FINAL COMPREHENSIVE REPORT

Housing Search Assistance for Non-Elderly People with Disabilities

U.S. Department of Housing and Urban Development | Office of Policy Development and Research

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Prepared for
U.S. Department of Housing and Urban Development
Office of Policy Development and Research

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Foreword

Since the 1999 *Olmstead* U.S. Supreme Court decision affirming the right of people with disabilities to live in integrated housing settings according to their needs, community-based housing assistance and services and support options have expanded for people with disabilities. Despite this progress, people with disabilities still face significant barriers to accessing supportive housing assistance due to difficulties such as navigating program eligibility requirements, searching for housing, and coordinating services and supports.

Through a literature review, interviews with key stakeholders, and nine case studies, this study identifies significant barriers that people with disabilities face when accessing and using rental housing assistance and successful strategies to address those challenges. The study also developed one brief (published separately) that highlight participants' experiences in some of the programs included in the case studies.

The study found that significant challenges people with disabilities face include aligning the timing of services and supports with the timing of housing assistance so that needed services are available alongside housing, overcoming rigid screening requirements, accessing funds for accommodations or necessary modifications that exceed what a landlord is required to provide, and covering transition and initial expenses after move-in.

Successful strategies that help people with disabilities succeed in supportive housing programs include a consistent and extended case management approach, understanding participants' circumstances beyond housing, using flexible funds to address gaps, supporting staff and engaging their expertise, incorporating individuals with lived experiences, engaging with landlords to mitigate the challenges people with disabilities face, and effective partnerships with state and local agencies.

We hope this report can be a resource to housing agencies and service providers and help them improve housing and service outcomes for people with disabilities.

Solomon Greene
Principal Deputy Assistant Secretary for Policy Development and Research
U.S. Department of Housing and Urban Development

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Executive Summary

In 1999, the U.S. Supreme Court ruled in *Olmstead* v. *L.C.* (527 U.S. 581) that unjustified segregation of people with disabilities constitutes unlawful discrimination under the Americans with Disabilities Act, requiring public entities to deliver community-based services as an alternative to institutional care. That decision paved the way for significant progress in the expansion of housing options for people with disabilities across the United States. State and federal governments increased community-based housing and services for people with disabilities, thereby diminishing reliance on institutions, such as nursing facilities and psychiatric hospitals. In recent years, states and the federal government have further expanded their support for people with disabilities through programs, such as rental assistance and health and human services agencies delivering home- and community-based services (HCBS).[1]

Despite this expansion of housing assistance and service programs at the federal and state levels, people with disabilities continue to face structural barriers, defined here as barriers to accessing housing that broadly affect low-income individuals and households, including those with disabilities. These barriers include a limited supply of affordable rental housing, limited availability of rental assistance, and limited availability of accessible units. Even when rental assistance and accessible units are available, renters often face difficulties finding landlords who are willing to participate in housing assistance programs. At the same time, leasing rates for vouchers and units designated for people with disabilities trend below the target rate set by the U.S. Department of Housing and Urban Development (HUD).[2] These facts suggest that the need for housing assistance is going unmet while, simultaneously, housing resources are being underutilized.

Against this backdrop, HUD sought to conduct a study exploring promising approaches that help people with disabilities overcome these barriers and successfully use housing assistance. This study drew on input and recommendations from a group of expert researchers, practitioners, and policymakers to identify programs that use effective strategies to assist people with disabilities to secure housing—including pre-tenancy services, such as assistance across the housing search, leasing up, moving in, and transition components of the process. The selected programs have a wide geographic range and target different populations, such as people moving from institutional settings or experiencing

[1] This support includes HCBS delivered through federal and local programs and organizations.
[2] As of November 2022, only 73 percent of Mainstream and 87 percent of Non-Elderly Disabled vouchers were leased—rates that trend below the 90-percent minimum target set by HUD. Furthermore, only 59 percent of units under contract for the section 811 Project Rental Assistance program had been leased as of June 2022.

homelessness. Although many organizations and government agencies measure success by the ability of participants to maintain stable housing after moving in, the scope of this study did not include post-move-in services needed for people with disabilities to maintain housing.[3] Because past research has widely documented persistent structural barriers, this study focused on uncovering the challenges that emerge when a person has secured housing assistance and is attempting to locate and obtain housing for his or her individual needs, which the research team refers to as *implementation and process challenges*.

The study's findings stem from three primary areas of research:

- A systematic review of published articles, federal reports, state and local documents, and local and national organization reports.
- An environmental scan that involved semi-structured interviews with key stakeholders who work closely with people with disabilities.
- Nine case studies that sought to identify the major components of promising housing assistance programs, including the key organizations and agencies involved, key services provided, staffing models and needs, funding sources, and unique strategies. For each case study, the research team conducted interviews with program staff, program partners, and, where possible, individuals who have received assistance from the program.

The study's main findings fall into two key categories:

- Process and implementation challenges people with disabilities face in accessing and using housing assistance.
- Successful strategies for assisting people with disabilities as they locate, lease up, and move into housing.

Key Findings: Process and Implementation Challenges to Accessing and Using Housing Assistance

Nongovernmental organizations and agencies actively work to mitigate these often highly context-dependent challenges when supporting people with disabilities in

[3] Because of the ways in which programs measure their success and impact (typically based on the maintenance of stable housing), this study used each program's measures of pre-tenancy success and expert researchers' assessment of their impact on participants to select case study sites and distill key findings and successful strategies.

using housing assistance.[4] The study characterized these challenges using the following groupings.

ALIGNING THE TIMING OF SERVICES AND SUPPORTS WITH HOUSING

Programs experienced challenges aligning the timing of services and supports with the different steps that people with disabilities encounter in the housing process. The window of time a person has to use their voucher makes it difficult to align the timing of a participant's voucher issuance, their housing search and move into housing, and the timing of service delivery. If someone has a 60-day window to find, lease up, and move into a unit, that may not be enough time to put together and execute a service plan to coordinate support services that address the participant's needs and make any necessary accommodations to the unit.[5] Throughout the housing process, several factors can be time-consuming and often cause delays, including navigating eligibility requirements, difficulties acquiring needed supplies (such as furniture before move-in), and coordinating services to begin in a timely manner after the move-in, which is often affected by the limited availability of direct support workers. Programs reported instances in which severe delays in the process may keep a person from successfully obtaining housing if their voucher expires before they are able to find, lease up, and move into housing and, in other cases, people may become eligible for HCBS yet are unable to access housing assistance.

SEARCHING FOR HOUSING

Challenges while searching for housing include difficulty navigating complex federal, state, and local assistance systems, which may be more significant for people with disabilities; the limited number of housing coordination or navigation staff to support housing searches; and lack of access to transportation while searching for housing.

APPLYING FOR A LEASING AGREEMENT

These challenges include rigid screening requirements, such as those that screen people out due to past evictions, credit checks, a lack of access to required documentation, and discrimination from landlords, all of which may preclude people with disabilities from renting a unit.

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[4] People with disabilities also commonly face challenges with maintaining housing after the move-in process, and many programs profiled offer services to mitigate those challenges. However, such challenges were not the focus of this study and are not discussed here.

[5] The 60-day term is a minimum and initial term. PHAs may grant families one or more extensions of the initial voucher term as a reasonable accommodation.

MOVING INTO HOUSING

Even after securing a rental property, people with disabilities may still face challenges in the form of a lack of funds for accommodations or necessary modifications that exceed what a landlord is required to provide; a lack of transition assistance, such as neighborhood orientation; and a lack of funding flexibility to cover key costs related to housing transitions, such as moving assistance, funds for security and utility deposits, the stocking of pantries, and furniture funding.

Key Findings: Successful Strategies in Assisting People with Disabilities Locate, Lease Up, and Move into Housing

The programs profiled in these case studies helped the research team identify promising strategies for overcoming the aforementioned challenges. Many programs have employed each of the following strategies.

A CONSISTENT CASE MANAGEMENT APPROACH DURING AN EXTENDED PERIOD IS ESSENTIAL FOR SUCCESS

Supporting people with disabilities in accessing and maintaining housing is most effective with strong case management and coordination. Effective case management begins with program staff developing a tailored plan for the individual. Such plans allow staff to develop an approach for each participant on the basis of their specific needs and housing goals. Furthermore, these plans consider the need to extend support services[6] beyond the move-in of participants to ensure longer-term housing stability. For example, the ability of Connecticut's Medicaid Money Follows the Person (MFP) program to offer a consistent case management team for up to 180 days before move-in and 1 year after move-in allows sufficient time for participants to settle into their homes and secure additional supports as needed.

EFFECTIVE PROGRAMS ADOPT A HOLISTIC APPROACH TO SERVING PARTICIPANTS

Effective programs employ a holistic approach, defined as the idea that individuals should be empowered to set their standards for a good life. Programs use this principle by adopting strategies that stress the need for an understanding of a participant's full circumstances beyond merely their housing needs and incorporate those needs and the participant's input into their plans and case management strategies. This process is composed of two phases:

[6] Support services include activities that support an individual's opportunity to prepare for, find, and transition to permanent housing that meets their needs in their given environment or context and to sustain their tenancy after move-in.

1. Understanding the participant's circumstances, context, and needs. This evaluation includes their specific housing needs, such as number of bedrooms, accessibility features, location, and cost, and any barriers that may prevent them from successfully locating, leasing up, and maintaining stable housing, such as a criminal background, past evictions, or current substance use.
2. Providing coordinated support services to address the participant's needs throughout the pre-tenancy process. This support may include tenancy and independent living skills education, support with navigating the locating and leasing-up process, counseling and recovery services, and neighborhood orientation, among others.

PROGRAM EFFICACY IS STRENGTHENED BY FLEXIBILITY IN FUNDING

Housing assistance programs can draw from both public and private sources to fund their efforts, and effective programs rely on a mix of different funding sources to maximize their impact. Sources of public funds include federal or state grant funds, housing funds, Medicaid funds, and targeted funds for veterans. Public funds often have strict guidelines dictating how funds may be used. Sources of private funds include corporate sponsors, individual donors, and partnerships with other local nonprofit organizations. Program staff emphasized the importance of receiving private funds that have the flexibility to fill gaps resulting from misaligned program funding requirements. Seattle's Downtown Emergency Services Center's (DESC) supportive housing program receives private donations used to support furniture acquisition, gift cards for move-in expenses, and other transition supports for program participants. Louisiana's Permanent Supportive Housing and Connecticut's MFP programs are two examples that demonstrate the extent to which Medicaid HCBS funding allows for significantly greater flexibility in supporting a wide range of activities. These services and supports include pre-tenancy case management and planning, housing search, move-in costs, housing modifications, short-term rental assistance, tenancy skills and education support, post-move-in case management, and ongoing in-home services.

CREATIVE APPROACHES TO STAFFING CAN IMPROVE PROGRAM CAPACITY TO MEET INDIVIDUAL NEEDS

The way programs approach staffing is a key aspect of providing holistic services, including hiring and training for specific staff dispositions and skills.

The study identified specific staff dispositions to be key components of program success. These personality traits include approaching participants without

judgment, understanding that harm reduction is the first goal for long-term success, and tailoring a system of support that will help participants maintain housing.

This approach also involves leveraging staff skills in complementary ways to address process and implementation challenges. Programs reported that they developed specific staff skills to mitigate the challenges they frequently encounter. Louisiana's Permanent Supportive Housing, for example, employs staff who are certified Housing Quality Standards inspectors, which increases their efficiency because they can inspect a unit quickly and early in the housing process before starting any paperwork. This strategy mitigates the wait time that typically occurs when relying on outside Housing Quality Standards inspectors and provides staff the certainty that the unit is suitable before moving too far along in the housing application process.

A DEDICATED APPROACH TO SUPPORTING PROGRAM STAFF IS A KEY COMPONENT OF A PROGRAM'S SUCCESS

The required work of housing assistance programs is demanding, and staff always face the risk of burnout. Effective programs take a dedicated and intentional approach to supporting their staff by prioritizing staff development, offering trainings, setting shared goals, and incorporating staff perspectives. For example, Connecticut's MFP program offers informational sessions, provides quarterly training, and holds meetings every 2 weeks for staff to discuss challenges and solve problems as a team.

INCLUSION OF INDIVIDUALS WITH LIVED EXPERIENCE IN DESIGNING SERVICE DELIVERY MODELS CAN ENSURE THAT PROGRAMS MEET PARTICIPANTS "WHERE THEY ARE"

The perspectives of individuals who have previously been served by programs or have relevant lived experiences are critical inputs to designing approaches for housing assistance and ensuring that solutions are effective and supportive. Individuals with lived experiences can serve as outreach staff, provide ongoing peer support after move-in, or assist in other ways. New Reach's supportive housing program in New Haven, Connecticut, for example, invites past participants to serve on its board to ensure that their perspectives play a role in program services.

STRONG RELATIONSHIPS WITH LANDLORDS MITIGATE CHALLENGES FACED BY PEOPLE WITH DISABILITIES WHEN LEASING HOUSING UNITS

Effective programs form strong relationships with landlords. This rapport provides program staff the opportunity to educate landlords about the services they offer, build trust between the program and landlords, and allow staff to negotiate on behalf

of program beneficiaries. Strong relationships ultimately reduce challenges to both successful acquisition and continued possession of stable housing. Seattle's DESC Supportive Housing program, for example, uses this strategy and signs a master lease agreement with landlords whereby DESC is responsible for any damage that occurs in the unit during the lease term. This agreement incentivizes landlords to participate in leasing units to tenants who are not subject to the landlords' screening criteria.

EFFECTIVE PARTNERSHIPS WITH STATE AND LOCAL HOUSING AUTHORITIES MITIGATE SOME CHALLENGES TO HOUSING

Effective programs develop partnerships with their state and local housing authorities, particularly in providing accessible housing units, vouchers, and rental assistance. These partnerships allow programs to coordinate access to rental assistance for participants and expedite the process of acquiring rental units. For example, Connecticut's MFP and Louisiana's Permanent Supportive Housing programs partner with their state's Department of Housing or Housing Corporation to coordinate access to rental assistance for program participants.

Opportunities for Future Research

This study focused on the pre-tenancy phase of the housing process across nine programs in various regions of the United States. The approaches employed by these programs provide important information about how best to support people with disabilities as they move into assisted housing. Given this study's scope, ample opportunities exist for future research to build upon its findings. Policymakers, program staff, and advocates would benefit from a better understanding of the following:

- How do best practices differ on the basis of the needs of participants with different disabilities?
- How does greater flexibility in the timing and sequencing of state and federal programs affect the challenges this report has identified?

This study focused on pre-tenancy support; however, program staff consistently described the importance of post-tenancy support for participants to maintain stable housing. It would be valuable to learn more about the experience of people with disabilities using housing assistance after moving into housing. The following research questions may build on the study's findings:

- How can pre-tenancy and post-move-in services better align to support people with disabilities?
- Which post-move-in services are most effective in maintaining housing?
- How do approaches to service delivery differ on the basis of whether a participant is placed in a scattered-site unit versus a single-site unit?[7]

HUD may consider drawing from a larger number of programs across different geographic regions for future research. Studies that incorporate a greater variety of program approaches and sampling from a more diverse range of program participants would bring even greater insights into the role of housing assistance in the lives of people with disabilities.

[7] *Scattered-site* refers to individual housing units throughout the community. Programs using scattered-site housing place their clients in private market apartments throughout a geographical area as opposed to a specific cluster in a single property with multiple assisted units. *Single-site* refers to housing units that are centralized within a single housing project and location.

1. Introduction

In 1999, the Supreme Court ruling in *Olmstead* v. *L.C.* (527 U.S. 581) prompted state and federal governments to expand community living options for people with disabilities. Despite significant progress, a large proportion of people with disabilities continue to have unmet housing needs and be at risk of homelessness or being placed in an institutional setting. Data from the 2021 Worst Case Housing Needs Report to Congress shows that 1.04 million very low-income households with people with disabilities did not receive assistance and had worst-case housing needs, defined as paying more than half of their income for rent, living in severely inadequate conditions, or both (Alvarez and Steffen, 2021). More than 4.8 million non-elderly people with disabilities rely on Supplemental Security Income, which is typically insufficient for securing housing; therefore, many people with disabilities may be unable to afford housing without rental assistance (Bailey, de la Huerga, and Gartland, 2021). People with disabilities have a higher risk of experiencing homelessness or being placed in nursing homes or other institutional settings (U.S. Interagency Council on Homelessness, 2018).

In addition to having unmet housing needs and being at a higher risk of experiencing homelessness or being placed in institutional settings, people with disabilities face several structural barriers in obtaining access to high-quality and affordable housing: barriers to accessing housing that broadly affect low-income individuals and households, including those with disabilities. These barriers include an overall lack of affordable units (Alvarez and Steffen, 2021) and a lack of units with accessibility features, such as ramps, permanent grab bars, and entry-level full bathrooms (Souza et al., 2011). Even when units are available, people with disabilities may face higher rates of rejection when applying for housing (Pinkett et al., 2018). Furthermore, essential health and support services,[8] such as access to transportation or providers offering assistance with personal activities, such as bathing, dressing, cooking, or cleaning, may not be close to the available units (Shea et al., 2004). Many people with disabilities ultimately turn to housing assistance services to overcome these challenges and gain access to housing. People who are 62 years old or older can access housing assistance services targeted to both seniors and people with disabilities, and, as a result, additional supports and resources designed for older adults may help to mitigate some of these challenges. However, non-elderly people with disabilities do not have access to the same services targeted to seniors and,

[8] Support services include activities that assist individuals to live in the community in ways that meet their needs and help them sustain tenancy.

therefore, may have different needs, challenges, and experiences in locating affordable housing.

To better identify the challenges with accessing and using housing assistance programs and to identify promising strategies that organizations use to secure housing for non-elderly people with disabilities, 2M Research Services, LLC, conducted research under the Housing Search Assistance for Non-Elderly[9] People with Disabilities study for the U.S. Department of Housing and Urban Development (HUD), Office of Policy Development and Research. The focus of the study was pre-tenancy services, such as housing navigation and transition coordination to investigate how these services meet the needs of non-elderly people with disabilities as one component of the housing process. The study did not include post-move-in services needed for people with disabilities to maintain housing.

Categories of Disability in this Study:

1. People with serious mental illness
2. People with substance use disorders
3. People with physical or sensory disabilities
4. People with intellectual or developmental disabilities

Note: Categories can be co-occurring

The study addresses the following six research questions:

1. What are the major barriers or challenges that people with disabilities face when applying to rental assistance programs, searching for housing, leasing up, and moving into a unit?
2. What are the major strategies, approaches, or programs that housing agencies and partners use to address the barriers or challenges people with disabilities face when applying for and using rental assistance?
3. What are the major service and funding gaps in addressing the barriers or challenges of people with disabilities in the use of rental assistance?

[9] The housing assistance programs included in the study serve people with disabilities of all ages and do not distinguish between non-elderly people with disabilities and elderly people with disabilities. Therefore, the study's findings may apply to people with disabilities more generally and are not necessarily exclusive to the non-elderly population.

4. How do the need and availability of services vary for different populations, including those who come from different settings or have different types of disabilities?
5. For up to nine promising strategies, approaches, or programs, what are their major characteristics, such as providers involved, types of services offered, targeted population and number of people served, strategies employed, staffing and funding sources, and major results or impacts?
6. What are a few major recommendations worth considering for local housing and service agencies that target housing assistance to people with disabilities, policymakers responsible for the formulation of housing and services programs for people with disabilities, and future research topics?

Programmatic and Policy Context

Several federal and state programs offer housing search assistance to non-elderly people with disabilities. Key housing assistance programs include rental assistance programs and Medicaid-funded health and human services programs.

HOUSING ASSISTANCE PROGRAMS THAT SERVE PEOPLE WITH DISABILITIES

Various rental assistance programs and other housing assistance programs serve people with disabilities. Two types of HUD-administered rental assistance programs target non-elderly people with disabilities:

- **Tenant-based rental assistance,** provided through the Housing Choice Voucher (HCV) Program, includes Special Purpose Vouchers for people with disabilities that enable eligible participants to choose public or private housing that meets the requirements of the program. Choices are not limited to units in subsidized housing projects. Special Purpose Vouchers for people with disabilities include the Mainstream[10] and the Non-Elderly Disabled (NED) vouchers.[11] As of November 2022, more than 400 public housing agencies (PHAs) had used this tenant-based rental assistance through 69,017 Mainstream and 54,727 NED vouchers (HUD, 2022a).

[10] HUD, n.d.b. "Mainstream vouchers assist non-elderly persons with disabilities and are administered using the same rules as other housing choice vouchers. Funding and financial reporting for Mainstream Vouchers is separate from the regular tenant-based voucher program."
[11] HUD, n.d.c. "NED vouchers enable non-elderly disabled families to lease affordable private housing of their choice." NED vouchers are awarded to PHAs in the form of two categories: Category 1 (NED1) and Category 2 (NED2). "NED1 vouchers enable non-elderly persons or families with disabilities to access affordable housing on the private market. NED2 vouchers enable non-elderly persons with disabilities currently residing in nursing homes or other healthcare institutions to transition into the community."

- **Project-based rental assistance,** provided through Section 811 Project Rental Assistance (PRA) Program, includes units set aside for people with disabilities (HUD, n.d.d.). State housing agencies contract with multifamily property owners to set aside subsidized units for eligible participants. As of June 2022, state housing agencies had 5,483 units under contract for the Section 811 PRA program (HUD, 2022b).

