVs

This resource is prepared by technical assistance providers and intended only to provide guidance. The contents of this presentation, except when based on statutory or regulatory authority or law, do not have the force and effect of law and are not meant to bind the public in any way. This presentation is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

Webinar Logistics

- This is session is being recorded. Recording will be shared at: https://www.hud.gov/ehv
- All participants are muted. If you are having trouble connecting your computer audio, you can call in using the following information:
  - +1 646 558 8656
  - Webinar ID: XXX XXXX XXX
  - Passcode: XXXXXX
- Please submit your questions in the Q&A box
- If you are having technical issues, please send a chat message to Laura Harris

Welcome and Introductions

- Welcome
- Introduce Technical Assistance Providers
  - Technical Assistance Collaborative (TAC)
  - Corporation for Supportive Housing (CSH)
- Today's Presenters & Panelists
  - Nicole LiBaire, Senior Associate, TAC
  - Janis Ikeda, Senior Program Manager, CSH
  - Marcella Maguire, PhD, Director, Health Systems Integration, CSH
  - Emma Chapple, Senior Program Manager, CSH

Overview of EHV Training Series

Date/Time	TA Topic
May 11 3-4pm EDT	EHV Program Overview
May 12 2:30pm - 4pm EDT	EHVs for CoCs
May 13 3pm - 4:30pm EDT	Partnerships for EHVs
May 18 3pm – 4:30pm EDT	Strategy for Targeting EHVs and Related Resources
May 20 3pm – 4:30pm EDT	**Pairing Services and EHVs**
May 25 3pm – 4:30pm EDT	Coordinated Entry and EHVs
June 1 3pm – 4:30pm EDT	Making the Most of EHV Waivers

Poll – Who is Listening in Today?

- ❑ Public Housing Agency (PHA)
- ❑ Continuum of Care (CoC)
- ❑ Victim Service Provider (VSP)
- ❑ Other

Today's Agenda

- Transition supports and services
  - Housing search and other examples
  - Organizations providing transition services
  - Funding transition services
- Supportive Services
  - Planning and Considerations
  - Levels of Intensity and Service models
  - Funding for Supportive Services
  - Defining Quality Services
- Q+A with HUD

Definitions

- **Transition services and supports**: individualized services that assist the household to transition from their homeless or at-risk living situation into housing
- **Supportive services**: Voluntary, ongoing services that provide individualized support for the household for as long as needed. Type and amount of support can change over time with changes in needs and preferences.

Transition Services and Supports

What assistance may be needed to transition?

- Assistance securing documentation necessary for PHA or for property manager- noting flexibility and waivers that exist
- Housing search assistance such as identifying units meeting household's needs and preferences, completing applications, negotiating with property managers, making appeals, and reasonable accommodation requests

What assistance may be needed to transition?

- Move-in assistance such as funds for security or utility deposits, application fees, moving costs, securing furniture and household items, as well as with moving these into the new apartment
- Orientation to the:
  - Unit and property
  - Tenancy responsibilities
  - Neighborhood

Identify Individualized Supports

- Individual households' prior experiences and capacity will differ
- Some individuals may already have friends, family, or advocates to provide resources and help the household make the transition
- Other individuals will have little or no assistance already in place
- It is important to get input from priority populations you are intending to serve on what type of transition services and resources may be needed

Community Organizations

- Organizations in your community that may be able to provide transition assistance (services or resources):
  - Homeless service providers
  - Victim service providers
  - Population-specific service providers, e.g. mental health, substance use, harm reduction providers, centers for independent living, re-entry agencies
  - Culturally-specific organizations such as YWCAs, Urban Leagues, CDCs, local NAACP chapters, communities of faith
  - Task-specific providers, e.g. housing counseling agencies, credit repair, etc.

Identify Transition Service Gaps

- Are there existing providers who can provide the transition services to the community's priority population(s)?
- Do these providers have capacity to provide services to the number of persons who will receive EHVs?
- What gaps may exist?
- How can PHA/CoC/VSP and others collectively strategize to fill these gaps?