The Consolidated Appropriations Acts of 2017, 2018, and 2019 allocated $500 million for new Mainstream vouchers, which are designated for non-elderly people with disabilities and currently serve approximately 50,000 households. Mainstream and NED vouchers are two resources that help HUD reach its goals of ending homelessness and supporting the integration mandate of the Americans with Disabilities Act. However, for both voucher programs to realize their full potential, PHAs must ensure the maximum utilization of these vouchers. As of November 2022, only 73 percent of Mainstream and 86 percent of NED vouchers were used. Both rates trend below the expected 90 percent utilization rate for high-performing PHAs (HUD, 2022a). Moreover, only 59 percent of units under contract for the Section 811 PRA program (through the state housing agencies) have been leased as of June 2022 (HUD, 2022b). These data demonstrate how housing resources may be underused.

The HUD Continuum of Care (CoC) Program is also an important resource to fund housingfor people with disabilities who are experiencing homelessness or at risk of experiencing homelessness. The CoC Program provides funding to nonprofit providers and state and local governments to support the operation of both tenant-based and project-based Permanent Supportive Housing programs which offer non-time limited rental assistance with wrap-around supportive services. The CoC program also funds Rapid Re-Housing programs to quickly rehouse individuals and families experiencing homelessness using time limited tenant-based rental assistance that can also promote access to other mainstream services and supports for individuals and families experiencing homelessness.

In addition, some states and local governments have their own rental assistance programs. In 2023, the National Low Income Housing Coalition identified 353 active state- and city-funded rental housing programs (Abdelhadi and Aurand, 2023) The following are a few examples of rental assistance programs targeted to people with disabilities:

- The Arizona Bridge Subsidy Program
- The Connecticut Rental Assistance Program
- The Elderly Rental Assistance Program

- The Delaware Rental Assistance Program
- The Georgia Housing Voucher Program
- The Illinois Bridge Subsidy Program
- The New York Rental Subsidy and Support Service Program
- The Oregon-Supported Housing Rental Assistance Program

These programs, many of which are modeled on the federal HCV program, aim to expand the supply of permanent supportive housing for people with disabilities. Some states and cities also provide emergency assistance to help people with disabilities avoid eviction or homelessness, including security deposits and move-in assistance. Examples of such programs are the DC Emergency Rental Assistance Program and the Phoenix Emergency Assistance Program. In addition, some states and cities offer rental assistance through tax relief in the form of a rebate for qualified renters. Examples of these tax relief programs are the Colorado Property Tax, Rent, and Heat Rebate Program and the Connecticut Renters Rebate Program.

MEDICAID-FUNDED PROGRAMS THAT ASSIST PEOPLE WITH DISABILITIES WITH HOUSING

In addition to the aforementioned housing assistance programs, states are allowed to use Medicaid funds to provide home- and community-based services (HCBS) for people with disabilities, including housing-related services. Medicaid historically has not covered certain housing costs (including rent) due to a statutory prohibition on paying directly for room and board in HCBS.[12] However, the Centers for Medicare & Medicaid Services (CMS) recently clarified opportunities to address social determinants of health using Medicaid funds, including housing and tenancy supports (CMS, 2021a), and has approved several state demonstration waivers authorizing services to meet "health-related social needs," including coverage of short-term rental assistance and tenancy supports to address housing instability for certain populations (CMS, 2022a).

The Money Follows the Person (MFP) demonstration is a federal grant program that supports state efforts to transition Medicaid-eligible individuals from residing in institutional settings—such as nursing facilities, intermediate care facilities for individuals with intellectual or developmental disabilities, and long-term psychiatric care facilities—to living more independently in the community. MFP allows states to use Medicaid funds to cover the cost of services and activities, such as home accessibility modifications, pre-tenancy supports, community transition services, and case management for up to 6 months before the person moves out of the institution and transition and supportive services costs for up to 12 months following

[12] 42 U.S.C. 1396n §1915(c).

the move (CMS, 2022b). Upon transitioning to the community, MFP participants receive Medicaid HCBS for ongoing support. Many states have used MFP funds to hire housing navigators, such as housing specialists, housing coordinators, and transition coordinators, to provide various housing supports and services to MFP participants (Irvin, Denny-Brown, and Morris, 2016). Between 2008 and 2019, the MFP demonstration transitioned 101,540 persons from institutions to community living in homes, apartments, or other community residential settings. Coordination between housing and health and human services programs can help to develop, build, and strengthen housing and health partnerships, as suggested by Nisar et al. (2021).

STRUCTURAL BARRIERS FOR THOSE SEEKING AFFORDABLE HOUSING

Despite the expansion of housing options for people with disabilities at the federal and state levels, these individuals continue to face structural barriers to obtaining housing. These structural barriers are overarching and affect all low-income households seeking housing, as well as barriers specific to people with disabilities, and include the following:

Limited supply of affordable rental housing. The country has a widespread shortage of affordable rental units for very low-income renter households. Data for 2019 indicated that only 70 affordable units existed for every 100 low-income renter households, and only 40 of the 70 affordable units were available for occupancy by low-income renter households (Alvarez and Steffen, 2021). Even in situations in which eligible households receive housing assistance, finding housing under HUD's payment standard can be difficult (Mazzara and Gartland, 2022).

Limited availability of housing assistance relative to the need. The most recent "Worse Case Housing Needs" report finds that HUD assistance is limited and serves only one-fourth of the housing need for very low-income renters (Alvarez and Steffen, 2021). The limited availability of rental assistance is evidenced by long waiting lists for these programs. In 2020, eligible households who had applied for and received a voucher had waited an average of 2.3 years (Alvarez and Steffen, 2021). The average rent for a one-bedroom apartment exceeds the entirety of a Supplemental Security Income payment (Technical Assistance Collaborative, 2021), the primary income source for more than 4.8 million Americans with disabilities. This gap between income and housing affordability increases the demand for rental assistance for people with disabilities.

Difficulties finding landlords willing to participate in rental assistance programs. Beneficiaries of housing assistance programs sometimes face difficulties finding landlords to accept vouchers even when vouchers and suitable units are available

(Cunningham et al., 2018; Garboden et al., 2018; Nisar et al., 2018). As a result, housing choices remain extremely limited.

Shortage of accessible housing. Although the lack of available affordable housing and available housing assistance is not unique to people with disabilities, many people with disabilities face the additional challenge of searching for accessible units or units that will allow for environmental modifications, such as ramps or permanent grab bars. Several studies of various housing assistance programs and housing-related service programs found that the shortage of accessible housing remains a major challenge to people with disabilities using housing assistance (Hoffman, Kehn, and Lipson, 2017; Irvin, Denny-Brown, and Morris, 2016; Kellett, Ligus, and Robison, 2021; Thompson et al., 2021). The 2019 housing accessibility data from the American Housing Survey show that although 19 percent of households include an individual who has a mobility-related disability, these households live in homes that are not fully accessible (SP Group LLC, 2022). This study also conducted interviews with expert stakeholders, who revealed that accessibility is a key challenge, and many multifamily housing units, especially units built before the introduction of legal requirements for physical accessibility as a fair housing right, are inaccessible to people with physical disabilities. Nearly 40 percent of households that include a person with accessibility needs live in homes that do not have accessibility features, such as "ramps, lifts, [and] entry-level bedrooms or full bathrooms" (HUD, 2021). Bo'sher et al.'s (2015) analysis of U.S. housing data examined the amount of accessible housing and found that "around a third of housing in the [United States] is potentially modifiable for a person with a mobility disability." However, the study also found that "less than [5] percent is currently accessible for individuals with moderate mobility difficulties and less than [1] percent of housing is accessible for wheelchair users."

Report Organization

This report is organized into five chapters. Following the **introduction,** the research team details in **chapter 2** the study methodology and includes a summary of the data used. **Chapter 3** discusses the challenges people with disabilities face when applying for and using housing assistance. **Chapter 4** provides an overview of the programs selected as case studies; summarizes the programs as they relate to program purpose and goals, service delivery approaches, staffing, partnerships, and funding models; and identifies the key strategies the programs have used to locate, lease up, and transition people with disabilities into housing. The research team presents the conclusions in **chapter 5** with a discussion of the key findings across the literature review, environmental scan, and case studies. The research team also describes the limitations of the research and suggests avenues for future inquiry.

The case study for each program is included in **appendix A.** Details on the systematic literature review process are detailed in **appendix B,** and the master interview guide for the case studies is available in **appendix C.** References are included in **appendix D.**

2. Study Design and Data Analysis Methods

This study used a mixed methods approach consisting of four major phases:

1. A **literature review** that systematically examined published articles, federal reports, state and local documents, and local and national organization reports to identify major challenges that non-elderly people with disabilities face in accessing and using housing assistance (considering people with different types of disabilities and from different housing settings).

2. An **environmental scan** that involved semi-structured interviews with key expert stakeholders who work closely with non-elderly people with disabilities to identify programs that work to address challenges people with disabilities have accessing housing that meets their needs.

3. Nine **case studies** of promising approaches and programs that help non-elderly people with disabilities overcome challenges in obtaining and ultimately moving into housing (namely through rental assistance using tenant-based and project-based vouchers).

4. A **synthesis** of the data gathered during earlier phases that culminated in a Comprehensive Report.

Exhibit 2.1 provides a summary of the phases that make up the study's design. The approach to each phase is detailed in the remainder of this chapter.

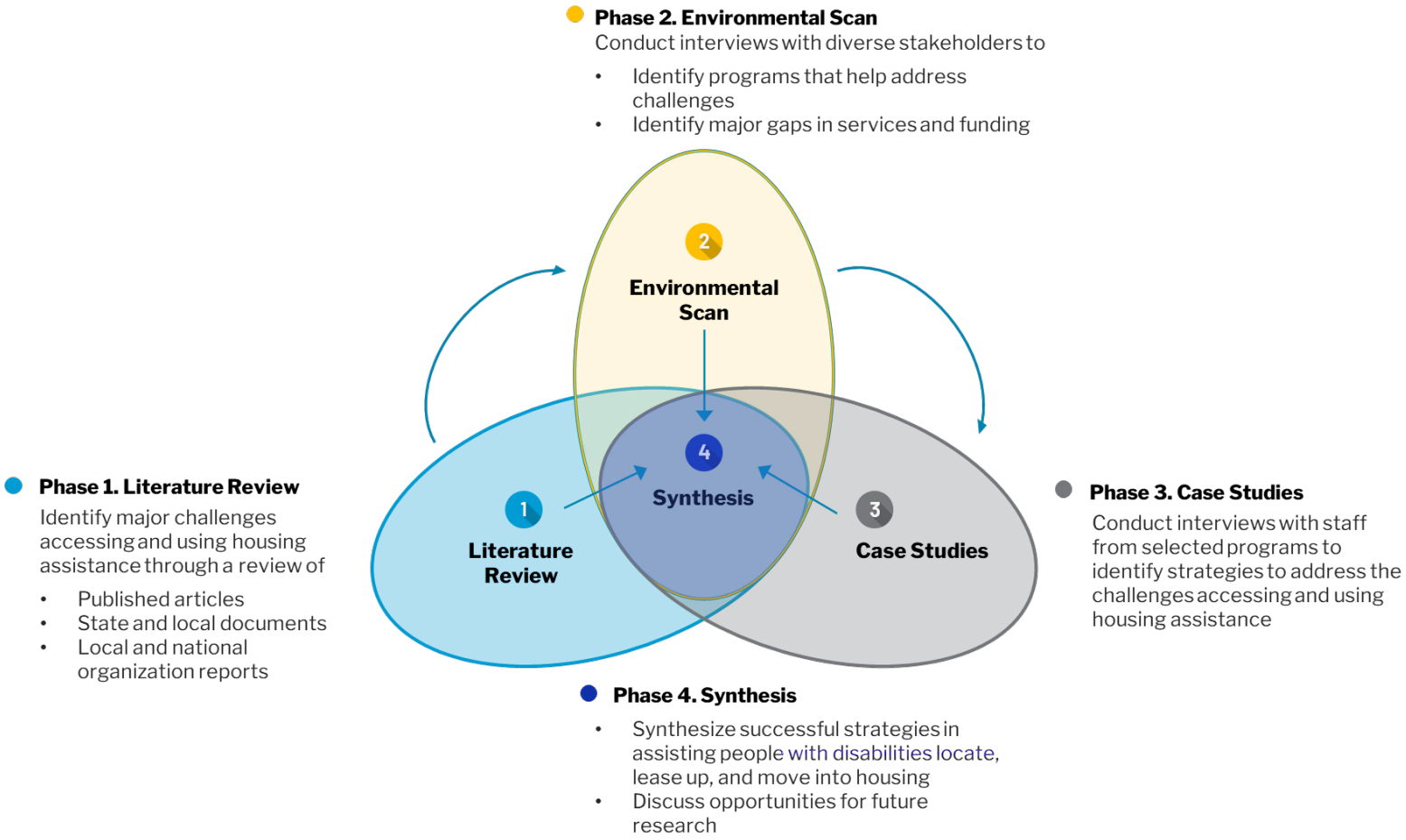


Exhibit 2.1: The Study's Mixed Methods Design

Source: Authors' graphic representation of the methodology

Literature Review

The objective of the literature review was to provide insights into the challenges people with disabilities face when applying for and using housing assistance. Between December 2021 and February 2022, the research team comprehensively searched pertinent academic databases, state and federal government websites, and organizational websites to identify potentially relevant articles and reports published or written in the past 10 years (2011 or later) on housing assistance programs that serve people with disabilities. Example searches included the NED Voucher, the Mainstream Voucher, Section 811 PRA programs, and Medicaid programs that help people with disabilities address their housing-related needs and transition into their communities (for example, HCBS and the MFP demonstration). Additional details on the systematic literature review process are available in **appendix B**.

The research team systematically tracked and reviewed all titles and abstracts, including the reasons for exclusion based on criteria listed in **exhibit B.5** in **appendix B**. Each included report received a full-text review, and the research team extracted information regarding the challenges that people with disabilities face while securing housing. The research team then synthesized all these challenges into the findings available in **chapter 3**.

Environmental Scan

The objective of the environmental scan was (1) to leverage the literature review's findings to help the research team better understand the strategies and programs that assist people with disabilities to overcome the challenges of accessing and using housing assistance and (2) to make a final selection of nine programs for the case study component of the study. In conducting the environmental scan, the research team interviewed nine diverse expert stakeholders, including disability advocacy experts, affordable rental housing providers, supportive housing providers, disability law experts, technical assistance providers, and service providers who work closely with people with disabilities.

These expert stakeholders have deep knowledge of the following:

- The needs of people with disabilities and the services they require to successfully use housing assistance.
- The challenges that people with disabilities face in securing housing using assistance.

- The promising strategies and programs that assist people with disabilities to overcome these challenges.
- Any major service and funding gaps in addressing these challenges.

List of Programs in the Study

1. Bridgeway Supportive Housing
2. Swords to Plowshares' Supportive Housing
3. Home Forward
4. DESC's Permanent Supportive Housing
5. Louisiana's Permanent Supportive Housing
6. New Reach's Supportive Housing
7. Connecticut's MFP Demonstration
8. Alliance for Disability Advocates
9. LIFE Inc. Center for Independent Living

As part of the interviews conducted during the environmental scan, the research team asked expert stakeholders to identify the strategies, approaches, and programs that communities use to assist people with disabilities in securing housing assistance and ultimately moving into new homes. The team asked expert stakeholders to recommend particular programs and approaches to be considered for the case studies.

After completing the interviews, the research team conducted a qualitative analysis of the interview data using a multistep coding process. Upon completion of the coding, the research team ran structured queries to explore the data and create a matrix based on emergent themes while carefully considering program characteristics. The research team then conducted a thematic analysis of the coded data to identify themes relevant to the associated research questions and extract key learnings regarding programs that may be ideal for developing the case studies.

Approach to Developing the Case Studies

The objective of the case studies was to identify promising programs and to investigate how the selected programs are addressing the challenges that people with disabilities face when obtaining and moving into housing. The research team identified 20 programs with promising and successful approaches to serving groups of people with different disabilities on the basis of feedback from the expert stakeholders interviewed during the environmental scan. The research team then worked with staff from HUD and the Administration for Community Living (ACL) to

choose 9 programs from the original 20 for inclusion into the case studies on the basis of the following selection criteria:

- The target population included people with disabilities (including people with serious mental illness[13], substance use disorders[14], physical or sensory disabilities, and intellectual or developmental disabilities).
- The programs represented different geographic areas across the United States.
- The programs provided housing-related services.

After selecting the programs, the research team scheduled and conducted interviews with program staff, partners, and past program participants.

DEVELOPMENT OF THE INTERVIEW GUIDE AND QUALITATIVE DATA COLLECTION

Following the selection of programs, the research team used information gathered from the environmental scan, discussions with HUD and ACL, and publicly available information and documents from the various programs to develop a master interview guide for each program. The research team then organized the content of each master guide into standard domains based on the research questions and included questions specific to the unique and innovative aspects of each program and questions relevant to the types of stakeholders to be interviewed for each program. **Appendix C** includes the master interview guide for each program. The research team scheduled 60-minute telephone interviews with up to nine stakeholders per program between June and September 2022. To interview individuals assisted by the programs, the research team sought assistance from program staff to schedule and organize the interviews with program participants. Ultimately, the research team interviewed eight program participants across six programs on the basis of these individuals' availability and willingness to participate.

QUALITATIVE DATA ANALYSIS

The research team developed a high-level codebook to distill the interview data by program, which was tailored to each program on the basis of key components. Interview transcripts were grouped by program and assigned one team member to

[13] Serious mental illness is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

[14] Substance use disorder is a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications.

code data per program; this method enabled the coders to build familiarity with the nuances of their assigned programs. After data coding, the research team completed a within-program thematic analysis of the data to create a case study of each program. This analysis summarizes critical components of the program's promising strategies in helping people with disabilities obtain and move into housing facilities, including service delivery approaches, relevant tools, staffing, and partnerships. These case studies are included in **appendix A**.

Approach to Synthesis

The objective of the final phase was to provide suggestions that help inform local housing and service agencies that assist people with disabilities and federal and state policymakers responsible for formulating housing services and to identify topics for future research. To achieve this objective, the research team synthesized data from the earlier phases, which involved integrating the findings from the literature review, environmental scan, and case study analysis. The results of this analysis and informational brief are being shared in this Comprehensive Report.

3. Challenges in Obtaining and Using Housing Assistance for People with Disabilities

Drawing from the literature review, environmental scan, and case studies, this chapter presents the findings on the major challenges that non-elderly people with disabilities face when using housing assistance. It specifically presents challenges related to searching for housing, leasing up, and ultimately moving into a unit. Because past research has widely documented persistent structural barriers, such as a limited supply of affordable rental housing, limited availability of rental assistance, and limited availability of accessible units, this chapter focuses on uncovering implementation and process challenges. Such challenges occur after housing assistance is secured and a person is seeking to locate and obtain housing that is appropriate for their individual needs. These barriers are challenges that nongovernmental organizations and agencies actively work to mitigate when supporting people with disabilities in using housing assistance and are often highly context specific.[15] Chapter 4 discusses the promising strategies programs employ to mitigate these challenges for their clients.

Aligning the Timing of Services and Supports with Housing

Program staff identified a key issue of fragmentation across the housing assistance process, in which locating, leasing up, and moving into appropriate housing using housing assistance often require engagement with various public programs. The coordination between agencies may lead to potential points of failure, such as misaligned timelines during the transition between dwellings when people living in institutional settings are scheduled to transition before their new unit is available, oversight on expiration dates of housing vouchers, and the omission of necessary modifications to housing units before move-in. This fragmentation also makes it difficult to align the timing of services and supports across the different steps in the housing process. For example, participants may not have access to a housing voucher at the time of their transition to a new home. Other participants could have a voucher yet be unable to secure housing before the voucher expires. Vouchers typically expire after 60 to 180 days, providing people with disabilities and the housing assistance programs a very limited timeframe to identify, secure, and move into a rental unit.

[15] People with disabilities also commonly face challenges with maintaining housing after the move-in process, and many programs profiled offer services to mitigate these challenges. However, these challenges were not the focus of this study and are not discussed here.

Throughout the housing process, several factors can be time consuming and often cause delays, including the completion of eligibility processes; difficulties acquiring needed supplies, such as furniture before move-in; and coordination to initiate services upon the move-in, which is often hampered by the limited availability of direct support workers.

Searching for Housing

COMPLEX PROCESS OF NAVIGATING SYSTEMS TO FIND AVAILABLE HOUSING RESOURCES

Most expert stakeholders interviewed during the study's environmental scan noted the complexity of federal, state, and local housing assistance systems. A wide range of community programs exists, and each one has differing requirements, target populations, and resources. Depending on eligibility, location, and the methods used to search for housing, individuals may not learn about every resource and option available to them. This situation is exacerbated by the limited availability of accessible and affordable units and the lack of a centralized and comprehensive database of existing accessible housing options for people with disabilities.

Expert stakeholders explained that public housing waiting lists are not always separated into those who need accessible units and those who do not, resulting in frequent mismatches between what residents need and the units offered to them. In addition, some applicants may lack a clear understanding of how to request an accessible unit when they apply for housing.

INADEQUATE NUMBER OF HOUSING COORDINATION OR NAVIGATION STAFF

Housing coordinators and navigators are individuals trained to help program participants navigate the many complex layers of the housing assistance system. Program staff stressed the importance of having knowledgeable and dedicated housing navigators and acknowledged that such navigators are frequently unavailable. This scarcity raises further challenges for people with disabilities as the burden of searching for both housing and housing assistance falls on them. Such individuals must first call housing assistance programs to receive a list of potential public housing agencies and property owners. Participants then contact these agencies or property owners to learn if there is an open waitlist, if any units are available, and whether any of those units are accessible. Even if participants successfully find appropriate housing, they must then gather the requisite documentation and fill out their application, which takes additional time, knowledge, and skill. This process can be time-consuming and daunting for people trying to

work their way through a complex and fragmented system, ultimately making the housing search more difficult.

LACK OF TRANSPORTATION

Transportation for people with disabilities is often a tremendous challenge, particularly in locations heavily reliant upon cars. An estimated 13.4 million Americans ages 18 to 64 have travel-limiting disabilities, and working-age adults with disabilities are less likely to drive (60 percent) than adults without a disability (92 percent) (Brumbaugh, 2018). This situation adds to the complexity of the housing search and the need to identify housing in geographic areas with adequate and accessible transit options. These conditions include unobstructed sidewalks and walkways usable by people with mobility limitations; walkable distances to affordable goods, services, and social and economic opportunities; and accessible green spaces and other features.

For people searching for housing in their community while residing in an institution, these competing needs and challenges may be exacerbated by the unique circumstances of institutional living. For example, an expert stakeholder noted that if an interview is required for an available housing unit, scheduling might become a challenge due to the difficulty of finding a time that works for both the landlord and the institutionalized resident. In many cases, the resident may have limited transportation options due to possible unreliable scheduling of public transportation, limited availability of staff members or shuttles at the institution to transport residents, or rules set by the institution limiting times when residents can leave.

Applying for a Leasing Agreement

RIGID SCREENING REQUIREMENTS AND LACK OF ACCESS TO REQUIRED DOCUMENTATION

Several of the profiled programs specifically serve people experiencing homelessness, and program staff noted that although their target population is people experiencing homelessness, many participants also have a disability, such as mental or behavioral health conditions. As such, a major challenge to using housing assistance for people with disabilities is the rigid screening requirements of housing providers. Program staff and expert stakeholders reported that many individuals in this population often struggle to provide needed basic documents, such as a birth certificate or a driver's license, to apply and meet eligibility requirements for housing assistance. For many people, the lack of a regular fixed address also serves as a hindrance to obtaining such documents.

Applications frequently ask individuals to provide additional documents, such as positive references from current landlords, third-party income verifications, credit scores, criminal history, and wet signatures. These established rules and criteria can prevent people experiencing homelessness, many of whom have a disability, from completing all the steps required to apply for housing using housing assistance. Some people may believe the housing is not intended for them or that they would be required, as one program participant said, "to give up too much" to get the housing due to time restrictions or other requirements.

DISCRIMINATION AND PREJUDICE AGAINST PEOPLE WITH DISABILITIES

Some expert stakeholders and program staff noted that discrimination and prejudice are major challenges to obtaining housing assistance for people with disabilities. People with disabilities appear to face housing discrimination disproportionately. More than half of the discrimination complaints reported to the National Fair Housing Alliance (2017) by private fair housing organizations, HUD, and the Department of Justice (DOJ) in 2016 were cases of discrimination against persons with disabilities. Some examples of housing discrimination based on a disability may include charging higher deposits to cover reasonable accommodations and modifications, refusing to rent specific units on the basis of assumptions about someone's disability, and stereotyping people with serious mental illness. For example, landlords might express reluctance to rent to people with disabilities or complex medical conditions due to perceived risk (Hoffman, Kehn, and Lipson, 2017) or fear of damage to the unit (Thompson et al., 2021). In addition to these stereotypes, the expert stakeholders revealed that private landlords, in many instances, presume that people with disabilities may be unable to work and thus cannot pay their rent on time. Some expert stakeholders argued that people with disabilities are "screened out through some process because the housing providers do not have the capacity to work with a population that requires more intense care."

Moving into Housing

LACK OF REASONABLE ACCOMMODATIONS AND MODIFICATIONS TO EXISTING HOUSING UNITS

Under the Fair Housing Act, landlords are required to provide reasonable accommodations, such as changes, exceptions, or adjustments to a rule, policy, practice, or service (for example, allowing a service animal in a "no pets" building or assigning an accessible parking space). However, these required reasonable accommodations often do not meet all the accessibility requirements for people with disabilities.

Federally assisted housing providers are required to make reasonable accommodations and bear costs that do not "amount to undue financial and administration burden." Structural modifications that do amount to undue financial burden on the housing provider are allowed, but the housing provider does not cover these costs. In such a case, tenants are responsible for not only requesting approval for needed modifications from the landlord but also securing the necessary funds to cover the expense. In many cases, the tenants must also cover the cost of restoring the unit to pre-modification conditions at move-out.

Expert stakeholders explained that even when a private landlord allows modifications, the tenant must expend substantial time and costs to negotiate the specific changes with the landlord, identify resources to cover expenses, seek any needed permits, contract for the work, and ensure that the work is complete before move-in. This additional burden often becomes another challenge for occupancy for the tenant.

LACK OF OR INADEQUATE TRANSITION ASSISTANCE AND SUPPORT INTO PERMANENT HOUSING

Expert stakeholders noted that the transition of people with disabilities, especially from homelessness or an institutional setting, into permanent housing is often a complex and time-consuming process that requires thoughtful planning, coordination across housing and support services, and the securing of financial resources and reasonable accommodations. Adequate time and assistance for transition support are therefore crucial for people with disabilities to successfully move into and remain in housing.

NONCOVERAGE OF KEY COSTS RELATED TO HOUSING TRANSITIONS

Expert stakeholders reported that most housing assistance programs do not cover key costs related to housing transitions, such as moving assistance, funds for security and utility deposits, the stocking of a pantry, and furniture. This noncoverage creates logistical challenges for people with disabilities as they move into housing. Program staff confirmed that existing funding streams may not always be sufficient or flexible and that funding overall can be an ongoing challenge for many of these programs.

Several expert stakeholders described that many people with disabilities had found suitable housing, but they were unable to use their vouchers because they lacked the extra money needed to hire a rental truck to move into their unit. In the absence of flexible funds to cover these shortfalls, securing housing through housing

assistance could be particularly challenging for people with disabilities, especially those who have extremely low incomes.

4. Successful Strategies to Assist People with Disabilities Locate, Lease Up, and Transition into Housing

In this chapter, the research team identifies promising strategies that organizations use to assist people with disabilities in overcoming challenges in accessing pre-tenancy services and securing housing. It begins with an overview of the nine programs reviewed in this study and provides details of their purposes, goals, offered services, modes of delivery, target populations, staffing, partnerships, and funding (**exhibit 4.1).** The chapter continues by identifying approaches to service delivery, funding, and support that these programs share. The chapter concludes by discussing what successful strategies have in common and highlighting eight key elements of successful programs.

Exhibit 4.1: Overview of Programs

Program	Housing-Related Services Offered[a]	Funding	Key Partners	Target Populations
Bridgeway Supportive Housing (Elizabeth, NJ)	Housing location and navigation; housing coordination and transition	Mix of state funds; U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA); and HUD	State and local housing and health agencies; partners who provide healthcare-related services, such as Bridge to Wellness	People with serious mental illness[b] who are experiencing chronic homelessness or who are coming out of state hospitals
Swords to Plowshares' Supportive Housing (San Francisco, CA)	Housing location and navigation; housing coordination and transition	U.S. Department of Veterans Affairs (VA) funds and HUD funds; city and county funds; and other resources	VA; local supportive services organizations; local businesses; and nonprofit organizations	Veterans experiencing homelessness or at risk of homelessness[c]
Home Forward (Portland, OR)	Rental assistance; housing location and navigation; housing coordination	HUD funds; Low-Income Housing Tax Credit (LIHTC); and other resources	Multnomah County Joint Office of Homeless Services	Households that meet all Housing Choice Voucher (HCV) Program requirements
Downtown Emergency Service Center's Permanent Supportive Housing (Seattle, WA)	Rental assistance; housing location and navigation; housing coordination and transition	McKinney-Vento Continuum of Care (CoC) funds; HUD funds; Medicaid funds;[d] income earned through the program's rental properties; and other resources	Local housing agency; local housing navigation and healthcare providers; University of Washington; meal provider organizations	People (and their families) with serious behavioral health conditions and serious mental illness who are experiencing chronic homelessness
Louisiana's Permanent Supportive Housing Program (LA)	Rental assistance; housing location and navigation; housing coordination	HUD funds; state Medicaid funds	State housing and health agencies; service providers, such as	People with significant and long-term disabilities who meet Medicaid

Program	Housing-Related Services Offered[a]	Funding	Key Partners	Target Populations
			Easterseals and Startcorp	institutional level of care
New Reach's Permanent Supportive Housing (New Haven, CT)	Rental assistance; housing location and navigation; housing coordination; peer support	Mix of HUD funds, state funds, income earned through the program's rental properties, and other resources	State housing and health agencies	Individuals, primarily women, who are experiencing homelessness or are at risk of homelessness[e]
Connecticut's Money Follows the Person Demonstration (CT)	Rental assistance; housing location and navigation; housing coordination and transition	Mix of Medicaid and state funds	State housing and health agencies; private case management entities; area agencies on aging and independent living centers; University of Connecticut	People with disabilities and older adults who have been institutionalized for at least 60 days
Alliance for Disability Advocates (Raleigh, NC)	Housing location and navigation; housing coordination and transition coordination	Predominantly Center for Independent Living (CIL) grant; state and local grants; private donors	State housing finance and health agencies; local housing and social services providers; local reentry commissions; and nonprofit organizations	People with significant disabilities
LIFE Inc. Center for Independent Living (Lubbock and San Angelo, TX)	Housing location and navigation; housing transition and coordination; payee services	Predominantly CIL grant; state funds	Local housing and social service providers	People with significant disabilities

[a] Housing navigation and location services include assistance with activities, such as, but not limited to, submitting applications, obtaining documentation, locating housing, and processing discharge from other settings. Housing transition services include assistance with activities, such as, but not limited to, making home modifications, paying initial deposits, acquiring household goods, and setting up community services. Payee services include, but are not limited to, providing support for budgeting, maintaining funds for tenants, and processing payments to landlords and other services. For additional description and definition of these and other services, please refer to the Services Offered section within this chapter.
[b] Participants can have co-occurring diagnoses, such as intellectual or developmental disabilities and substance use disorders.
[c] Although having a disability is not a requirement of the program, approximately 44 percent of all veterans served reported living with a disability, including traumatic brain injury or post-traumatic stress disorder.
[d] Medicaid historically has not covered certain housing costs (including rent) due to a statutory prohibition on paying directly for room and board in HCBS. However, CMS recently clarified opportunities to address social determinants of health using Medicaid funds, including housing and tenancy supports. CMS has also approved several state demonstration waivers authorizing services to meet "health-related social needs," including coverage of short-term rental assistance and tenancy supports to address housing instability for certain populations (CMS, 2021a).
[e] New Reach's services are not limited to serving people with disabilities, but many of its participants have mental illness disabilities or substance use disorders.
Source: Authors' analysis of qualitative interviews with programs' stakeholders

PROGRAM PURPOSE AND PERFORMANCE METRICS

Five of the nine programs reviewed in this study are housing assistance programs. These programs—Bridgeway's Supportive Housing, Home Forward, Swords to Plowshares' Supportive Housing, Downtown Emergency Service Center's (DESC) Permanent Supportive Housing, and New Reach's Permanent Supportive Housing — provide direct access to services and housing, including both public housing and options through private landlords. For example, Home Forward is a public housing authority that operates a supportive housing program through the Bud Clark Commons, a housing development project using project-based rental subsidies, and multiple scattered-site housing options. DESC owns and operates approximately 1,400 units of permanent supportive scattered-site housing across 16 buildings. In addition to providing permanent housing to their beneficiaries, these housing assistance programs help with accessing supportive services. Examples include activities that support an individual's opportunity to prepare for, find, and transition to permanent housing and support for sustaining their tenancy after move-in. These programs typically combine affordable housing with intensive, coordinated services to meet the housing and health needs of people with disabilities.

The four other programs—Connecticut's MFP Demonstration,[16] Louisiana's Permanent Supportive Housing, North Carolina's Alliance for Disability Advocates, and Texas's LIFE Inc.—are supportive service programs. These programs provide home- and community-based services to people with disabilities as alternatives to placement in institutions, such as nursing facilities. Louisiana's Permanent Supportive Housing,[17] Connecticut's MFP program,[18] and Home Forward[19] are operated through government agencies, whereas the other six programs are operated by private nonprofit 50©)(3) organizations.

[16] Connecticut's MFP program has succeeded partially due to a unique state-funded rental assistance program that helps participants access subsidized housing in a timely manner for Medicaid-eligible individuals moving out of institutional settings.
[17] Louisiana's PSH program employs a systems-level approach using partnerships between state-level housing assistance administered through the Louisiana Housing Corporation and Medicaid-funded health and human services administered as Home and Community Based Services through the Louisiana Department of Health.
[18] Connecticut's MFP program is operated by the Connecticut Department of Social Services and the program funds certain positions at the state's Department of Developmental Services and the Department of Mental Health and Addiction Services.
[19] Home Forward is an independent housing authority federally funded and regulated by HUD.

Although all nine programs differ in their structure and approach to service delivery, they share a common goal of providing maximum independence and achieving community living[20] for their participants.

PROGRAM PERFORMANCE METRICS

Given the diversity in their approaches, funding structures, and locations, these nine programs share no standardized metrics against which their outcomes and successes are measured. Available metrics differ both in terms of what is measured and their period of measurement (for example, annual benchmarks versus cumulative benchmarks). The case studies in **appendix B** describe each program's benchmarks and reporting processes.

However, there are patterns in how programs measure efficacy. Most programs measure success through tenancy metrics, such as number of participants housed (participants served) and the percentage of those who maintain stable housing (retention rates). Additionally, several programs also track the extent to which participants use vouchers, transition from institutional or temporary housing settings, and avoid the use of emergency services or hospitalization (**exhibit 4.2**).

[20] The programs generally define *community living* as the opportunity to choose where they live in noninstitutional settings, earn a living, participate in society, and make decisions about their lives.

Exhibit 4.2: Cross-Program Benchmarking Goals

	Voucher Utilization	Retention Rates	Transition Rates	Hospitalizations/ Emergency Services	Participants Served
Bridgeway Supportive Housing		X		X	X
Swords to Plowshares Supportive Housing					X
Home Forward	X	X		X	X
Downtown Emergency Service Center's Permanent Supportive Housing	X	X		X	X
Louisiana's Permanent Supportive Housing	X	X			X
New Reach's Permanent Supportive Housing		X	X	X	X
Connecticut Money Follows the Person Demonstration		X	X		X
Alliance for Disability Advocates					X
LIFE Inc. Center for Independent Living	X		X		X

Source: Authors' analysis of qualitative interviews with programs' stakeholders.

SERVICES OFFERED

Housing Location or Navigation Services:

- Assist with submitting an application.
- Assist with obtaining all documentation.
- Assist with processing the discharge from an institutional setting.
- Assist with searching for or locating housing.
- Assist with transportation to visit housing.
- Assist with appeal to lease application denial.

Housing Transition Services:

- Assist with procuring furniture and household goods.
- Assist with paying security deposit.
- Assist with home modification request.
- Assist with physical move to the unit.
- Assist with moving paperwork and inspections.
- Ensure that needed medical equipment is delivered and set up before move-in.
- Assist with or set up community services.
- Orient individuals to new neighborhood.

All nine programs provide services for locating and transitioning to new housing. All programs share the goals of moving participants into stable housing and supporting them in maintaining that housing. The programs offer a range of services that include the following:

- case management or coordination services
- assistance with finding or modifying accessible housing
- crisis prevention and management
- health and wellness services
- independent living skills
- employment
- personal, peer, or social support to promote healthy relationships and interpersonal skills
- eviction prevention

- neighborhood orientation
- payee services to support budgeting and on-time payments to landlords and other third parties

TARGET POPULATION AND SERVICE DELIVERY

The programs generally target people with disabilities who are coming from institutional settings, are at risk of institutionalization, or have experienced chronic homelessness. We identified two categories of service delivery programs that differ based on the target population and funding sources. . **"Housing First" programs.,** which target people experiencing homelessness, including people with disabilities; and **"Disability-Focused" programs,** which targets people with significant disabilities who are seeking community housing while residing in institutions or other residential settings. These two categories of programs share many features; for example, Disability-Focused programs use an approach common to Housing First called Person-Centered Planning. These programs recognize participants as central in making decisions about their own lives, including housing choices and primarily differ in terms of the target population and the funding streams supporting those providers. However, because Disability-Focused programs are not targeted to people actively experiencing the crisis of homelessness they can consider and prioritize housing in the context of all the other domains of need, including health care, personal supports, transportation, employment, and family or social capital, among others.

The remainder of this section discusses key components of these two categories of programs.

Housing First Approach for People Experiencing Homelessness

Housing First programs emphasize a holistic understanding of participants' housing needs and provide them immediate access to safe, high-quality, and affordable housing and supportive services without prerequisites or preconditions (CSH, n.d.; Gilmer et al., 2014; Kertesz et al., 2017). Programs using a Housing First approach focus on creating stability through access to housing for people experiencing homelessness (including people with disabilities who experience additional barriers to pre-tenancy and tenancy services) while also providing access to necessary support and health services as an important component of the overall model. Programs employing this approach include Swords to Plowshares' Supportive Housing, Downtown Emergency Service Center's Permanent Supportive Housing,

New Reach's Supportive Housing, and Home Forward. Louisiana's Permanent Supportive Housing[21] also uses the Housing First approach for some populations.

Disability-Focused Approach for People in Institutions or Other Residential Settings

Disability-Focused programs employ person-centered[22] principles to provide HCBS to people with disabilities with a focus on providing services and supports before, during, and after moving into housing. Programs using a Disability-Focused approach typically target people with disabilities who are currently receiving care in, or facing the risk of placement in, a nursing facility, intermediate care facility, or psychiatric hospital. To be effective, staff working in these programs focus on understanding and planning holistically for the needs, priorities, and housing requirements of the program beneficiaries. In keeping with this approach to service delivery and because of the funding streams these programs utilize, Disability-Focused program staff often have the resources to customize services, supports, and housing options according to participant needs and wants along with their health and medical necessities, which often are identified through an assessment of participants' clinical and functional needs.

This report describes various aspects of the Disability-Focused approach across the nine programs; however, five of these programs target their services specifically to people with disabilities who are at risk of institutionalization or currently institutionalized; these programs include Alliance for Disability Advocates, Bridgeway Supportive Housing, Connecticut's MFP, LIFE Inc., and Louisiana's Permanent Supportive Housing Program. These programs generally assess a participant's needs before their transition into housing to ensure alignment between their needs, their housing, and the supportive services they receive. The Louisiana Permanent Supportive Housing program combines both approaches in its pre-tenancy work: moving people with disabilities experiencing homelessness into rapid housing options while also seeking to holistically meet the needs of people with

[21] Although Louisiana's PSH program also uses a Housing First approach to service delivery for some populations, their target populations are those meeting Medicaid eligibility, not necessarily people experiencing homelessness. Because the program targets people with disabilities, it qualifies more appropriately for the Disability-Focused category.

[22] Person-centered practices are generally supported by four key principles: (1) The person is at the center of the planning process, and his or her desires should be heard, honored, valued, and reflected in the services received. (2) People should make choices (with support, if needed and wanted) about services and supports, and with decisions regarding their health, well-being, and life goals. (3) People must have full access to the community and be treated with dignity and respect. (4) People should have access to an array of individualized services that meet their needs. (Human Services Research Institute, 2019)

disabilities who are seeking to move out of institutions or facing the risk of institutionalization.

STAFFING

All nine programs have dedicated staff who assist participants through the pre-tenancy and tenancy process, delivering different forms of case management, housing supports, and coordination services along the way. Stakeholders universally described these roles as critical to program success. Each program has its own language for describing these functions, the scope of activities, and case management roles, which are broadly defined in the following list:

- **Information and Referral or Intake Coordination:** These staff typically are the first point of contact for a potential program participant and usually engage participants to assess their functional and psychological needs. Furthermore, these coordinators assess participants' financial situation to understand their preferences and consider eligibility factors. In addition, these staff work with participants to set their goals and desired outcomes for program participation.
- **Transition and Services Coordination:** These staff seek to identify available housing and service resources that are aligned with the needs of participants. Furthermore, they assist participants in applying for eligibility-based services and support individual planning and implementation processes as participants plan to meet the goals they set in the referral or intake stage. This assistance may include activities such as helping people gather documentation or attend appointments.
- **Housing Coordination:** These staff work with eligible participants to identify their specific housing needs and preferences, including accessibility and location needs. Staff assist with the housing search and application process and coordinate applicants' transition into housing. These transition services may also include activities such as coordinating move-in efforts or assisting with home furnishings.