Funding Transition Services

- ESG and ESG-CV funds can be used to fund transition services
- EHV service fees can pay for many transition services, including:
  - Housing search
  - Security deposit/utility deposit/application/holding fees
  - Owner recruitment, retention, incentive payments
  - Household items, moving and other expenses
- Other potential sources depending on the population and local sources e.g. private funders, United Way, faith-based entities, etc.

Supportive Services

Promoting Housing Stability

- Based on the populations eligible EHV, some form of housing stabilization and housing sustainability support will likely be helpful
- Services provision and funding for those services will vary based on need and what is available within the community
- The need for ongoing services for EHV households (after lease up and the initial transition) will depend on the general needs of the populations prioritized for referral, as well as the individual needs of each household.

Planning for Supportive Services

- Coordination and partnership between the PHA, CoC, VSPs, and local providers will be necessary to ensure that the services needs of EHV households are ,et
- As your community uses an inclusive planning process to identify how households will be prioritized by CE for EHV referral, consider what the service needs of those populations may be, what they say they need, and how you can identify appropriate services funding or connections.

Examples of Supportive Services

- Housing Case Management
- Primary Health Care
- Behavioral Health Care
- Care Coordination
- Aging Services
- Developmental Disability Services
- Workforce and Education supports
- Benefits Assistance
- Legal Services
- Connection to community services

Key Services Considerations

- What services may be needed to help EHV households maintain housing stability?
- How may service needs differ depending on the populations prioritized for referral?
- How do we keep safety and privacy in the foreground, honor housing choice, practice Housing First, and approach services with trauma-informed approaches?
- How can we leverage or build partnerships with a diverse array of providers that can offer a variety of services to EHV households (and others that we serve)?

Key Services Considerations, cont.

- How can we ensure that services are accessible to, meet the unique needs of, and are trauma-informed for people of color, LGBTQ-identifying individuals, non-native speakers, and other historically marginalized populations?
- How can we provide safe access to trauma-informed and specialized services for survivors of domestic violence, dating violence, sexual assault, or human trafficking?

Ongoing Services: Levels of Intensity and Service Models

Acuity and Services Needs

Acuity Level	Possible services	Possible scattered-site caseload
High-Acuity Intensive, individualized, multi-disciplinary supports	Therapeutic supports, care coordination, life skills and tenancy supports, behavioral health case management, supportive employment, transportation to appointments, crisis intervention, education & workforce services	10-20 (ind.) 10-12 (fam.)
Moderate-Acuity Individualized, housing-focused supports	Care coordination, tenancy supports, connections to mainstream providers and services, crisis management	1 to 20-30 (ind.) 1 to 20-25 (fam.)
Low-Acuity Broad, low-intensity supports	Broad support to increase connection to mainstream services and providers, group activities, educational and wellness programming	1 to 50

- For more, see: Primer on Serving People with High-Acuity Needs and Case Management Ratios

High-Acuity Needs: Service Models

- Assertive Community Treatment (ACT) Teams: A service-delivery model deployed by a multi-disciplinary team with a shared caseload. ACT teams provide intensive individualized, flexible, comprehensive services to people with serious mental illness (SMI)
- Intensive Case Management (ICM): A lower staff to client ratio, case management model that is particularly effective for clients with co-occurring SMI and substance use. ICM services can both provide and coordinate appropriate care.
- For more, see: Evidence-Based Service Delivery

Moderate-Acuity Needs Services Models

- **Housing-focused case management:** Rapid rehousing case management and similar models provide individualized, strengths-based, home-based support to help program participants obtain, stabilize in, and retain housing.
- **Medicaid housing supports**: If your state has housing supports in its Medicaid plan, these services can provide eligible households with care coordination, education around tenancy skills, help navigating landlord relationships and issues that come up, and other supports to help individuals and families maintain housing stability.
- **Aging Services:** from Area Agencies on Aging (Triple As) or Centers for Independent Living (CILs): Can help eligible clients get access to supports from and navigate systems and programs like Medicaid, Medicare, and Home and Community Based Services (HCBS)

Low Acuity Needs Service Models: Services Coordination

- Services coordination is a useful model for serving individuals and families that do not need intensive, individualized supports, but could still benefit from very broad, low-intensity support.
- An EHV services coordinator could work with a large group of households to provide referrals to mainstream service providers, help clients connect to community resources, and arrange for educational, recreational, or wellness-focused group activities.

Low Acuity Needs: Moving On Aftercare

- Services that are offered after a household moves on from PSH (or exits from another housing program to an EHV) to ensure they are stable and successful in their new living situation. Typically consists of:
  - Periodic check-ins, as agreed upon in an aftercare plan co-created by case manager and household
  - Low-intensity supports when requested, such as connections to a mainstream services provider

Funding for Supportive Services

Funding for Supportive Services

How to fund housing services or partner with other systems to offer households access to mainstream, community-based services:

- Medicaid/Medicare/Managed Care
- Primary health care
- Behavioral health care
- Aging Services
- Developmental Disability Services
- Hospital Community Benefit Funds
- Local/Private Services funds

Poll: Connections with Health Systems

- **Select all that apply:**
  - We have no partnerships with health care organizations/systems
  - We have connected with health care partners for discussions
  - We are connected with health partners and are doing some work together
  - We have a coordinated referral system with health care sector partners (or health partners participate in the CoC's Coordinated Entry system)
  - We have integrated health and housing funding for joint projects

Medicaid/Medicare/Managed Care Organizations (MCOs)

Engage your local Medicaid and Medicare health plans:

- Are EHV households enrolled for eligible benefits (Medicaid, Medicare, VA)? How do we ensure that they are?
- What services do the MCOs offer in your state ? Physical health? Behavioral Health? Care Coordination? Dental/Oral Health? Long-Term Services and Supports? Special services for people experiencing homelessness or other unique populations? Is Housing Supports in your state's Medicaid Plan?
- Does the plan have a housing navigator or coordinator on the staff of the health plan ? If not, can the plan assign a member facing staff person to assist your PHA or COC?
- How can the MCOs work with the PHA and CoC to increase access to mainstream benefits for eligible EHV households? Are there opportunities for services and coordination partnerships?

Medicaid/Medicare/Managed Care (cont.)

Strategies for engagement:

- PHAs, CoCs, and MCOs each operate in different areas of expertise – be prepared to educate and be patient with each other.
- Recognize that each partner has limited resources and capacity, and great need. Try to come together on shared goals.
- Be strategic about who is engaged – start with leadership buy-in and move on to key partners with similar roles across agencies and sectors.

For more, see: Managed Care Resource Brief and Public Housing Agencies and Medicaid Managed Care Organizations

Home and Community Based Services

- Home and Community Based Services (HCBS) for Housing Support Services if your state has a benefit. Check your states status here: Summary of State Actions: Medicaid & Housing Services.
- The American Rescue Plan includes incentives for states to develop new activities as part of their HCBS program. See more here: Additional Support for Medicaid Home and Community Based Services During the COVID-19 Emergency

Primary Health Care

- Health Resources Services Administration (HRSA) Federally Qualified Health Centers (FQHCs) are community-based organizations that deliver patient-centered primary care and other services to vulnerable, medically-underserved populations.
  - Engage health centers around partnership opportunities and ways to increase access of EHV households to high-quality, culturally competent, coordinated primary care, mental health and substance use treatment, and other health care services.
  - $6.1 billion for community health centers to address COVID-19, expand capacity, and enhance services. For more, see the National Health Care for the Homeless Council's issue brief: Using HRSA Health Center Funding from the American Rescue Plan Act to Improve Systems of Care for People Experiencing Homelessness

Behavioral Health Care

Behavioral Health can support ACT teams, Intensive Case Management, health and behavioral health services, and other critical supports.