PARTNERS

For most programs, a partnership with their state's department of housing and local PHA is crucial. Each program also fosters relationships with its state's department of social services, human services, mental health and addiction services, and the state Medicaid program. These state agencies provide participant referrals, especially in the case of Connecticut's MFP and Louisiana's Permanent Supportive Housing

programs, and they oversee funding to supportive housing organizations serving populations with disabilities, including people with mental illness or substance use disorders. Staff from all programs also described having effective partnerships with private landlords, community-based organizations, and related nonprofits to provide core housing services. Two programs, Connecticut's MFP and Seattle's DESC, have partnered with local universities for evaluation purposes.

FUNDING

Each of the nine programs receives funding from multiple sources:

- **Federal, State, and Local Funds.** Most of the reviewed programs rely upon multiple public funding streams. These organizations receive one or more types of federal HUD funding through initiatives, such as Community Development Block Grants, Mainstream HCVs, Section 811 Project Rental Assistance (PRA), or the Continuum of Care (CoC) program which is sometimes referred to as Shelter Plus Care. For housing-related health and social services, Medicaid is the most frequent payer across all programs; the Centers for Medicare & Medicaid Services (CMS) matches state investments with federal funding through a range of authorities, including the MFP Demonstration, HCBS 1915(c) waivers, and 1115 waiver demonstrations. Due to the statutory prohibition on room and board in community settings, however, Medicaid funds do not apply to long-term rental subsidies. Similarly, the MFP program allows only short-term rental assistance for up to 6 months after moving in. Some programs also rely on federal grant funds from the HHS Administration for Community Living or the HHS Substance Abuse and Mental Health Services Administration, whereas DESC accesses resources from the U.S. Department of Education through the McKinney-Vento Act. Except for Medicaid, state funding across the programs varies substantially. Connecticut's MFP program also receives state funds to support rental subsidies for MFP participants through the state's Rental Assistance Program. Finally, some programs, such as Home Forward, use local funds, which rely on a local municipal tax dedicated to homelessness.

- **Private Funding and Rental Income**. Other program funding sources include income from program-owned rental properties and private donations. In 2021, for example, DESC received donations of goods and services worth approximately $4 million. These funds support furniture acquisitions, gift cards, and other transition supports.

Key Strategies for Connecting Program Participants to Housing

> "I always put it as a comparison of taking a lion out of the jungle and putting them in a cage . . . It was overwhelming. It was a lot to handle. But in order for me to get back into the daily living skills . . . being a mom and learning how to pay bills, learning how to pay rent and getting a career . . . I needed to work in collaboration with my caseworker and . . . I wish that everybody would be able to utilize that . . . because I needed that structure but not forever."
>
> **—New Reach Program Participant**

As described previously, the nine programs included in this study share several features, but they also represent a diversity of approaches and serve broad target populations across the country. An analysis of the approaches together yields some overarching lessons drawn from these programs' experiences and potentially promising practices for other, similar programs around the country.

The study details eight key elements of promising strategies that emerged across the nine programs. These strategies are identified as "promising" for two reasons: first, they were consistently identified by staff within a program as strategies that these programs feel are key to their success, and second, they were defined as such across multiple programs and contexts, suggesting clear potential for portability to other programs and contexts.

1. A CONSISTENT CASE MANAGEMENT APPROACH DURING AN EXTENDED PERIOD IS ESSENTIAL FOR SUCCESS

Across many of the programs, a strong case management approach (whether a team of coordinators or only one case manager) helps ensure that highly individualized supports are identified, accessed, and delivered through multiple steps in the process—regardless of engagement with multiple programs and multiple needs. The case manager serves as a point of contact throughout either the entire process or at various points in the process (usually through a warm hand-off approach among coordinators) and often remains a formal or informal resource after a participant is housed; the case manager is also available as participants achieve housing stability and negotiate any new housing-related challenges. Case managers can function as a resource, providing information and connections, and a go-between, negotiating the participant's needs with third parties, such as landlords or healthcare professionals.

> "[My case manager] does anything that she's able to do. She makes the calls . . . cross networking as well. If I had questions, she would look up answers, and if she did not know, she'd refer me to certain other organizations."
> **—LIFE Inc. Program Participant**

Supporting people with disabilities to access and maintain housing appears to be most effective with strong case management or coordination during an extended period. For example, MFP's ability to offer a consistent case management team for up to 180 days before move-in and 1 year after move-in allows enough time for participants to work with the team to assess functional needs, determine housing and support preferences, set goals, make plans to meet those goals, and implement plans. These supports are informed by a holistic plan that program staff develop for each participant related to their goals, including housing outcomes.

2. EFFECTIVE PROGRAMS ADOPT A HOLISTIC APPROACH TO SERVING PARTICIPANTS

> "[The PSH service provider] made sure that I would be safe, everything will be okay. They played a big part in having me getting 811 and finding my housing for me."
> **—Louisiana's PSH Program Participant**

Six of the programs profiled in this study foregrounded a holistic approach when discussing key elements of their success in supporting participants in transitioning to housing. Although all programs take into account the idea that the vast majority of participants will need a network of supports to assist them in locating and maintaining housing, they differ in the degree to which participants are involved at all stages in planning their housing process, in the types of supports they offer, and in the points in the process at which they offer these supports. Programs that define themselves as person-centered first accomplish this approach by adopting strategies that stress the need for an understanding of a participant's full circumstances beyond merely their housing needs; these programs incorporate those needs and the participant's input into their plans and case management strategies. This implementation happens in two phases:

1. Understanding the participant's circumstances, context, and needs. This assessment includes their specific housing needs, such as number of bedrooms, accessibility, location, and cost, and any barriers that may prevent them from successfully locating, leasing up, and maintaining stable housing, such as a criminal background, past evictions, or current substance use.
2. Providing coordinated supportive services to address the participant's needs throughout the pre-tenancy process. This phase may include tenancy and independent living skills education; support with navigating the locating and leasing-up process; counseling and recovery services; and neighborhood orientation, among others.

These approaches seek to address more than just housing-related needs. Home Forward staff described the use of flexible funds from private donations as helpful to providing holistic supports. This assistance may include funding emergency housing stays in motels, paying application fees, and covering deposits. Staff from other programs also described using private funding for expenses, such as gift cards and coffee meetings with participants to help them transition to and maintain their housing.

> "Without [Bridgeway] I don't know if I could have made it through some things. I am very grateful you understand a client's possible episodes and do not take their behaviors personally. . . . What you guys do may be the difference between hope and hopeless, life and lifeless."
>
> **—Bridgeway Program Participant,** Bridgeway Winter 20–21 Newsletter

Although this study focuses on pre-tenancy services, the majority of programs indicated that pre-tenancy services usually are insufficient to guarantee housing stability among the populations they serve. Furthermore, staff suggested that programs need to extend these holistic, supportive services and contact with program staff, such as a case manager, beyond move-in.

3. PROGRAM EFFICACY IS STRENGTHENED BY FLEXIBILITY IN FUNDING

Public funds often have strict guidelines dictating how funds can be used. Program staff expressed that such guidelines often lead to gaps in available funding to cover all of a participant's needs. Staff recalled instances in which participants moved into unfurnished units because they did not have access to funds that could be used to

purchase furniture. Often, programs must rely on multiple resources to fully address the needs of their participants and to fill gaps that result from misaligned systems or program funding requirements. Nearly all the case studies depend on resources from multiple public programs, including federal or state grant funds, housing funds, Medicaid funds, or targeted funds for veterans.

Programs also rely on private funds raised through corporate sponsors, partnerships with other local nonprofit organizations, and individual donors. However, layering funding together can create more complexity and burden for programs when trying to align program requirements to meet participant needs.

Medicaid provides a critical source of flexible funding for both pre-tenancy activities and ongoing tenancy supports, and many programs rely on this funding across the spectrum of their services. Louisiana's Permanent Supportive Housing and Connecticut's MFP programs demonstrate the extent to which Medicaid funding allows for significantly greater flexibility and ensured continuity across the pre-tenancy and tenancy periods. For eligible populations, Medicaid HCBS funding can support a wide range of activities, including pre-tenancy case management and planning; housing search; move-in costs; housing modifications; short-term rental assistance; tenancy skills and education support; post-move-in case management; and ongoing in-home services. Because most programs measure their success through the ability of their participants to maintain housing, program staff highlighted the important link between access to affordable housing and housing-related services and supports, such as health care and transportation, to help participants meet their long-term housing goals. Funding flexibilities allow for these supports and services to be aligned as needed.

4. CREATIVE APPROACHES TO STAFFING CAN IMPROVE THE CAPACITY TO MEET INDIVIDUAL NEEDS

A key aspect of providing effective services is the programs' approach to staffing. Generally, programs took a creative approach to staffing by promoting and providing training for specific staff dispositions and skills and leveraging staff skills in complementary ways to address challenges.

Program staff identified specific staff dispositions as key components of program success. These personality traits include approaching participants without judgment, understanding that harm reduction is the first goal to long-term success, and tailoring a system of support that will help participants maintain housing. Staff who are flexible in the face of structural and funding challenges—in terms of stretching budgets, finding policy workarounds, and designing creative solutions—are critical to effective service delivery.

A few programs reported developing specific staff skills to build capacity, allow for greater flexibility, and address process and implementation challenges. Louisiana's PSH employs certified Housing Quality Standards inspectors to increase efficiency by inspecting a unit quickly and early in the housing process, before any paperwork begins. This strategy mitigates the wait time that typically occurs when relying on outside inspectors and gives staff certainty that the unit is suitable before progressing too far in the housing application process.

5. A DEDICATED APPROACH TO SUPPORTING PROGRAM STAFF IS A KEY COMPONENT OF PROGRAMS' SUCCESS

Several programs expressed that a dedicated approach to supporting their staff can prevent burnout and improve staff's experience, ultimately driving better service delivery. Effective programs take a thoughtful and intentional approach to supporting their staff by prioritizing staff development, offering trainings, setting shared goals, and incorporating staff perspectives. For example, Connecticut's MFP program offers informational sessions, provides quarterly training, and holds meetings every 2 weeks for staff to get together as a team to discuss challenges and solve staff problems, such as high caseloads and the need for a work-life balance. One program staff member explained the link between supporting staff and serving participants: "If we're not providing a healthy, supportive, respected work environment, then it's very hard for them to deliver compassionate and quality services. … I just like to punctuate that because [people] talk a lot about services, but they don't talk a lot about the people who are delivering them, and the nonprofits that are making sure that they have an environment … that they're able to deliver those very critical services to a very high-need population."

6. INCLUSION OF INDIVIDUALS WITH LIVED EXPERIENCE IN DESIGNING SERVICE DELIVERY MODELS CAN ENSURE THAT PROGRAMS MEET PARTICIPANTS "WHERE THEY ARE"

The perspectives of individuals that programs have previously served or those with relevant lived experiences are critical inputs to designing approaches for housing assistance and ensuring that solutions are effective and supportive. Many programs invite past participants to join the staff in the form of outreach staff, peer mentors, or other roles. For example, New Reach invites past participants to serve on its board to ensure that the program captures their perspectives. New Reach also established an integrated care program in which participants have access to peer workers and recovery workers. A staff member who was once a New Reach participant explained that this model has been so effective that they are expanding it: "What's really cool is that now they're hiring more recovery workers and peer workers. We're trying to get more people who have graduated from New Reach to … if they're interested in

becoming peer workers … to come back and work because they make a difference. Saying [to clients] 'Hey, listen, you know, we got the inside scoop. How about we try it this way rather than this way and see how that works?'" Swords to Plowshares, Alliance for Disability Advocates, and LIFE Inc. also employ this approach to staffing and have people with lived experiences working in various levels of the program organization.

7. STRONG RELATIONSHIPS WITH LANDLORDS MITIGATE CHALLENGES FACED BY PEOPLE WITH DISABILITIES WHEN LEASING HOUSING UNITS

Another strategy highlighted by several programs focused on fostering relationships with landlords in the community—namely, landlords who are willing to work with their participants. These relationships allow program staff to educate landlords about the services they offer, build trust between the program and landlords, and negotiate on behalf of program participants.

Staff reported that landlords tend to be more willing to work with their participants when staff can act as a mediator or liaison between the agency, the property owner, and the participant. Program staff considered this strategy critical to serving people with behavioral or mental health conditions. Staff explained that many of their participants are in the process of learning their expectations as tenants and may not engage with management in a respectful manner. When program staff act as a mediator or liaison between the participant and the landlord, staff can work directly with the participant to reach a resolution. Program staff also believed that tenancy skills training was critical to the success of the tenant and landlord relationship. Tenancy skills training includes the provision of program participants with clear expectations of what is required of them as a tenant (for example, making on-time rent payments, engaging with management respectfully, maintaining unit cleanliness, and being courteous to neighbors).

In addition to a willingness to lease up units to program participants, landlords will sometimes waive eligibility requirements that would otherwise deem a participant ineligible if an established relationship exists with the program; these requirements include background checks or income requirements. Ultimately, these relationships ensure that landlords feel secure in the idea that tenants will receive continuing tenancy support from these programs, which will enable tenants to maintain stable housing. The DESC Supportive Housing program signs a master lease agreement with landlords whereby DESC is responsible for any damage that occurs in the unit during the lease term. Program staff reported that this agreement incentivizes landlords to lease units to tenants who are not subject to the landlords' screening criteria.

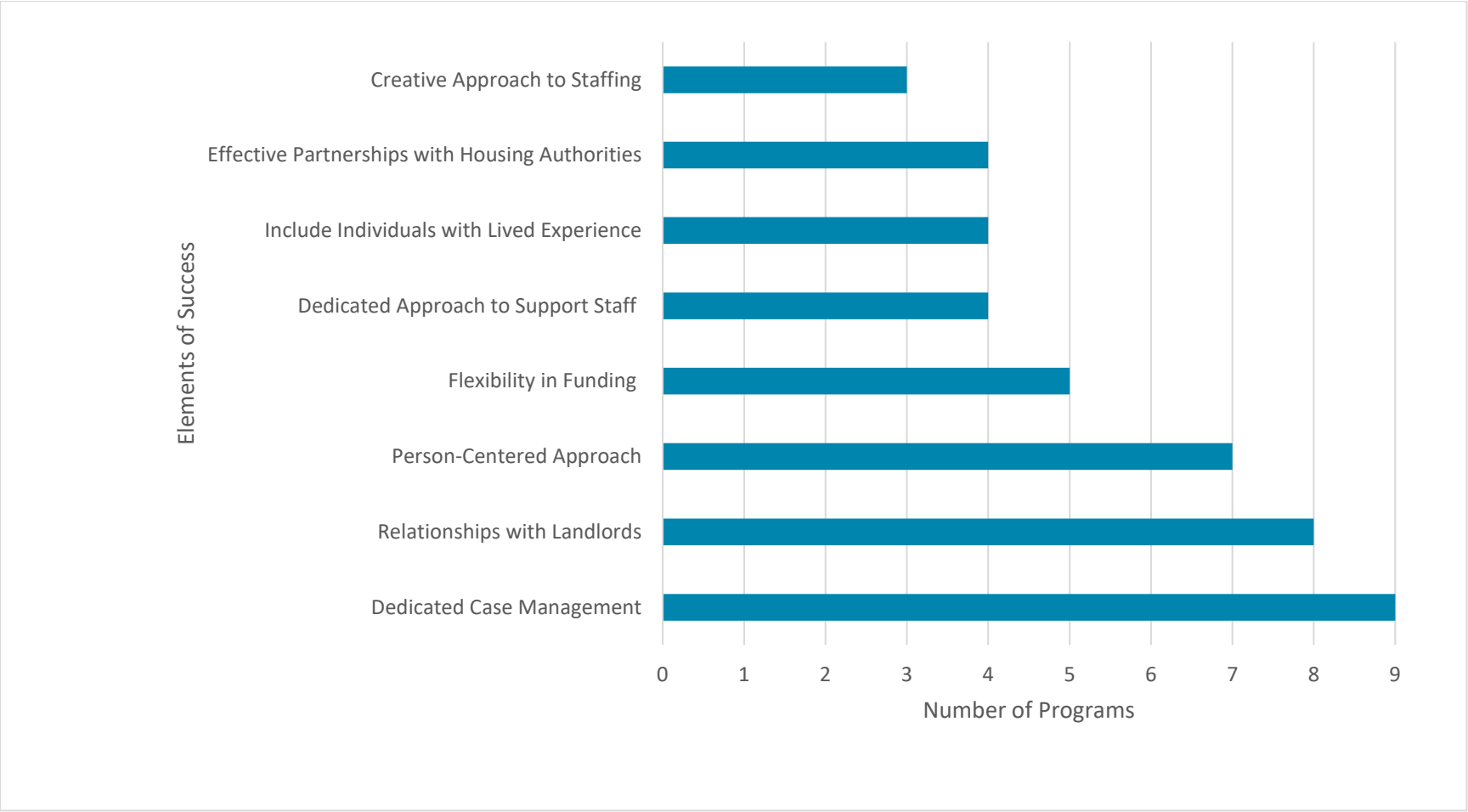
8. EFFECTIVE PARTNERSHIPS WITH STATE AND LOCAL HOUSING AUTHORITIES MITIGATE SOME BARRIERS TO HOUSING

To mitigate challenges related to limited rental assistance, many programs have developed partnerships with their state and local housing authorities, particularly in the provision of housing units, vouchers, and rental assistance. Through a collaboration with the state's Department of Housing, for example, Connecticut provides long-term rental subsidies to MFP participants through the state's rental assistance programs. The Louisiana Permanent Supportive Housing program partners with the Louisiana Housing Corporation to administer coordinated housing assistance to Permanent Supportive Housing participants. These relationships have been helpful because they not only coordinate access to rental assistance for participants but also expedite access to rental units across the state.

Exhibit 4.4 highlights the number of programs in which staff identified key elements of success as components of the program's approach.[23]

[23] Staff were not asked about these elements specifically during the interviews. Rather, these elements emerged from the interviews across each of the programs. Elements not mentioned by program staff may still be used by these programs but are considered to be less successful or less integral to their overall strategy.

Exhibit 4.4: Cross-Program Elements of Success



Source: Authors' analysis of qualitative interviews with programs' stakeholders

5. Conclusion

Taken together, the literature review, environmental scan, and nine case studies illuminate key findings that may better inform service delivery approaches for similar organizations across the country. Furthermore, these insights offer guidance to policymakers working to mitigate the structural and implementation challenges that people with disabilities face as they seek affordable housing and the organizations that support them. These findings also offer avenues for future research because they uncovered other areas of inquiry that would benefit policymakers and practitioners. The following section discusses the study's key findings, describes the limitations of the research, and suggests avenues for future inquiry.

Key Study Findings

Many of the findings from the case studies confirm research in the existing literature, particularly as they relate to some of the major challenges and promising strategies for supporting people with disabilities. In addition, these case studies provide nuance and insight into the discussion surrounding challenges and strategies in the literature—specifically, the implementation and process challenges that people with disabilities face in locating, moving into, and maintaining housing. The case studies also describe the ways in which the various program supports and services work with governmental partners to provide effective services to people with disabilities.

KEY FINDING: IMPLEMENTATION AND PROCESS CHALLENGES TO ACCESSING AND USING HOUSING ASSISTANCE

The study found various implementation and process challenges that people with disabilities experience when using housing assistance. Such challenges emerge when a person has secured housing assistance and is attempting to locate and obtain appropriate housing for his or her individual needs. Nongovernmental organizations and agencies actively work to mitigate these often highly context-dependent challenges when supporting people with disabilities in using housing assistance. The study characterized these challenges using the following groupings:

- **Aligning the timing of services and supports with housing** can be difficult when participants have a limited amount of time to use their voucher, move into housing, and access needed services. Factors that may affect this timing include eligibility requirements, difficulties acquiring needed supplies (such as furniture before move-in), and coordinating initiation of services after the move-in when direct support workers are in short supply.

- **Searching for housing** can be difficult for people with disabilities amid the complexity of federal, state, and local housing assistance systems, the limited number of housing coordination or navigation staff, and the lack of transportation.
- **Applying for a leasing agreement** can be difficult for people with disabilities because of rigid screening requirements, required documentation that may not be available to all participants, and discrimination and prejudice from landlords and housing owners.
- **Moving into housing** can be challenging for people with disabilities because of a lack of funds for reasonable accommodations or necessary modifications that exceed what a landlord is required to provide, a lack of transition assistance, and a lack of funding flexibility to cover key costs related to housing transitions, such as funds for security or utility deposits and the purchase of furniture or household goods.

KEY FINDING: PROGRAMS POINT TO SUCCESSFUL STRATEGIES IN ASSISTING PEOPLE WITH DISABILITIES TO LOCATE, LEASE UP, AND MOVE INTO HOUSING

Across the nine programs, staff identified a set of common strategies for assisting people with disabilities to overcome challenges in obtaining and moving into housing. These strategies may prove beneficial for other Money Follows the Person (MFP) programs, Centers for Independent Living (CILs), and Community-Based Organizations working to serve people with disabilities around the country, particularly as the nine profiled programs have leveraged these strategies in different ways to best fit their contexts. Key promising strategies include the following:

- A consistent case management approach during an extended period is essential to success.
- Effective programs adopt a holistic approach to serving participants.
- Program efficacy is strengthened by flexibility in funding.
- Creative approaches to staffing can improve program capacity to meet individual needs.
- A dedicated approach to supporting program staff is a key component of a program's success.
- The inclusion of individuals with lived experience in designing service delivery models can ensure that programs meet participants "where they are."

- Strong relationships with landlords mitigate the challenges that people with disabilities face when leasing housing units.
- Effective partnerships with state and local housing authorities mitigate some challenges to housing.

Limitations of the Study and Possible Uses for Findings

Although this study has provided important insights into the ways in which available programs support people with disabilities in locating and moving into housing, the research team recognizes the limitations that exist in the scope of the study. These limitations include the following:

- The study examined nine programs for its case studies. A larger sample of programs would enable the research team to capture a more exhaustive list of barriers and successful approaches that may affect people with disabilities seeking to access and secure affordable housing using housing assistance.
- The findings from the nine case studies do not allow the research team to disaggregate their findings by different types of disability and target populations. In engaging program participants, the group that was interviewed was not representative of all demographics, target populations, and disability types, nor did the study seek or reach saturation across the qualitative data collection. Although their input was highly valuable in understanding the challenges, their insights cannot be generalized across all programs and populations.
- The case studies allowed the research team to understand how the MFP demonstration and CILs function in these specific contexts, but their findings are closely related to an individual program's local context and may not be generalizable to other MFP demonstrations and CILs throughout the country. Other state or local models may be useful in identifying and profiling best practices and service delivery successes—ultimately helping provide a better understanding of the range of pre-tenancy services available to people with disabilities.

Despite these limitations, the study demonstrates the important link between access to affordable housing and housing-related services and supports, highlighting the ways in which housing, health, and human services can interact effectively to support people with disabilities. At the same time, the study also highlights how structural and process barriers often lead to fragmentation across

the housing search process, making obtaining and maintaining stable housing difficult for people with disabilities.

Areas for Future Research

This study focused on the pre-tenancy phase of the housing process. The approaches employed by the studied programs provide important information about how to support people with disabilities as they locate and secure assisted housing. However, given the limitation of the small sample size of programs studied and the number of program participants interviewed, the research team was unable to examine specific in-depth findings of the study, such as the potential disconnect between the sequencing of housing and supportive services that may hinder a program's efficacy. Given the study's scope and limitations, the research team believes that additional research can build upon the findings and assist policymakers, program staff, and advocates to develop even stronger and more nuanced policy recommendations. The research team also believes that improving the collective understanding of the following topics would be beneficial for future research related to pre-tenancy services:

- How do best practices differ on the basis of the needs of participants with different disabilities?
- How do greater resources and flexibility in state and federal funding programs affect the challenges that this report has identified?

A key finding of the study was the importance of post-tenancy support for participants to maintain stable housing. Learning more about the experience of people with disabilities using housing assistance after moving into housing would be valuable. The following research questions may further build on the study's findings:

- How can pre-tenancy and post-move-in services better align to support people with disabilities?
- Which post-move-in services are most effective in maintaining housing?
- How do approaches to service delivery differ on the basis of whether a participant is housed in a scattered-site unit versus a single-site unit?[24]

[24] *Scattered-site* refers to individual housing units throughout the community. Programs using scattered-site housing place their clients in private market apartments throughout a geographical area as opposed to a specific cluster in a single property with multiple assisted units. *Single-site* refers to housing units that are centralized within a single housing project and location.

Many of these topics would benefit from broadening the study's scope, and the authors recommend that HUD consider drawing from a larger number of programs across the country, representing a wider range of potential models of funding, governance, and support. Studies that engage a larger and more representative sample of program participants would improve understanding of the overall program challenges and effective strategies, bringing even greater insights into the role of housing assistance in the lives of those living with disabilities.

The profiled programs in this report represent various promising practices for supporting people with disabilities to locate, lease up, and ultimately move into housing. However, persistent challenges and barriers remain across these approaches and offer insight into how policies and practices might benefit from improvements to better support this population through the pre-tenancy process. In addition, during this study, the research team learned that post-move tenancy services are equally important for this population. As a result, future research should consider how pre-tenancy and post-move-in services can best align to support people with disabilities and the types of post-move-in services that are most effective in assisting people with disabilities to maintain stable housing.

Appendix A: Case Studies

- Bridgeway Supportive Housing
- Swords to Plowshares' Supportive Housing
- Home Forward
- Downtown Emergency Services Center's (DESC's) Permanent Supportive Housing
- Louisiana's Permanent Supportive Housing
- New Reach's Supportive Housing
- Connecticut's Money Follows the Person (MFP) Demonstration
- Alliance of Disability Advocates
- Lifetime Independence for Everyone Inc.

Bridgeway Supportive Housing

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

Bridgeway Behavioral Health Services (Bridgeway) is a nonprofit 501(c)(3) corporation based in Elizabeth, New Jersey, that provides several services related to housing access for people with disabilities. Following New Jersey's Olmstead Agreement, Bridgeway has been providing services to "place and support all appropriate persons who previously were treated in state hospitals for mental illness and had the potential to thrive living in their communities" (Martone and Kovich, 2017). Today, Bridgeway Supportive Housing Services provides an array of holistic services to approximately 500 eligible Hunterdon, Sussex, and Union County residents per year in New Jersey. Bridgeway also offers a Residential Intensive Support Team (RIST) for individuals in Essex, Hudson, Hunterdon, Middlesex, Somerset, and Warren counties. The program manages project-based vouchers with its own housing properties, local housing authorities, and local landlords. Bridgeway provides outreach, support, and case management services by finding people via community outreach efforts and referrals, helping them navigate eligibility processes to access housing and services, and providing them with ongoing supports. Their personalized and comprehensive wellness services, delivered through a multidisciplinary team approach, have led to Bridgeway becoming the preferred Olmstead partner for the New Jersey Division of Mental Health and Addiction Services to help individuals with serious mental illness live in integrated communities.

Overview of Bridgeway Supportive Housing
Geographic scope ▪ Residents of Hunterdon, Sussex, Essex, Hudson, Middlesex, Somerset, Warren, and Union Counties in New Jersey **Target population** ▪ Residents with a documented history of severe mental illness **Primary services offered** ▪ Housing location and navigation and supportive services **Main funding sources** ▪ New Jersey Division of Mental Health and Addiction Services and the Federal Substance Abuse and Mental Health Services Agency (SAMHSA) **Number of participants served** ▪ 500 per year **Initial year of operation** ▪ 1968 **Main partners** ▪ Housing authorities, state hospitals, Continuum of Care, and Bridge to Wellness

BRIEF OVERVIEW OF THE CASE STUDY

Bridgeway was selected due to the services it provides through the supportive housing program, which addresses some of the major barriers people with mental health disabilities face, including housing navigation, housing search, and tenancy support services. Another reason Bridgeway was selected is because it provides direct services and access to housing through private landlords. Since the Olmstead settlement agreement in New Jersey, Bridgeway "has been the leader in keeping people out of institutionalized care, and in their communities, where 24/7 rehabilitative care for mental illness is more successful and ultimately less expensive to deliver"(Bridgeway Behavioral Health Services, n.d.). This case study draws on interviews with key stakeholders (such as program staff and partners) and aims to provide multiple perspectives on the operations and impact of the program. The study highlights critical components of Bridgeway's successful strategies in helping people with disabilities to obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from the stakeholder experiences and highlighted in section 4.

2. Program Overview

PROGRAM PURPOSE AND GOALS

Bridgeway's supportive housing program's main goals are to assist participants in learning and practicing skills to restore or develop their abilities to achieve community living in integrated housing or remain living independently in the setting of their choice.

SERVICES OFFERED AND MODE OF DELIVERY

Services Offered
Housing Location and Navigation ▪ Assistance with housing voucher applications ▪ Coordination with the public housing authority to obtain vouchers ▪ Communication with landlords and housing authorities to locate apartments ▪ Transportation to view housing ▪ Assistance with the leasing process ▪ Down payment assistance ▪ Tenant education

Housing Support

- Move-in assistance
- Medical equipment setup
- Public entitlement procurement assistance.

Housing location and navigation

Participants typically are referred to Bridgeway by community partners (such as state hospitals) or are recruited directly by Bridgeway. A comprehensive rehabilitation needs assessment is conducted for each individual coming into the program to examine his or her physical and mental health, substance abuse, legal and financial needs, daily living skills needs, and case management needs. After identifying that a participant is a good fit for the program,[25] the housing support team begins working with participants to obtain a housing voucher if needed. Bridgeway assists participants with filling out the initial application to get approved and then sends the application to a public housing authority or the New Jersey Supportive Housing Connection to obtain the housing voucher. Since the onset of the COVID-19 pandemic, the turnaround time for this process has increased from approximately 2 to 3 months to 4 to 6 months due to a decrease in the number of available units and the increase in average rent. Once the participant obtains a voucher, the housing support team reaches out to landlords and housing agencies regarding available housing on the basis of participant preferences. The team goes with or provides transportation for participants to look at any available units while also providing advocacy for the participant. Once the team has located a unit, they walk through the leasing process with the participant and assist them with securing and paying a down payment based on the resources in the community. After locating housing, the participant begins the first part of Bridgeway's tenant education program, where they learn about their voucher, their timeframes, and landlord responsibilities. The second part of the tenant education program entails teaching participants about their rights and responsibilities and what they can do if they encounter issues with a landlord. Bridgeway works with the Community Law Project in New Jersey to make sure that participants can obtain the public entitlements and legal support (e.g., medical accommodations and child support) they need to support themselves.

[25] The eligibility criteria specify people living in Hunterdon, Sussex, and Union Counties who are diagnosed with a severe and persistent mental illness, who are ready for independent living, and who express an interest in learning and developing skills to restore function and promote community integration.

Housing support

Once the participant has located and secured housing, the team supports the participant on move-in day as needed. This support could include transporting them to housing units; obtaining keys; coordinating, obtaining, and delivering furniture; and signing paperwork. The team also ensures that medical equipment is set up in the housing unit and that any accommodations deemed necessary by state hospitals or other institutional settings have been met. After the participant has moved into the housing unit, the housing support team does a comprehensive assessment of the participant's needs. If participants lose their food stamps, Medicaid, or other public entitlements, Bridgeway supports them in the re-determination and review process. In addition, the team identifies what local resources participants can use (e.g., food banks) and helps participants get connected with any type of resource they need in the community (e.g., doctors or mental health providers). The team also accompanies participants to their first appointments if needed. After initial appointments, Bridgeway works to teach participants independent living skills, such as locating a bus route or linking them to a transportation service, to encourage independence without reliance on the team.

Other services

Bridgeway offers additional services to ensure that participants can maintain housing and integrate into the community while recovering from severe mental illness. Before or soon after participants move into housing, the housing support team develops an individualized recovery plan through a comprehensive personalized needs assessment. The goal is to help participants identify what areas they want to work on that will help them to become as self-sufficient in the community as possible; this assessment helps to ensure that the services provided pre-tenancy and post-move-in tie directly to those identified areas. All Bridgeway staff get trained in supportive education and employment to help get participants back to work. Other skills relating to technology use are incorporated into services, which can help participants with conducting housing searches, filling out applications, and getting in contact with their housing support team. On each supportive housing team, an addiction specialist will target approaches for people suffering from addiction to ensure that it does not derail participants from attaining their goals and maintaining housing.

TARGET POPULATION

Bridgeway supports people living in Hunterdon, Sussex, and Union Counties who are diagnosed with a severe and persistent mental illness; who are ready for independent living; and who express an interest in learning and developing skills to

restore function and promote living in integrated community settings. Participants can have co-occurring diagnoses (such as developmental disabilities or substance use disorder), can be experiencing homelessness, or can be coming from state psychiatric hospitals or other institutional settings. Individuals in Essex, Hudson, Hunterdon, Middlesex, Somerset, and Warren Counties who are experiencing homelessness or are at risk for state hospitalization qualify for intensive supportive housing and can work with Bridgeway's Residential Intensive Support Team (RIST).

STAFFING

Bridgeway Supportive Housing and RIST have seven supportive housing teams that cover eight counties in New Jersey. Each team includes clinical and nonclinical staff. The clinical staff includes a licensed clinician who primarily conducts the assessments and treatment guides and staff who perform the treatment plans. The nonclinical portion includes at least one housing specialist who takes the lead in helping those individuals with housing navigation services (approximately one housing specialist per 40 participants), a co-occurring specialist position that takes the lead in providing services for the substance abuse population (e.g., engaging participants and trying to help them break down the steps to manage their recovery goals), a person with lived experience, and all other supportive housing team members.

PARTNERS

To provide a wide range of services and supports, Bridgeway has many partnerships. Bridgeway works closely with local housing authorities in an attempt to leverage some of the housing authorities' housing choices and CoC program funded Shelter Plus Care Permanent Supportive Housing vouchers. Bridgeway has a significant working relationship with the Elizabeth Housing Authority, which refers tenants and provides units to Bridgeway participants. Before the COVID-19 pandemic, landlords worked closely with Bridgeway to accept housing vouchers, and, in return, they could rely on a stable payment. Another key partnership is with the Continuum of Care (CoC) unit in the Union County Department of Human Services, where collaboration to identify and fund additional needs of program participants occurs. One example is Bridgeway and the CoC working together to obtain 125 Permanent Supportive Housing vouchers and the CoC referring residents with mental health diagnoses to Bridgeway. Bridgeway also works with healthcare-related partners—including state and local hospitals, Intensive Outpatient Commitment, and Bridge to Wellness—to get participants evaluated and access medications as needed, program recruitment, and comprehensive primary care.

FUNDING

Bridgeway Behavioral Health Services is primarily funded through the New Jersey Division of Mental Health and Addiction Services (DMHAS), the federal SAMHSA, HUD's Continuum of Care program, and other state funds. Their homeless outreach programs are federally funded through Projects for Assistance in Transition from Homelessness (PATH) grants and services. In addition, Bridgeway bills Medicaid for eligible services related to medical care.

3. Key Strategies for Connecting Program Participants to Housing

WHOLE-PERSON APPROACH

Program staff discussed how impactful taking a "whole-person" approach has been in serving their participants. This approach consists of treating each participant as an entire person, considering their employment, education, and housing statuses along with their mental and physical health. By supporting each domain in a coordinated manner, a person is more likely to remain housed in the community. Each participant is also included in the development and implementation of a comprehensive plan to ensure that they are served in the way they want and need to be. This concept is demonstrated in housing location, navigation, and transition services by allowing participants to indicate their housing preferences, set their own goals, and receive as much or as little support to achieve those goals as they deem necessary.

HOUSING SUPPORT TEAMS

> "Somebody might be very strong in one area, and then we can tap into that, and we … we know … the different members of the team and what their strong points are. We try to really individualize that for the workload too … if somebody is really good at helping someone apply for Medicaid and navigating that system, then we'll send that staff person out to help the person served with that."
>
> **—Bridgeway Program Staff**

Program staff noted that the team-based approach to the housing support program has led to the program's success, allowing participants to have access to numerous people with different expertise. Participants can benefit from each team member's unique strengths. For instance, each housing support team includes at least a

housing specialist, clinical staff, a specialist with expertise in any co-occurring diagnoses, and a person with lived experience. Having a diverse set of people assigned to each team also allows for collaboration to solve unmet needs, such as sharing with the team available housing options that have been identified within the community. Having more people who know about each participant's needs allows for the use of each team member's connections and resources. Team members who live on the other side of the county from other team members, for example, might be able to identify additional community resources unavailable in other parts of town that the team or program can access.

EVIDENCE-BASED PRACTICES

Program leadership frequently brought up the use of evidence-based practices as contributing to the program's success. Bridgeway adopts evidence-based models and practices of implemented services to ensure that program participants are receiving the best practices Bridgeway has to offer. Although this procedure means that more time is needed to train staff, program leadership noted how beneficial this method is for clients and staff over time. These resources are typically available online for free, and if training is not free, the program finds the means to cover the cost. For example, Bridgeway trains all staff on motivational interviewing, which teaches staff how to engage with participants in a way that meets them where they are, thereby building trust and enabling staff to focus on doing the best they can to help someone without imposing their personal beliefs on participants. According to program leadership, this rapport-building approach shows respect for each individual and can be or has been lifesaving. In addition, Bridgeway staff are trained in cognitive behavioral techniques (e.g., modeling, shaping, and role playing) to better help people learn independent living skills in the community. All staff are taught the SAMHSA evidence-based practices regarding addictions, illness management, and supportive housing. Following or teaching evidence-based practices directly benefits program participants, but staff also benefit personally and professionally from learning and practicing reputable, proven skills and practices.

PARTNERSHIPS WITH LANDLORDS

Although Bridgeway has partnerships with many organizations and agencies across New Jersey, partnering with landlords has been key to their success. Before the COVID-19 pandemic, Bridgeway staff had good relationships with landlords and could lean on them to find a housing unit for a participant. Nearly all staff emphasized the importance of these relationships because having a good rapport with landlords can help the program advocate, mend issues, and act as mediators during any challenges that may occur with a participant. Staff understand that some

of their participants may be people who are still learning tenancy skills; as a result, maintaining these relationships with landlords can help to keep struggling participants in housing. After the pandemic, this relationship has been strained due to a lack of availability in housing units. Nonetheless, Bridgeway understands that maintaining these partnerships is important for the program and its participants.

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

Bridgeway uses an electronic healthcare record system that contains a "monthly outcome" section that each manager completes. These outcomes include the number of people who gain employment, go back to school, maintain permanent housing, and have been hospitalized. The outcomes are aggregated and reported every 6 months to give Bridgeway an overview of what each program has accomplished. Each team sets its own target, and Bridgeway tries to keep rehospitalization rates under 8 percent. According to Bridgeway leadership, "Most teams do well at meeting their goals."

CHALLENGES DURING PROGRAM IMPLEMENTATION

The housing market and housing vouchers

After the pandemic, the housing market became extremely competitive. Program staff speculate that, with a lack of available, affordable, and accessible housing, guaranteed income at a lower rate is not as enticing to landlords as it once was, especially if they have had problems or concerns with Section 8 housing voucher holders in the past. This lack of housing can be particularly troublesome for participants who need accommodations, such as to be in a first-floor apartment, because this need limits the number of possible units even further. This limitation, coupled with the decrease in rental assistance based upon calculated fair market rents, creates a gap between housing assistance and fair market rent levels in areas where transportation, healthcare access, employment needs, and other support services can be met. Barriers to transportation, healthcare access, and employment opportunities for people with disabilities are often exacerbated because they typically need more frequent supportive services. In addition, even if apartments become available, systematic barriers, such as the timing of housing inspections with the New Jersey Supportive Housing Connection, can be challenging. For example, if the inspection cannot be scheduled right away or the apartment fails the inspection, the landlord might walk away. Program staff and partners noted that the administrative process can be bureaucratic and time consuming, creating additional hurdles that can be costly and difficult to address in the current rental market. When

a housing unit and tenancy paperwork must be reviewed and inspected by additional parties outside the program, the amount of time it takes to get a person housed is prolonged, which can prevent a program participant from securing a unit even if the application is approved.

Mental illness, addiction, and stigma

The stigma associated with mental illness and addiction presents additional barriers to locating housing. Nearly all staff expressed that sometimes, due to assumptions and previous experiences with tenants with mental illness, landlords turn away participants or the program altogether for tenants who are a "better fit," making the already few housing opportunities even fewer. This stigma can arise from numerous circumstances, including a lack of education regarding people with mental health support needs. In addition, people damaging a rental unit repeatedly or getting involved with illicit drug use can cause landlords to be wary of continuing to work with people with mental illness. The more times these cases occur, the less likely a landlord is to serve this population. The population with co-occurring disorders (people with mental illness and substance use disorders) can be difficult to find housing for because their credit and background checks often are undesirable, making housing even more challenging to secure. When applicable, Bridgeway tries to educate and offer supports to landlords or refer the case to legal aid resources if necessary.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

> "Every organization has to make a commitment to developing a supervisory structure [when] it's like, 'Oh, we're going to skip supervision this week because we got too much to do.' Then it falls flat and then people start to lose faith…You need a structure within your organization, mostly including middle managers … They deserve the most attention, the greatest attention to teach them the strategies but to teach them how to supervise those strategies."
>
> **—Bridgeway Program Staff**

Program staff and partners emphasized the importance of having a holistic approach to housing support. If the program only addresses an individual's lack of housing, they believe that people are less likely to be successful living in the community, and the problems are likely to repeat themselves. By caring for the "whole person" and addressing co-occurring issues with education, employment,

and physical and mental health supports, the person is more likely to achieve their goals, develop independent living skills, and attain self-sufficiency. Other lessons learned during the implementation of the program are outlined in the following list.

- Staff should meet participants where they are, using the following guidelines:
    - Harm reduction may ultimately be the goal.
    - Setting aside personal philosophies can save lives.
    - Recovery is not linear.
- Staff should be flexible:
    - Staff should be willing to accept imperfect outcomes.
    - Staff must be able to leverage the tools they have at the moment.
- Staff should consider, explore, and apply new ideas to determine the helpfulness of the idea.
- Leadership should value and take advantage of each staff member's unique strengths and perspectives.
- Leadership should provide and support effective staff training, clear expectations, and shared philosophies and strategies.