- Engage local and state health and behavioral health agencies
  - States have vast new resources to expand substance use disorder treatment and services and new funding from ARP that is very flexible.
- Funding: Substance Abuse and Mental Health Services Administration
  - Mental Health Block Grant
  - Substance Abuse Block Grant
  - Grants to Address Homelessness
  - American Rescue Plan (ARP) Funding for Block Grants

Agencies to Support Older Adults and Persons with Disabilities

- Area Agencies on Aging (Triple As)
- Aging and Disability Resources Center (ADRCs)
- Centers for Independent Living (CILs)
- Find your local partners via the Administration For Community Living (ACL)'s Eldercare Locator

Hospital Community Benefit Funds

- Not-for-profit hospitals are obligated to fund activities that benefit their communities. Such funds can be used in many ways, and there are many examples of hospital community benefit projects focused on improving outcomes for people experiencing homelessness and other vulnerable populations.
- Connect with your local hospitals to understand their needs assessment processes, current priorities, and opportunities for partnership.
- For more, see the National Healthcare for the Homeless brief: Hospital Community Benefit Funds

Array of Community-Based Services

Mainstream services and resources available to the community, including EHV households, may include:

- Benefits counseling
- Childcare
- Educational supports
- Workforce supports
- Legal services
- Culturally-specific organizations
- Food and diaper banks
- Financial literacy education
- Financial management and credit building/repair services
- Social, self-help, or other community groups
- Faith communities

Seek out a diverse array of partners, including those that are trusted by people experiencing homelessness, people of color, people with disabilities, LGBTQ-identifying individuals, and other historically marginalized groups.

Community-Based Services: Questions to Ask

- How are households already connected to community-based services? Are there service needs that still are unmet?
- What partnerships already exist and what connections can be made to those agencies already funded to provide these services? How can you help those agencies better understand the needs of the populations you serve?
- Are there options for services that are easily accessible to (and offered by providers that are trusted by) people from historically marginalized populations and subpopulations prioritized by the community for EHVs?
- Can households navigate making connections on their own or do they need support? Can any of those connections be made during the transition period?
- Are services active or passive? Do they actively engage or do they rely on households coming to them?

Defining Quality Services

Voluntary Services

- All supportive services for EHV households should be voluntary
- Housing First does not mean Housing Only
- Service providers use outreach and assertive engagement to connect with individuals
- Services are customized and comprehensive, reflecting the evolving needs of a household

Person-Centered Services

- Individuals lead their services; co-create services plan
- Individuals set their own goals
- Services are flexible
- Service providers are there to support people in housing, not manage them
- Services are culturally specific and providers are trained in cultural humility

Harm Reduction

- Acknowledges that all people engage in risky behavior.
- Helps people engage in risky behavior more safely through education.
- Helps service providers engage with people who are actively engaged in risky behaviors including, substance use, sex-work, choosing not to take medications, etc.
- Non-judgmental approach to providing services.

Trauma

Trauma has a profound impact on functioning and well-being, and is likely present to a high degree in EHV-eligible populations because of overlapping, intersecting trauma from circumstances including:

- Losing housing
- Negative experiences with the homeless assistance system
- Surviving domestic violence, dating violence, sexual assault, stalking, or human trafficking
- Experiencing the stress and pain of discrimination (including being subjected to harm or threats of harm, being humiliated or shamed, experiencing micro-aggressions, and witnessing discrimination) based on one's race or ethnicity, national origin, gender identity, sexual orientation, ability status, or other factors

Trauma-Informed Services: Core Principles

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration
- Empowerment
- Humility and Responsiveness

Source: https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

Services for Survivors

- In addition to safe housing and other basic needs, survivors of domestic violence, sexual assault, stalking, dating violence, and human trafficking may have unique needs for rehousing and recovery, including:
  - Trauma-informed services that take into account physical health, mental health, and safety concerns resulting from abuse
  - Legal services to obtain protective orders, restraining orders, or child support assistance, to resolve warrants, or address other needs
  - Assistance regaining economic independence, including credit repair
  - Services responsive to the needs of survivors from historically underserved or marginalized populations
  - Heightened confidentiality and information sharing protections

HUD Q+A

Reminder- Next Webinar

Date/Time	TA Topic
May 11 3-4pm EDT	EHV Program Overview
May 12 2:30pm - 4pm EDT	EHVs for CoCs
May 13 3pm - 4:30pm EDT	Partnerships for EHVs
May 18 3pm – 4:30pm EDT	Strategy for Targeting EHVs and Related Resources
May 20 3pm – 4:30pm EDT	Pairing Services and EHVs
May 25 **3pm – 4:30pm EDT**	**Coordinated Entry and EHVs**
June 1 3pm – 4:30pm EDT	Making the Most of EHV Waivers

Thank you!