5. Summary

Bridgeway's success in transitioning people with disabilities from institutions into the community is due to the program's strategies. These strategies include employing a "whole-person" approach to caring for participants, having a staffing model that allows for a team-based approach to use each staff member's unique strengths, using evidence-based practices, and establishing good relationships with landlords. Staff underscore the importance of following a holistic approach to housing support, meeting participants where they are in terms of needs, having flexible staff, and maintaining a consistent supervisory structure.

Swords to Plowshares' Supportive Housing

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

Swords to Plowshares is a nonprofit 501(c)(3) corporation based in San Francisco, California, that provides several services in housing access for veterans. Swords to Plowshares was started by Vietnam-era veterans in 1974 to provide quality supportive services to address unmet veteran needs. Today, Swords to Plowshares provides varying levels of housing support to approximately 600 eligible veterans in San Francisco per year through rent support, emergency housing, transitional housing, and Permanent Supportive Housing. The organization currently has six permanent housing locations and two transitional housing locations. In addition to housing support, the organization also offers health, wellness, and legal supports to veterans experiencing homelessness. The housing teams manage project-based vouchers both in their housing locations and with local landlords. They provide outreach, support, and case management services by obtaining referrals from the local Veterans Administration (VA) or recruiting in homeless encampments, assisting individuals in navigating eligibility processes to access housing and services, and providing them with ongoing supports.

Overview of Swords to Plowshares' Supportive Housing
Geographic scope: ▪ The City and County of San Francisco and Alameda County in California **Target population:** ▪ Veterans in the Bay Area who are experiencing homelessness or at risk of homelessness **Primary services offered:** ▪ Permanent Supportive Housing, emergency housing, transitional housing, and rent support **Main funding sources:** ▪ Federal, state, and local grants; fundraising; City and County of San Francisco **Number of participants served:** ▪ 600 **Initial year of operation:** ▪ 1974 **Main partners:** ▪ VA, local businesses, local nonprofits, the City and County of San Francisco

BRIEF OVERVIEW OF THE CASE STUDY

Swords to Plowshares was selected due to its ability to successfully assist veterans with disabilities in accessing effective pre-tenancy services that result in positive

housing outcomes. The organization offers stand-alone case management, legal assistance, and benefits assistance programs to all veterans who qualify, even if they may not live in Permanent Supportive Housing. This case study draws on interviews with program staff, program partners, and one person with program experience and aims to provide multiple perspectives on the operations and impact of the Swords to Plowshares housing program. The case study highlights critical components of Swords to Plowshares' successful strategies in helping people with disabilities obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. The authors have drawn recommendations and lessons learned from the stakeholder experiences.

2. Program Overview

PROGRAM PURPOSE AND GOALS

The main goal of the Swords to Plowshares housing program is to assist veterans in obtaining and maintaining housing in an individualized and compassionate manner.

SERVICES OFFERED AND MODE OF DELIVERY

Services Offered
Housing Location and Navigation ▪ Assisting with housing voucher applications ▪ Coordinating with the housing authority to obtain vouchers ▪ Locating apartments ▪ Transporting people to view housing ▪ Assisting with the leasing process ▪ Providing financial assistance ▪ Securing public entitlements
Housing Support ▪ Move-in support ▪ Unit setup ▪ Connection with community setup ▪ Transportation ▪ Continued counseling

Housing location and navigation

The program typically accepts applicants referred from the local VA hospital, selected as walk-ins, or recruited directly by program staff. Swords to Plowshares can pay for rental applications, fees for birth certificates, security deposits, and any

other expenses that may arise in the housing location process. They will pay for a hotel stay or try to place a veteran in a shelter until the veteran can move into a unit. Swords to Plowshares will pay for security deposits, 100 percent of the rent for up to 1 year, and items necessary for housing stability, such as a bed and household items. If needed, they can also pay for moving expenses, utility deposits, and utilities in most cases. The case managers can refer veterans to the Swords to Plowshares legal department or the VA if they need aid in obtaining other public assistance (such as Supplemental Nutrition Assistance Program benefits and Medicaid) and legal assistance (such as child support). For veterans moving from transitional to permanent housing, Swords to Plowshares staff will do a "warm handoff" and provide full initial support before easing assistance at a decreasing rate to build independence.

Swords to Plowshares has multiple housing programs: Supportive Services for Veterans' Families, San Francisco Access Points, Drop-In Centers, Permanent Supportive Housing, and transitional housing. As outlined in the following paragraphs, the level of support varies between each of these programs.

Supportive Services for Veteran Families: The main goal of these services is to rapidly rehouse veterans and their families. To be eligible for support services, at least one family member must be an eligible veteran[26] who was not dishonorably discharged, be either experiencing homelessness or facing eviction, and have a gross household income under 50 percent of the Area Median Income. Once a potential participant has been identified, the case is assigned to a staff housing navigator who will conduct an intake with the veteran and assess if he or she qualifies for any type of subsidy, such as the U.S. Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH) voucher or housing through a city program. On the basis of the initial findings, the housing navigator will move forward with an internal housing search. Navigators then assist with providing transportation to veterans to allow them to view housing options in person. Depending on the location of housing options, this process can take several days or weeks to complete. All program participants receive a referral to the organization's internal employment and training services to help increase their employment opportunities and, ultimately, their income. If necessary, the organization's legal department can assist veterans with discharge upgrades to see if they can qualify for more VA benefits. The organization also has a program that can assist veterans with Social Security applications.

[26] The Swords to Plowshares definition of *veteran* is someone who is active duty or reserve duty with at least 1 day of active-duty service.

Drop-In Center: Veterans can go to the Drop-In Center for assistance with a variety of needs, including emergency housing. The center can provide veterans with an emergency housing voucher for hotel stays as long as the veteran is working toward fulfilling a housing plan either with the HUD-VASH voucher or through the Supportive Services for Veteran Families program described previously.

San Francisco Access Point: The San Francisco Access Point is a HUD-mandated coordinated entry point for veterans experiencing homelessness to access the affordable housing system in the city of San Francisco. Like the Supportive Services program, the Access Point allows walk-ins, and many veterans are referred to the Access Point by the VA. Once an eligible veteran is identified, program staff first have a conversation with him or her about potentially moving in with family or friends before the program takes any further steps toward public assistance. Veterans who need housing in San Francisco fill out a universal housing application (a coordinated entry assessment) that is used by all local federal subsidy teams.

Transitional and Permanent Housing: To qualify for permanent housing, veterans must be able to prove that they or their household are experiencing chronic homelessness. If veterans do not meet this initial qualification, Swords to Plowshares will continue to support them via the Drop-In Center, transitional housing, and other pre-tenancy resources offered by the program. If veterans are deemed eligible on the basis of VA standards,[27] case managers work with them to determine housing needs, including type, location, and terms. If necessary, case managers work with veterans to fill out documentation and coordinate with the VA to help them receive a HUD-VASH voucher. Once the voucher is obtained, the case manager locates a unit either in-house (the only option for transitional housing), with other nonprofits in the Bay Area, or in an independent apartment. The case manager then submits the case to the housing authority, which draws up the lease. This process can take up to 3 or 4 months. For veterans moving from transitional housing to permanent housing, case managers also counsel them on how to manage the anxiety of moving and the loss of peers and support staff on which they have relied. Depending on the needs of the veteran, this support will typically last through the post-transition period.

Housing support

Once the participant has located and secured housing, the Swords to Plowshares team supports them on move-in day as needed. This assistance could include transporting the participant to the unit, helping obtain furniture or coordinating the

[27] Eligibility is based on a history of homelessness, certification of homelessness, and income and asset verifications.

delivery of furniture, setting up the unit, paying deposits, and signing paperwork. The team ensures that any medical equipment is set up in the unit and that any accommodations deemed necessary by VA hospitals, healthcare providers, or occupational therapy assessments have been made. After the participant has moved into the unit, the housing teams conduct a comprehensive assessment of the participant's needs. If a veteran does not access healthcare services at the VA, a VA healthcare navigator will help initiate his or her medical care, transfer medications, and support any other healthcare-related needs. Swords to Plowshares also provides transportation to any medical or psychiatric appointments with the VA if needed. If necessary, housing staff provide referrals to in-house education and training programs on the basis of the veteran's goals.

TARGET POPULATION

Swords to Plowshares supports veterans who are experiencing homelessness or at risk of homelessness living in San Francisco and Alameda Counties. Although having a disability is not a requirement of the program, approximately 44 percent of all veterans served reported living with a disability, including traumatic brain injury or post-traumatic stress disorder (PTSD). The temporary and permanent housing teams work with the veteran only, whereas Supportive Services for Veteran Families works with veterans *and* their families.

STAFFING

Although Swords to Plowshares has a variety of housing programs, staffing is similar throughout each program, and roughly 20 percent of the staff is veterans:

- **Site case managers** manage cases at housing sites at approximately a 1:25 case manager-to-veteran ratio.
- **Housing navigators** operate at approximately a 1:50 navigator-to-veteran ratio and support the housing location process.
- **Housing specialists** maintain community connections to locate available units.
- **Supportive services staff** include mental health specialists, peer support specialists, and community organizers who provide wraparound services to veterans once they are housed.

PARTNERS

Although Swords to Plowshares offers a wide range of in-house services, their partnerships within the community help to fill gaps and ensure that veterans are

completely wrapped in supportive services. The organization meets biweekly with the VA, its largest partner, for a case conference. This partnership is a symbiotic relationship in which the organization and the VA make referrals back and forth on the basis of veterans' needs. If veterans experiencing homelessness seek assistance from the VA, for example, the VA refers them to Swords to Plowshares; and if veterans receiving assistance from Swords to Plowshares need medications or medical care, the program refers them to the VA. The VA has a Health Care for Homeless Veterans program that provides short-term contract beds that participants can use while waiting for housing. Supportive Services for Veteran Families and the Access Point work closely with the City of San Francisco through the Online Navigation and Entry (ONE) system, a program that enables local supportive service agencies to stay connected with each other. Also, a meeting occurs weekly between the VA and all local nonprofits that work with veterans to discuss how to serve this population.

FUNDING

Swords to Plowshares has an annual budget of approximately $25 million, primarily funded through the City and County of San Francisco, the VA, HUD-VASH, public and corporate grants, Medi-Cal, and other federal, state, and local contracts. Individual donations and fundraising efforts offer Swords to Plowshares the flexibility to spend funds on pre-tenancy support (e.g., down payment assistance and utilities) and housing support (e.g., visiting available units and buying furniture) without the typical restrictions that accompany public funding sources.

3. Key Strategies for Connecting Program Participants to Housing

HOUSING-FIRST APPROACH ALLOWS VETERANS TO GET HOUSED BEFORE PROVIDING WRAPAROUND SERVICES

Program leadership noted that Swords to Plowshares uses the Housing First model, an approach that has been fully adopted throughout the organization. According to the VA, "Housing First is an evidence-based, cost-effective approach to ending homelessness for the most vulnerable and chronically homeless individuals . . . [that] prioritizes housing and then assists the veteran with access to healthcare and other supports that promote stable housing and improved quality of life."[28] Swords to Plowshares staff noted that treatment and other support services are wrapped around veterans as they procure and maintain permanent housing. According to one participant, the housing process "moved quickly," and "there [were] no hang-ups."

[28] U.S. Department of Veterans Affairs, National Center on Homelessness Among Veterans. "Housing Interventions & Practices." (va.gov).

This veteran noted that after moving to San Francisco, he was quickly housed. Due to his mental illness, an organization without a Housing First approach would likely have first addressed his treatment rather than working on his most pressing issue—experiencing homelessness.

VETERANS SERVING VETERANS BUILDS TRUST WITH PARTICIPANTS

> "Having people with lived experience within our programs [enables us] to work with veterans, to build trust from the start, because that is the hardest barrier to overcome."
> **—Swords to Plowshares Program Staff**

As mentioned previously, Swords to Plowshares' current staff is approximately 20 percent "veterans serving veterans"—a number that program leadership says is trending below its goal. Nearly every staff member interviewed stated that having veterans, some who went through the program themselves, working at various levels of the organization has been particularly successful. This peer support network increases rapport with the participant from the start and helps show veterans that staff are genuinely on their side, with their best interests at heart. This trust encourages veterans to open up with candor about the challenges they face and the solutions they need as opposed to what staff perceive that they need. Staff provided examples of veteran-filled positions, including peer support specialists and community organizers. These groups of employees partner with housing sites and take the veterans on outings—such as to a beach, a sporting event, or a museum—to engage them in the community. These outings are beneficial for veterans in supportive housing because they pull the veterans out of their social isolation, an observation that many staff members expressed. The outings provide veterans with the opportunity to be part of the community. A program participant noted that a staff member, once a resident at Swords to Plowshares, remarked that he "resonates really well with everyone." He said he enjoyed the weekly check-ins with residents to observe progress, inquire about additional needs, and address any complaints.

FUNDING IS VITAL TO BEST SERVE PARTICIPANTS

Although Swords to Plowshares does significant work to serve veterans experiencing homelessness, many staff were quick to acknowledge that having adequate funding is vital to their success. For example, staff stated that they can be the "most compassionate and well-meaning agency, but if you don't have money to go along with that, folks are still going to be homeless." Having the ability to obtain

funding at the federal, state, and local levels via grants and being able to fundraise allow the organization to serve veterans comprehensively (across areas, such as housing, legal, and healthcare needs) and in ways that allow veterans to express their needs. Although public funds are vital to the program's success, the ability to use unrestricted private funds provides Swords to Plowshares the flexibility to fill gaps in services, such as with community outings, a "rainy day fund," and equine therapy. In terms of securing housing, as long as a veteran remains eligible, the ability to guarantee that landlords will receive rent for the entirety of the lease is a selling point to housing this population.

STRONG COMMUNITY TIES HELP TO WRAP VETERANS IN SERVICES AND COMMUNITY

Swords to Plowshares internal policy department works on educating businesses, organizations, and community members on how to serve veterans and understand their experiences. This work has been key to successfully providing veteran-supportive wraparound services by ensuring that community partners can also effectively serve these participants. When the community knows the organization's "brand" of helping veterans with disabilities or who are experiencing homelessness, fundraising potential increases, as businesses are more likely to donate to a cause they believe is making a difference.

The community partnership with landlords is critical. Landlords understand that the organization will pay the rent on behalf of participants for 1 year as well as security deposits and other costs as needed. Staff offer to be a point of contact for the landlord if issues arise, which improves the housing process for veterans.

INDIVIDUALIZED CASE MANAGEMENT ALLOWS STAFF TO MEET THE NEEDS OF PARTICIPANTS ON A PERSONAL LEVEL

Working with each participant on a personal level allows staff and veterans to work in a partnership in which staff provide guidance to veterans on the basis of the veterans' self-identified needs. This type of partnership helps veterans feel secure to communicate their needs, further allowing staff to meet them where they are and support them in ways that are beneficial and desired by participating veterans. Understanding that each veteran is a unique person with unique needs helps the staff to truly make a difference rather than just "pushing agendas" or "trying to change their behavior" (as expressed by Swords to Plowshares staff).

4. Program Outcomes and Lessons Learned

CHALLENGES DURING PROGRAM IMPLEMENTATION

Prioritization of people homelessness experiencing

HUD requires communities receiving CoC program funding to operate a coordinated entry system. As a part of implementing coordinated entry, CoC establish processes through which people experiencing homelessness are triaged and prioritized for available housing resources. For Permanent Supportive Housing providers, this means following HUD guidance on prioritizing the *chronically homeless.*[29] For example, staff noted that although San Francisco has managed to house many chronically homeless veterans, Swords to Plowshares reported being unable to help some veterans with or without disabilities who do not meet the chronic homelessness definition (even when the program had housing capacity). HUD guidance recommends prioritizing chronically homeless households first, but recommends serving *"homeless individuals and families with a disability with severe service needs"* who would not meet the chronic homelessness definition if there are no people experiencing chronic homelessness in the community. [30,31] Balancing federal guidance with the realities of operating within a local Coordinated Entry system, particularly in larger communities with substantial need, can be a challenge for some providers. Swords to Plowshares staff noted that if they had greater flexibility to serve people who fall outside this HUD definition of chronically homeless, then housing resources would be more fully utilized.

[29] See the HUD definition of *chronic homelessness* at https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/.

[30] Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing https://www.hudexchange.info/resource/5108/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh/

[31] Published in the Federal Register as a final rule on December 4, 2015. 24 CFR Parts 91 and 578. https://www.govinfo.gov/content/pkg/FR-2015-12-04/pdf/2015-30473.pdf.

> You have to meet the client where they're at and try and understand them as a person, whether in a demographic because, for instance, everyone in a wheelchair is not going to be the same. Every Black person you deal with is not going to be the same. … We work really hard on that; it's just treating people like people."
>
> **—Swords to Plowshares Program Staff**

90-day rule

Program staff noted a 90-day rule that states that a client must exit from a subsidy if he or she has been out of the housing unit for more than 90 days.[32] Although this rule is reasonable under some circumstances, it is detrimental to veterans who may need medical care for more than 90 days because they will have to go through the coordinated entry system again after losing their subsidy. Depending on how long they have been experiencing homelessness, they may be unable to qualify for many of the same services they were receiving before treatment. Program staff perceive that these situations are more likely to occur within the population of veterans with a disability because many veterans with disabilities have mental illness disorders or substance use disorders. This 90-day rule can result in a larger number of veterans with a disability who are experiencing, or will continue to experience, homelessness.

Availability of units

Although the availability of units is an issue in general, people with physical disabilities have even more difficulty in finding accessible units. Program staff meet with community stakeholders weekly or biweekly to track available units in an effort to stay current on resources they can tap into as soon as they become available. Because many places in San Francisco are not wheelchair accessible, even fewer units are acceptable and available, further complicating efforts to serve the

[32] This rule may be related to regulation 24 CFR 982.312(a) that requires families to be absent from the unit for brief periods. For longer absences, the rule requires the PHA administrative plan to establish a policy on how long the family may be absent from the assisted unit. The rule also requires families to not be absent from the unit for a period of more than 180 consecutive calendar days in any circumstance or for any reason. At its discretion, the PHA may allow absence for a lesser period in accordance with PHA policy.

It is important to note that reasonable accommodations should be available to individuals who are out of the unit for more than 90 days due to medical treatment.

homeless population with disabilities. Another challenge is the placement of veteran families who have more than two children.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

- Train staff to meet participants where they are.
    - Harm reduction may be the best outcome.
    - Staff need to put personal philosophy aside and help people in ways they want and need to be helped.
    - Staff should understand that each person is unique and treat them as such.
- Use a Housing-First model to allow staff to focus on the most basic and pressing need of participants: housing.
    - By meeting a participant's basic needs first, staff help set them up to be successful in achieving their goals.
    - When staff gradually decrease the support for participants who are moving from transitional to permanent housing, they help the transition to be successful.
- Build relationships with other businesses, nonprofits, and organizations in the community.
    - These relationships increase an organization's ability to serve clients holistically.
    - These relationships allow the program to educate the public about the people they serve and how the organizations in the community can help.
- Ensure that the staffing team have common purposes and goals and work together by promoting the program's philosophy in trainings and service delivery.
    - By respectfully working through differences and focusing on moving forward, staff are better able to serve the interests of their clients.
    - By incorporating people with lived experience into the staffing model, program staff can build trust with participants.

RECOMMENDATIONS

Designating funding to create Permanent Supportive Housing that is structured like a group home can help veterans move from transitional housing to permanent housing.

The transition from constant peer-to-peer interactions and intensive support to a more independent setting can be difficult. Case managers noted that some veterans thrive in settings like transitional housing and group homes. As such, a permanent housing location grounded in the ideal of a close community between similar people could be beneficial. On the basis of these observations by program staff, surveying veterans on this topic could provide valuable insights into the reality and feasibility of such a program structure.

Increasing the length of the VA Shallow Subsidy program can allow veterans to build upon their independent living skills, education, credit, and income in a sustainable manner.

The VA Shallow Subsidy program provides grantees of Supportive Services for Veteran Families with rental assistance payments to landlords on behalf of the veteran household. The rental assistance comes at a fixed monthly rate regardless of changes in the veteran household's income or monthly rent amount. Staff noted that the veterans who have entered the Shallow Subsidy program are more likely to maintain housing long term because they can focus on key skills, such as building credit, which will set them up for success. Because building credit, taking classes, and generating income can take time, increasing the length of the Shallow Subsidy program increases the odds that veterans can maintain long-term housing.

5. Summary

The success of Swords to Plowshares in supporting housing for veterans, many of whom have disabilities, stems from the program's strategies, such as adopting the Housing First approach, hiring veterans to encourage a peer component, and partnering with community stakeholders, such as landlords, nonprofits, and local corporations. Staff noted the importance of providing a wraparound approach to housing support, meeting participants where they are in terms of needs, and ensuring that staff are trained and "buy in" to the philosophy and culture of the program.

Home Forward

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

The Housing Authority of Portland, Oregon, was first established in 1941; it was eventually renamed in 2011 as Home Forward. Home Forward is the largest provider of affordable housing in the state of Oregon,[33] offering rental assistance, public housing, and various housing vouchers. Home Forward also partners with service providers in the community to connect participants with supportive services. After discussing the goals and focus of the case study, Home Forward staff identified its mainstream voucher program as one that directly targets people with disabilities. As a result, this case study focuses on the strategies that Home Forward uses to help people with disabilities and connect them with community resources through the Mainstream Voucher program.

Overview of Home Forward
Program type ▪ Housing authority **Geographic scope** ▪ Multnomah County, Oregon **Target population** ▪ Non-elderly people with disabilities for Mainstream Voucher program **Primary housing-related services offered** ▪ Housing vouchers (housing choice vouchers, Mainstream Vouchers, etc.) ▪ Housing navigation services ▪ Rental assistance **Main funding source** ▪ HUD **Number of participants served** ▪ 131 Mainstream Vouchers were used as of February 2022 **Initial year of operation** ▪ 1941 **Main partners** ▪ Joint Office of Homeless Services

BRIEF OVERVIEW OF THE CASE STUDY

This case study draws on interviews with key stakeholders, including program staff, partners, and a person with program experience. The study aims to provide multiple perspectives on the operations and impact of Home Forward and highlights critical

[33] This information was relayed by program staff in interviews and confirmed by Home Forward's website.

components of Home Forward's successful strategies in helping people with disabilities to obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from interviews with stakeholders.

2. Program Overview

PROGRAM PURPOSE AND GOALS

Home Forward's mission is to ensure that all people in their local community are sheltered by providing them with access to safe, quality, and affordable housing regardless of income or disability. This case study focuses on Home Forward's approach to coordinating and transitioning participants into community-based housing by partnering with jurisdiction-level and community partners to provide access to affordable housing and supportive services through their Mainstream Voucher program.

SERVICES OFFERED AND MODE OF DELIVERY

- Rental assistance through public housing, housing choice vouchers (HCVs), or Mainstream Vouchers
- Housing navigation services
- Coordination of supportive services through partnerships with service providers, including additional housing navigation, housing search, and ongoing supportive services

TARGET POPULATION

Mainstream Voucher eligibility is determined at the federal level, and the vouchers are reserved for households that (1) include a non-elderly person with a disability[34] and (2) meet all housing choice voucher requirements:[35]

- A household's income may not exceed 50 percent of the median income for the area in which the household resides.
- At least one member of the assisted family must be a U.S. citizen or belong to a specified category of non-citizens who have eligible immigration status.

[34] Information about Mainstream Vouchers can be found at https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/mainstream.
[35] For information about housing choice vouchers, see https://www.hud.gov/topics/housing_choice_voucher_program_section_8#hcv02.

STAFFING AND PARTNERS

Home Forward program staff directly involved in working with non-elderly people with disabilities to use housing assistance include the following:

- The housing program supervisor, who oversees a team that reviews referrals, administers the waitlist, and confirms any housing preferences of the referred individual.
- The leasing team staff, who assist with housing locations and guide participants through the application process.

The Home Forward housing navigator serves families or participants who require more assistance than the leasing team typically provides, prioritizing participants with disabilities and those with zero to very low fixed income. For example, the housing navigator might work one-on-one with a person with a mental disability to walk them through every stage of the housing process, assisting them with filling out applications, acquiring identification documents, and learning their tenant rights and responsibilities.

Program staff identified the Multnomah County Joint Office of Homeless Services (JOHS), which is funded by the county and the city of Portland, as Home Forward's primary jurisdictional partner. JOHS is the lead agency for their Continuum of Care (CoC) and manages the Coordinated Entry System with shared assessment and prioritization of people based on vulnerability factors for homelessness services. JOHS manages referrals for Home Forward's Mainstream Voucher program, and, in more recent rounds of the program, JOHS identifies individuals that meet eligibility criteria and then prioritizes them within the Coordinated Entry System.[36] JOHS also has relationships with other county departments, including the Department of County Human Services, the Health Department, and the Department of Community Justice, which oversees leveraged services for non-elderly people with disabilities. JOHS also has relationships with nonprofits and other community agencies and contracts with service providers to connect participants with resources and supportive services.

[36] Eligibility criteria are detailed in the Target Population section.

FUNDING

Program staff estimated that approximately 70 to 80 percent of Home Forward's budget comes from HUD subsidies and grants.[37] Additional funds come from rental income from the program's housing communities and local funding at the city or county level. For example, staff noted that Home Forward received local funding to support emergency short-term rental assistance. Furthermore, the City of Portland recently passed two housing bonds, Portland's Housing Bond[38] and the Metro Housing Bond,[39] which are designed to build new affordable housing, acquire and improve existing housing, and convert units to permanently affordable rental housing.

Home Forward's work to effectively assist non-elderly persons with disabilities through the Mainstream Voucher program relies heavily on aligning HUD-funded Mainstream Vouchers with housing search, retention, and supportive services provided and funded by external partners. The funding for these external supports comes primarily from the City of Portland and general funds and the Metro Supportive Housing Services measure.

3. Key Strategies for Connecting Program Participants to Housing

USING EXISTING INFRASTRUCTURE IN THE COUNTY HOMELESSNESS SYSTEM TO PROVIDE COORDINATED SERVICES

By partnering with JOHS, Home Forward uses its existing relationships and contracts with community agencies, service providers, and other county departments to coordinate housing and services for non-elderly people with disabilities. For example, the Department of County Human Services, the Health Department, and the Department of Community Justice have played a major role in the Mainstream Voucher program, in which services from across the county have been leveraged to support participants. Program staff explained that JOHS can put money into contracts with providers to fund flexible resources for supporting housing navigation and retention, including funds for application fees, security deposits, and housing debt. In some cases, these funds were available to stabilize participants in motels during their housing search. As JOHS manages referrals, it can use its partnerships with other county departments to coordinate service delivery

[37] Home Forward is a public housing agency with a Moving to Work (MTW) designation. MTW is a HUD demonstration program that provides agencies the opportunity to design and test innovative, locally designed strategies. MTW allows PHAs exemptions from many existing public housing and voucher rules and provides funding flexibility with how they use their federal funds.
[38] See details about Portland's Housing Bond at https://portlandhousingbond.com/.
[39] The Metro Housing Bond is described here: https://www.portland.gov/phb/metro-housing-bond.

across systems. In this way, all parties can work toward the same goal once a participant is on the voucher waitlist. This coordinated service delivery helps connect people with disabilities with housing and supportive services to overcome barriers and promote long-term housing retention.

USING PARTNERSHIPS TO COORDINATE SERVICES TO OVERCOME BARRIERS RELATED TO LANDLORD HESITANCY

Home Forward's partnership with JOHS provides coordinated access to services for participants with disabilities, helping them overcome barriers when using housing assistance. For example, JOHS contracts with JOIN, a nonprofit that serves people experiencing homelessness, to use its landlord outreach team to identify landlords with eligible units and educate them about the different programs. Staff shared that JOIN maintains a list of landlords who are willing to work with Mainstream Voucher recipients and distributes the list to partner agencies and other service providers on a monthly or biweekly basis.

CREATING A HOUSING NAVIGATOR POSITION ON STAFF TO PROVIDE ADDITIONAL SUPPORT TO INDIVIDUALS WITH HIGH LEVELS OF NEED

Program staff explained that Home Forward created an in-house housing navigator position after noticing that some participants required more assistance than the leasing team and partnering service providers typically offer. The housing navigator assesses participants' barriers before connecting them with different housing providers that are more likely to work with those barriers. Services provided by the housing navigator include one-on-one mentoring, education, housing search, paperwork and application assistance, and assistance with application fees.

CREATING A GENERAL APPROACH TO MAINSTREAM VOUCHER FUNDING ITERATION

Program staff described their strategies for targeting specific population groups in one funding iteration of the Mainstream Voucher program, in accordance with HUD's preference. Although overall use of the program was slow as a result of these efforts,[40] the strategies allow staff to reach those targeted and underserved communities more effectively—specifically, those individuals transitioning from institutional settings. Before opening the waitlist for these individuals, Home Forward worked closely with JOHS and different county-level partners in the system that assist people transitioning out of institutional settings, such as the Department of Community Justice, Aging and Disability Services, and the Behavioral Health Division. Staff then coordinated broad community outreach directly with organizations that work with the targeted population, informing them that the

[40] This challenge is discussed more in depth in the Challenges During Program Implementation section.

waitlist would be open for 10 days ahead of time; the goal was to give as many people as possible the opportunity to apply and secure a place on the waitlist. Once the waitlist opened, Home Forward estimated the number of households needed to use all 99 reserved vouchers and held a lottery for those who met the eligibility criteria; Home Forward then added and removed participants accordingly.

COORDINATING SERVICES UNDER MAINSTREAM VOUCHER FUNDING ITERATION

With the funding iteration described previously, Home Forward had to take a different approach to coordinating services for participants. For this preference, targeting people transitioning out of institutionalized settings, JOHS was able to help coordinate referrals through its contracted partners and other county departments. Given the presence of a lottery system, however, staff lacked control over who was ultimately selected, making braiding services with these vouchers more challenging. Once participants were selected through the lottery, Home Forward and JOHS worked with contracted partners and other county departments to coordinate services for them.

Home Forward's new approach gave applicants the option to participate in a voluntary system-level release of information (ROI) that would allow staff at Home Forward to share participant information with their broad set of partners for case coordination. This coordination involved services that participants were currently receiving and needed services that were still outstanding. If applicants signed the ROI, Home Forward was able to work with JOHS to connect them with supports from agencies in the homeless services system. Applicants were eligible for these supports if they encountered challenges with either navigating the system to secure a voucher once pulled from the waitlist or if they struggled with leasing up once they received the voucher. A secure SharePoint site with restricted access for partners was used to keep track of a participant's status and share information across partners. If participants declined the ROI, Home Forward was unable to implement this strategy and instead worked with JOHS to identify an agency that could provide some housing search assistance for those individuals.

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

The primary benchmark for the mainstream program is voucher use. Multiple staff estimated that the goal was to reach about 80 percent use. Internally, staff noted that the program continuously monitors demographics to ensure that the program

is successfully reaching disadvantaged groups, promoting race equity, and providing insights to staff on what kind of supports are needed for certain populations in terms of age, race, gender, and family size.

Even when benchmarks for voucher use were unmet, staff shared that they felt their efforts successfully targeted the intended populations. According to a February 2022 dashboard report, 131 vouchers were being used at the time, and 13 new vouchers had been leased year-to-date in 2022.

CHALLENGES DURING PROGRAM IMPLEMENTATION

Implementation challenges when targeting people who are transitioning out of institutionalized settings

Staff noted that people with Mainstream Vouchers leaving institutionalized settings generally take longer to complete housing searches in the private market due to the level of support required throughout the housing process and the time needed to coordinate that support. Staff also recalled challenges with the wait time between applying for the voucher and being pulled off the waitlist. Staff expressed that having the voucher available at the moment of transition is critical to supporting people transitioning out of institutionalized settings. Staff believed that having two separate lists, one for the general HCV participant and one for those transitioning out of institutions, could reduce the wait time for participants leaving institutionalized settings.

Policy challenges to meeting voucher use benchmarks

> "I think the thing that we've learned with this [program] and then our other projects that serve people leaving homelessness … it has to be voluntary, but a voluntary system-wide ROI that allows sharing of information for the purpose of case coordination to help people be successful has been really important in setting up good communication, periodic communication with partners to track where people are throughout the process."
>
> **—Home Forward Program Staff**

Staff discussed their challenges with meeting the voucher use benchmark while also being intentional in reaching vulnerable populations. Implementing the preference for people transitioning out of institutionalized settings successfully

reached the targeted population but took time to execute, resulting in slower voucher use rates. Staff mentioned that this delay placed Home Forward at risk of not receiving additional Mainstream Vouchers based on the use level from the previous award iterations. One staff member explained, "I understand HUD's perspective around using utilization benchmarks, but it needs a little more nuance if they're serious about housing authorities trying to target assistance to folks who have a lot of vulnerabilities and barriers to leasing in the market because that's always going to take longer to utilize." Instituting a preference for people transitioning out of institutionalized settings may be particularly challenging in Oregon due to the low numbers of institutionalized individuals residing there; less than 18 percent of Oregon's long-term services and supports funding goes to institutions, compared with the national average of 41 percent (Murray et al., 2021). Because low numbers of people are in institutionalized settings, the few eligible non-elderly people with disabilities are likely to have the greatest needs and require more effort to transition.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

Program staff described the following lessons learned during implementation:

- Having strong partnerships with a network of community agencies to be part of a coordinated working group is essential to helping people with disabilities overcome barriers.
- Providing housing and supportive services through all stages of the housing process is essential to ensure that participants can overcome barriers and successfully move into housing.
- Coordinating supportive services delivered by partners for more vulnerable populations may be necessary to reduce the time for vouchers to be used.
- Providing education to housing search partner agency staff about the voucher program and its requirements is essential to a successful outcome for the participant.
- Being clear from the beginning about the support types participants will need throughout the process and expectations in terms of provider capacity helps to set realistic expectations for participants.
- As an MTW agency, having flex funds to mitigate barriers, such as application fees, deposits, and expenses for temporary lodging, is crucial to stabilize an unhoused participant during the housing search process.

5. Summary

Home Forward uses its jurisdictional partnerships to connect non-elderly people with disabilities to housing and supportive services to overcome barriers and promote long-term housing retention through its Mainstream Voucher program. Home Forward employs several strategies in successfully helping people with disabilities to obtain and move into housing, including collaborating with jurisdictional partners, taking referrals from the Coordinated Entry System, coordinating with a landlord outreach team, and creating a housing navigator position on staff to provide additional support to individuals with high levels of need. Lessons learned from program staff implementing these strategies emphasize the importance of having strong partnerships with a network of community agencies that are willing to come together and be part of a coordinated working group to help people with disabilities overcome barriers.

Downtown Emergency Services Center's Permanent Supportive Housing

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

Downtown Emergency Services Center (DESC) is a Seattle-based, private, nonprofit 501(c)(3) organization that provides housing, shelter, and health services to people with complex needs associated with homelessness, substance use disorders, and serious mental illness. DESC operates several programs targeted to this specific population group, including the following:

- Survival services, including an emergency shelter, are aimed at people with serious mental illness and substance addiction.
- Behavioral health programs, including outpatient mental health and substance use disorder treatment.
- Behavioral health crisis services, including a short-term crisis stabilization facility and mobile crisis response services across all of King County.
- Street outreach and engagement programs aimed at connecting people who have serious untreated psychiatric conditions to services.
- Permanent Supportive Housing program, which is the focus of this case study.

DESC's Permanent Supportive Housing program is principally focused on people with serious behavioral health conditions and serious mental illness, such as schizophrenia or other psychotic disorders, and long-term substance use disorder. Some participants are people with other kinds of disabilities, such as mobility impairments or chronic disabling health conditions, typically in addition to an existing behavioral health condition.

Overview of DESC Program
Program type ▪ Supportive Housing Program **Geographic scope** ▪ Seattle (King County), Washington **Target population** ▪ People with serious behavioral health conditions and serious mental illness **Primary housing-related services offered** ▪ Rental assistance, housing search, accessibility modifications, security deposits, household furnishing, and moving expenses

Main funding sources
- HUD's Continuum of Care program
- Medicaid-funded Foundational Community Supports program
- Local funding through donations

Number of participants served
- Approximately 40 people a month
- 1,567 people living in DESC homes as of the end of 2021

Initial year of operation
- 1979

Main partners
- Seattle Housing Authority
- Housing Connector
- University of Washington
- Healthcare entities, including Harborview, NeighborCare, and Veterans Affairs
- Meal provider organizations, including FareStart and Operation: Snack and Lunch

BRIEF OVERVIEW OF THE CASE STUDY

This case study draws on interviews with key stakeholders, including program staff, partners, and a person who has received services from the program. The case study aims to provide multiple perspectives on the operations and impact of DESC's Permanent Supportive Housing program and highlights critical components of the program's successful strategies in helping people with disabilities to obtain and move into housing facilities, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from interviews with stakeholders.

2. Program Overview

PROGRAM PURPOSE AND GOALS

DESC was founded in 1979 to provide emergency shelter and survival services for people who were living in a state of chronic homelessness and, due to their severe and persistent mental illnesses and substance use disorders, were not being served by existing missions. The fundamental goal of DESC's Permanent Supportive Housing program is to help promote self-sufficiency and recovery by helping participants obtain, move into, and maintain permanent housing.

SERVICES OFFERED AND MODE OF DELIVERY

Housing-Related Services Offered

Housing Location Services

- Acquiring legal documentation, such as IDs, birth certificates, and marriage licenses
- Searching for and locating available housing units

- Fostering relationships and negotiating with landlords
- Transporting people to visit housing units

Housing Transition Services

- Paying security deposits and first month's rent
- Procuring furniture and household goods
- Modifying units and providing reasonable accommodation
- Coordinating rental assistance paperwork
- Accompanying residents on move-in day

DESC operates two types of Permanent Supportive Housing programs, differentiated principally by the clustering (single-site program) or separation (scattered-site program) of housing units. In the single-site program, DESC owns and operates approximately 1,400 units of housing across 16 buildings. The bulk of the single-site units are supported by other resources, such as HUD Continuum of Care (CoC) funds for supportive housing and several state and local funding programs aimed at either affordable housing, homelessness response, or both; in some cases, they are also aimed at behavioral health response. According to program staff, these units are furnished with furniture and household goods, such as linens and pots and pans, and come with full kitchens and bathrooms equipped with safety features, such as automatic shut-off ovens and grab bars in the bathrooms (Malone, Collins, and Clifasefi, 2015).

In its scattered-site program, DESC uses housing subsidies—CoC program funded Shelter Plus Care Permanent Supportive Housing managed through Plymouth Housing—to place clients into rental properties throughout Seattle. DESC operates two different scattered-site programs: Master Lease and Keys to Home. In the Master Lease program, DESC is the master tenant and enters into a lease with landlords. By contrast, in the Keys to Home program, the tenant holds the lease directly with the landlord. Keys to Home "empowers individuals to maintain housing through community integration, advocacy, and supporting individuals in meeting their recovery goals" (DESC, n.d.). Between the two scattered-site programs, DESC offers Permanent Supportive Housing services to approximately 400 clients in an independent housing market scattered throughout King County. Before moving into scattered-site housing, participants receive direct services from DESC staff, including assistance with searching for and locating housing units, helping them through the leasing process, procuring furniture and household goods, arranging for reasonable accommodation, assisting with moving into the housing unit, and paying the security deposit and first month's rent. For all its scattered-site programs, DESC provides bus tickets for people who can move back and forth to inspect housing

units. The program housing specialist coordinates unit inspection dates with clients during the housing search. DESC also has vehicles on site that scattered-site teams can use to visit housing units.

TARGET POPULATION

Everyone who moves into the DESC Permanent Supportive Housing program has some kind of disability, with the majority having a behavioral health, mental health, or substance use disorder.

STAFFING AND PARTNERS

DESC operates an integrated approach to service provision in which the entire team is responsible for every client. Through its Homeless, Outreach, Stabilization, and Transition Project program, DESC has outreach and engagement Specialists "who work within specific geographic regions or in other targeted programs or facilities such as drop-in centers for women, local hospitals, and jails to find people who are chronically homeless and help them connect to services and housing." DESC also has a housing placement and coordinated entry manager who works with internal and external local service providers within the Coordinated Entry System to prioritize housing for people considered the most vulnerable using the Vulnerability Assessment Tool. For clients who are placed into the scattered-site program, a housing specialist works with them to determine their housing preferences and coordinate their transition into housing. Once the clients move into either of the Permanent Supportive Housing programs, they are assigned a dedicated clinical support specialist, whose primary responsibilities are to ensure that clients maintain their housing and help them with anything they need, including making medical appointments, connecting them with mental health or substance abuse services, and cleaning their units. For clients who can obtain work, DESC's employment specialists assist them with coaching and job skills.

DESC receives support from the following key local and state agencies and organizations:

- The Seattle Housing Authority supports DESC's mission by providing subsidies for more than half of DESC's supportive housing units.
- Housing Connector[42] serves as a community partner to DESC, working together to build relationships with landlords throughout the King County metro area. This partnership allows the county to provide more housing and

[42] Housing Connector is a Seattle-based organization that "partners with property owners and managers to lower barriers to housing and increase our region's affordable housing capacity" (https://www.housingconnector.com/about-us).

work with the landlords to adapt their standards to make housing available for tenants who may have past evictions, have very low credit scores, or would likely be screened out of independent living situations or the regular market.

- Several healthcare service agencies, including Harborview Medical Center and NeighborCare Health, help to ensure that physicians and nurses have regular on-site hours at DESC housing facilities to serve DESC clients. Also, Veterans Affairs provides a specialized medical team to serve veterans in different facilities.
- Nonprofit meal provider organizations, such as FareStart and Operation: Snack and Lunch, provide significant amounts of nutritional meal services to tenants through these partnerships.
- The Addictive Behaviors Research Center of the University of Washington partners with DESC to evaluate the Permanent Supportive Housing program.

FUNDING

DESC receives federal, state, city, and local dollars for the operation of its Permanent Supportive Housing program. DESC's federal funding comes mainly in the form of HUD Continuum of Care Permanent Supportive Housing vouchers, which are managed by the Seattle Housing Authority and Plymouth Housing. At the state level, DESC receives funding from the Foundational Community Supports program, which is a state Medicaid-funded, integrated healthcare 1115 demonstration that offers supportive employment and supportive housing services for Medicaid-eligible individuals with disabilities (Amerigroup Washington, Inc., 2018). According to stakeholders, the Foundational Community Supports demonstration has enabled providers to close the gap between the operating costs and operating revenues of the Permanent Supportive Housing program. The consistent funding from the 1115 demonstration allows DESC to not only maintain its staffing levels where they need to be but also increase them in certain places to lower caseload sizes and deliver the needed quality of care for Medicaid participants. Program staff also pointed to local funding through donations as an important funding source. As a nonprofit, DESC has an internal system that collects donations, including furniture, from the local community. In 2021, DESC received donations of goods and services worth approximately $4 million.

3. Key Strategies for Connecting Program Participants to Housing

ASSERTIVE OUTREACH AND ENGAGEMENT

According to the stakeholders interviewed, an important aspect of DESC's Permanent Supportive Housing program in addressing the barrier of searching and leasing up is their street outreach and engagement services, especially for people who are living with severe mental illness. Through assertive outreach efforts, DESC outreach teams go directly to wherever clients are and "visit them repeatedly and share their own stories to build rapport and trust" (DESC, 2019). By going where needed, the outreach team members recruit people who are unlikely to visit traditional service providers.

LEGISLATIVE ADVOCACY LEADING TO LOCAL AND STATE SUPPORT

Recently, resources for Permanent Supportive Housing have been strongly prioritized at the local, city, and state levels. For instance, the Washington State Housing Finance Agency, which authorizes Low-Income Housing Tax Credit (LIHTC) allocations, has set up its allocation system to prefer supportive housing for people experiencing chronic homelessness. The significant amount of buy-in across different government entities has come from decades of legislative advocacy about supportive housing being a critical element of Seattle's response to homelessness in the community.

DESC USES A HOUSING FIRST APPROACH TO SUPPORTIVE HOUSING

In providing supportive housing services, DESC uses the Housing First approach, in which staff provide "housing as a first step and then surround tenants with voluntary treatment and health services" (DESC, n.d.b). DESC's Housing First approach is founded on unconditional acceptance. By contrast with Continuum of Care (CoC) housing models, in which individuals are required to meet certain requirements or submit to drug testing before a housing placement, DESC prioritizes the most vulnerable and hard to reach, allowing those most in need to move into housing first, despite mental illness or substance use dependency. Staff mentioned that "Permanent Supportive Housing models that use the Housing First approach have proven to be highly effective at ending homelessness" (HUD, n.d.a). DESC's Housing First approach is guided by the following seven standards (Malone, Collins, and Clifasefi, 2015):

- The priority is to move people into housing directly from places not meant for human habitation and shelters without preconditions of treatment acceptance or compliance.

- Robust supportive services are provided by the housing agency and predicated on assertive engagement, not coercion.
- Continued tenancy is not dependent on participation in services.
- Units are targeted to the most disabled and vulnerable homeless members of the community.
- Housing First embraces a harm reduction philosophy and approach to addiction.
- Residents must have leases and tenant protections under the law.
- Housing First can be implemented as either a single-site or scattered-site model.

DESC USES THE VULNERABILITY ASSESSMENT TOOL TO PRIORITIZE RECIPIENTS

DESC has relied on the Vulnerability Assessment Tool to essentially score people on a measure that is largely focused on level of functioning. The tool helps to establish a clinical picture of an individual based on information provided by the client. This information—in tandem with DESC's internally developed client service tracking software, called CHASERS—enables staff to determine which individuals have the highest needs and help support them in long-term housing. Staff noted that a 2015 evaluation by the Canadian Housing First Assessment Taskforce rated DESC's Vulnerability Assessment Tool as the best "brief screening tool available that can assist with prioritization of clients for Housing First programs" (Aubry et al., 2015).

DESC USES A MASTER LEASE MODEL TO INCENTIVIZE LANDLORDS TO PARTICIPATE IN THE PROGRAM

For the scattered-site program, DESC signs a master lease agreement with landlords. Under this agreement, landlords are responsible for all common area maintenance and operations, whereas DESC is responsible for any damage that occurs in the unit within the lease term. In the event of unit damage, DESC care teams, in tandem with Housing Connectors, intervene quickly to restore and repair the unit to ensure that the cost is not borne by landlords. The exact language about landlord responsibilities is contained in the agreement for the Shelter Plus Care Permanent Supportive Housing voucher managed by Plymouth Housing. This leasing model incentivizes landlords to participate in leasing units to tenants who are not subject to the landlords' screening criteria.

INTEGRATED APPROACH TO CLIENT SERVICES

DESC's integrated approach to providing housing-related services is crucial to the success of its site-based program. To DESC, supportive housing is more than providing services; it involves "the design of the facility, staffing patterns, program values, and ways of interacting with residents, which all combine to create a program that helps people succeed over the long term"(DESC, n.d.c). In line with this approach, residents in single-site and scattered-site units have consistent access to wraparound services under "one roof." These services include state-licensed mental health and substance use disorder treatment, on-site healthcare services, daily meals and weekly outings to food banks, case management and payee services, medication monitoring, weekly community-building activities, and employment services.

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

DESC's Housing First approach has been the subject of several evaluations since 2009, with the most recent conducted in 2016. These evaluations have focused on outcome measures, including homelessness and psychiatric hospitalizations, emergency medical services, housing retention, jail time, and cost savings. Major findings from these studies included the following:

- Tenants showed high retention and significant reductions in days hospitalized (Brown et al., 2016).
- An average reduction of 54 percent in the number of emergency medical services contacts occurred (Mackelprang, Collins, and Clifasefi, 2014).
- Only 23 percent of chronically homeless people with severe alcohol problems returned to homelessness during a 2-year followup (Collins, Malone, and Clifasefi, 2013).
- Exposure to Housing First single-site housing predicted a significant decrease in jail time (Collins, Malone, and Clifasefi, 2013).
- Among chronically homeless people with severe alcohol problems, the provision of housing services without abstinence and treatment requirements is significantly more cost-effective than allowing them to remain homeless (Larimer et al., 2009).

CHALLENGES DURING PROGRAM IMPLEMENTATION

Despite the success of DESC's Permanent Supportive Housing program in providing low-barrier housing opportunities for people with serious mental illness and substance use disorders, program staff identified challenges that have limited the number of people served by the program. Commonly identified challenges included a lack of additional funding to keep up with inflation, the incidence of people with substance use disorders relating to methamphetamine use, and workforce hiring and maintenance for the program.

- The hardest challenge is that rents and inflation are rising at rapid rates without a commensurable increase in the budget that is allocated for supportive housing programs, thereby limiting the funding ability of DESC to serve more people. To capture the nature of this challenge, one program staff member stated, "We have the need; we have the resources and the relationships. We just need more financial assistance from funders to be able to keep up with the inflation year to year."
- A more recent challenge is that clients who use methamphetamines or have other substance use disorders have been particularly destructive in their units, causing damages that cost substantial amounts. Program staff further explained that this challenge is exacerbated by the lack of partnership with crisis response services, such as the police and fire departments.
- The nationwide worker shortage, a more recent challenge, has affected program operations because the program is unable to find personnel with the requisite skills.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

Program staff referred to the assessment conducted during the pre-tenancy portion of the housing process as crucial to the success of clients once they get housed. Using the clinical picture from the Vulnerability Assessment Tool helps staff to connect clients to the several wraparound services and layered supports. For instance, many clients receive Medicaid and other financial assistance after being supported by DESC to apply for disability programs. Identifying any undiagnosed and untreated disability helps with long-term stability and balances out the capacity of one entity trying to provide all the service needs for clients who may have layered needs.

5. Summary

DESC's Permanent Supportive Housing program assists people experiencing chronic homelessness, substance use disorders, and serious mental illness with achieving greater independence and self-determination by helping them to live in stable and safe housing in an inclusive community. DESC provides clients with support resources and services needed to thrive, including housing location and navigation, housing transition, rental assistance, and health and employment services. According to program staff, the success of the program stems from strategies such as Housing First and an integrated approach to supportive housing, effective partnerships with landlords and community organizations, strong state support through its legislative advocacy, and an individualized approach to services based on a comprehensive assessment of applicants' functional needs.

Resources

Vulnerability Assessment Tool (Vulnerability Assessment Tool - DESC).

Louisiana's Permanent Supportive Housing

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

Permanent Supportive Housing is a model of reintegrating people into their community by addressing their basic needs, providing housing, and offering access to ongoing supportive services (Louisiana Housing Corporation, n.d.). Established from the 2006 Louisiana's Road Home program for recovery after Hurricanes Katrina and Rita, Louisiana's Permanent Supportive Housing program is a large-scale, cross-disability, Medicaid-funded program that uses state-level partnerships to systematically provide access to integrated, affordable housing units. The program employs a systems-level approach using partnerships between the Louisiana Housing Corporation (LHC), which administers state-level housing assistance; the Louisiana Department of Health (LDH), which administers Medicaid-funded health and human services as home- and community-based services (HCBS); and service providers to create an integrated system that aligns housing opportunities with appropriate supportive services.

Overview of Louisiana's Permanent Supportive Housing Program
Program type ▪ Permanent Supportive Housing **Geographic scope** ▪ The entire state of Louisiana **Target population** ▪ People with significant, long-term disabilities **Primary housing-related services offered** ▪ Housing vouchers, housing location, landlord negotiation, housing inspection, and project-based rental assistance **Main funding sources** ▪ A federally funded community development block grant ▪ Medicaid funding **Number of participants served** ▪ Approximately 3,000 families currently housed **Initial year of operation** ▪ 2006 **Main partners** ▪ Louisiana Department of Health ▪ Louisiana Housing Corporation

BRIEF OVERVIEW OF THE CASE STUDY

This case study draws on interviews with key stakeholders, including program staff, partners, and a person who has received services from the program. The case study aims to provide multiple perspectives on the operations and impact of Louisiana's Permanent Supportive Housing program. The study highlights critical components of the program's successful strategies in helping people with disabilities to obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from interviews with stakeholders.

2. Program Overview

PROGRAM PURPOSE AND GOALS

According to program staff, one of the program's main goals is to provide Louisiana residents with safe and affordable housing in the community and help them remain housed. Louisiana's Permanent Supportive Housing approach is aligned with policy goals, such as increasing community living options for people with disabilities, preventing and ending homelessness, and reducing the unnecessary confinement of people with serious disabilities to institutionalized and restrictive settings. This case study focuses on Louisiana's Permanent Supportive Housing program's approach to coordination and transition into community-based housing for participants with disabilities.

SERVICE OFFERED AND MODE OF DELIVERY

Louisiana's PSH program employs a Housing First model that emphasizes immediate access to housing with no readiness requirements. Staff expressed that program participants were able to be placed into housing without waiting for a Medicaid waiver slot or enrollment in supportive services. However, supportive services are available when a participant's name is pulled off the waitlist to receive housing. Although these wraparound supports or supportive services are optional, staff expressed that they are often crucial to long-term success, and most participants use these resources.

The program structure consists of an integrated system that aligns housing assistance through housing vouchers and subsidies provided by LHC with support services, including pre-tenancy supports and wraparound services, provided by LDH and service providers. LHC issues vouchers and is responsible for Permanent

Supportive Housing unit development.[43] Through LHC, Louisiana's Permanent Supportive Housing program offers subsidized housing and different housing vouchers, including their Section 811 Project Rental Assistance Program.

LDH manages the services side, working directly with Permanent Supportive Housing service providers to make referrals, provide Permanent Supportive Housing training to providers, and monitor service delivery. LDH and service providers offer Medicaid-funded services, including information and referral services, housing location services, landlord negotiation, housing inspection, and other supportive services, that link participants to a Permanent Supportive Housing provider in the community. These services may include behavioral health supports, counseling, and transportation services.

In some cases, staff noted that funds from their initial U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant (CDBG)[44] were used to cover additional services that are not billable under Medicaid or to continue serving participants whose Medicaid eligibility had lapsed. The LHC and LDH partnership allows for coordinated access to housing as staff at both agencies collaborate to ensure that services are available at the same time a participant is pulled off a waitlist to receive housing. This Permanent Supportive Housing services infrastructure allows outreach, referral, and service coordination to be administered at the state level instead of by individual providers.

Unit Development

Program staff shared that Louisiana developed a policy requiring 10 percent of units in every newly developed Low-Income Housing Tax Credit (LIHTC) property and at least 5 percent of all units in new rental properties financed through LIHTC to be reserved for Permanent Supportive Housing program participants. Other housing units were available from private rental leasing through housing subsidies.

TARGET POPULATION

Louisiana's Road Home hurricane recovery plan defines a cross-disability target population for Permanent Supportive Housing, including people with mental illnesses, developmental disabilities, physical disabilities, and chronic health conditions, meaning that participants are not segregated on the basis of disability type. The program also maintains a prioritized waiting list for Permanent Supportive

[43] An in-depth discussion is available in the Unit Development section.
[44] An in-depth discussion is available in the Funding section.

Housing units for people with significant disabilities and those transitioning out of institutionalized settings.

To be eligible for Louisiana's Permanent Supportive Housing program, participants must be Medicaid HCBS-eligible and meet the following criteria:

- Meet federal low-income requirements.
- Establish a need for the offered housing supports.
- Have a significant, long-term disability that currently receives one of the following: Mental Health Rehabilitation Services, an eligible Office of Aging and Adult Services or Office for Citizens with Developmental Disabilities waiver, Ryan White services, or Medicaid institutional services, such as a nursing home.

STAFFING AND PARTNERS

The program's staffing model includes staff from the state agencies (LDH and LHC) and different Permanent Supportive Housing service providers.

- Permanent Supportive Housing service providers have staff who provide wraparound services to program participants, such as behavioral health supports, counseling, transportation services, and access to assistance programs such as food stamps. Each service provider agency has about five case managers on staff, with caseloads averaging 50 participants per case manager.
- The tenant services manager staffed by LDH acts as a liaison between the property manager or owner and the participant. This individual is responsible for identifying units for specific populations, including individuals with a disability; locating outside resources as needed for housing or wraparound supports; helping the participant to obtain and process paperwork (for example, applications and identification documents); and ensuring that the Permanent Supportive Housing unit passes inspection before lease up.
- Transition coordinators, staffed through Louisiana's Money Follows the Person (MFP) program under LDH, work with people transitioning out of an institutionalized setting into the community.

Staff identified two key Permanent Supportive Housing service providers, Easterseals and Start Corp, that provide wraparound services, such as advocacy, transportation services, and behavioral health supports, to help participants overcome barriers in obtaining housing assistance by addressing any underlying

needs. Staff noted that the state of Louisiana has approximately 13 Permanent Supportive Housing providers.

FUNDING

Louisiana's PSH program operates health services under a Medicaid funding model, meaning that all services provided must be billable through Medicaid. Program staff mentioned that the program received HUD CDBG disaster relief funds to start the project-based voucher (PBV) program, which included funding for 2,000 Section 8 PBVs and 1,000 CoC program funded Shelter Plus Care subsidies—a total of 3,000 PSH subsidies. Overall, the state received $73 million in disaster relief funds. As these funds have no deadline, they have been used to provide services that cannot be billed through Medicaid or to participants whose Medicaid coverage has lapsed (Center for Health Care Strategies, 2018). Although this initial funding only allowed the PSH to serve southern Louisiana, the program received a new line of funding in 2012 to develop its Section 811 Project Rental Assistance Program, extending the program's reach beyond southern Louisiana. Housing subsidies have multiple funding streams to promote sustainability and ensure access to Permanent Supportive Housing . Subsidies are funded by CDBG, LIHTC, housing choice vouchers, Section 811 Project Rental Assistance, and the CoC program.

3. Key Strategies for Connecting Program Participants to Housing

USING A HOUSING FIRST APPROACH

> "[The PSH service provider] made sure that I would be safe [and] everything will be okay. They played a big part in having me getting 811 and finding my housing for me."
> **—Louisiana's PSH Program Participant**

The program uses a Housing First approach to service delivery, in which receiving housing is not conditional on enrollment in supportive services. Program staff believed that prioritizing housing led to greater outcomes because participants could be stabilized in housing before or while receiving services.

USING A CROSS-DISABILITY APPROACH

Louisiana's PSH program addresses the needs of several subpopulations of people with different kinds of disabilities who are made eligible by Medicaid through different categories, allowing the program to serve a wide range of individuals who meet Medicaid HCBS eligibility.

INTEGRATING AND COORDINATING SERVICES USING A SYSTEMS-LEVEL APPROACH

Louisiana's Permanent Supportive Housing program is innovative in its structure. Whereas traditional Permanent Supportive Housing programs operate on the provider level, Louisiana's Permanent Supportive Housing program operates at the systems level and systematically provides access to affordable housing and creates an integrated system that aligns housing opportunities with appropriate services. Louisiana's systems-level approach mandated the development of a Permanent Supportive Housing services infrastructure of partnering state agencies to handle outreach, referrals, and service coordination at the state level instead of by individual provider. The program partners with Permanent Supportive Housing service providers, training them collaboratively to ensure that all parties have the same expectations and training. As a result, service providers are integrated into the program, and services are less siloed because all parties work to serve participants collaboratively.

HAVING FLEXIBLE FUNDING STREAMS

Having disaster relief funds that do not expire allows the program to cover any necessary services that cannot be billed under Medicaid.

BEING FLEXIBLE AND RESPONSIVE TO THE NEEDS OF PARTICIPANTS WHEN LOCATING UNITS

When locating a suitable unit for a program participant, program staff consider the participant's needs (for example, ensuring that units are on the bus line and close to any potential resources that the participant needs, such as grocery stores, libraries, and medical offices).

HAVING CERTIFIED HOUSING QUALITY STANDARDS INSPECTORS ON STAFF

Many program staff are certified Housing Quality Standards inspectors, allowing staff to inspect a unit quickly and early in the housing process before any paperwork begins. This strategy mitigates the wait time that typically occurs when relying on outside inspectors and gives staff certainty that the unit is suitable before moving too far in the housing process.

ACTING AS A MEDIATOR BETWEEN LANDLORD AND PARTICIPANT TO OVERCOME BARRIERS RELATED TO LANDLORD RELUCTANCE TO RENT TO THOSE RECEIVING ASSISTANCE

Program staff at Louisiana's Permanent Supportive Housing program reported that they act as mediators or liaisons between the landlord or owner and the participant.

One staff member explained, "In the event that there are some concerns while the tenant is leasing or renting … we don't just drop them off, and then nobody comes back. We're there. We're available. You can request a meeting at any time. Our housing commitment does not stop once they're in your unit. That has really helped us a lot." As a result, landlords are often more willing to accept a participant using a housing voucher or rental assistance.

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

Program Outcomes

- 95 percent of families remain stably housed (Louisiana Department of Health, n.d.).
- 80–90 percent lease-up rate of units.[45]

Program staff indicated that their primary benchmarks measuring program outcomes are the percentage of families who remain stably housed after being served by the Permanent Supportive Housing program and the percentage of leased-up units. Staff reported that the program exceeds its benchmark goal of having 77 percent of families served remaining stably housed, with a tenancy retention rate of approximately 95 percent. Staff also mentioned that approximately 80 to 90 percent of their Permanent Supportive Housing units are currently leased up.

CHALLENGES DURING PROGRAM IMPLEMENTATION

Staff identified several challenges to program implementation. The most common one was locating accessible units. Staff also mentioned challenges in convincing landlords to make necessary changes to units to meet Americans with Disability Act (ADA) compliance and finding first-floor, ADA-compliant units for participants using wheelchairs. Additional challenges with populations with mental health disabilities included participants failing to attend necessary appointments or abandoning a leased-up unit. Staff also mentioned that they often face delays when a property owner has trouble repairing a unit before the unit can be approved for a subsidy.

[45] Estimated by program staff.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

> "The main important thing is that if you have multiple disabilities, and multiple providers that we are all doing the same plan … we are communicating with each other on an ongoing basis, so we don't get into a situation where three different people thought three different things were going on."
>
> **—Louisiana's PSH Program Staff**

Staff discussed the following lessons learned during implementation:

- Having strong, state-level partnerships with a network of high-support agencies that are willing to come together and be part of a coordinated working group is essential to program success.
- Coordinating housing and supportive services allows for continuous, specialized support through all stages of the housing process and is essential to ensure that participants' needs are met.
- Taking participant needs into account when locating units promotes long-term housing retainment.
- Having staff who are flexible and willing to adapt to new strategies or approaches is key to serving a consumer's individualized needs and goals.
- Having staff who are certified Housing Quality Standards inspectors eliminates the potential wait time between identifying a unit and leasing it up that often occurs when relying on an outside agency for inspection.

5. Summary

Louisiana's Permanent Supportive Housing program is the first large-scale, cross-disability Permanent Supportive Housing program to use state-level partnerships to systematically provide access to integrated, affordable, and accessible housing units and supportive housing services. The program employs several strategies in successfully helping people with disabilities to obtain and move into housing, including integrating and coordinating services using a systems-level approach, considering participant needs when locating units, having certified Housing Quality Standards inspectors on staff, and acting as a mediator between landlords and participants. Staff emphasized the importance of having strong partnerships at the state level with a network of high-support agencies that are willing to come together

and be part of a coordinated working group that allows for continuous, specialized support through all stages of the housing process to ensure that participants' needs are met.

New Reach's Supportive Housing

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

New Reach is a 501(c) nonprofit in New Haven, Connecticut, dedicated to supporting people experiencing homelessness in locating and transitioning into housing. Many of New Reach's clients have mental health issues, substance use disorders, or both. The organization's programs are intended to address client needs at multiple phases of the housing process. This assistance includes shelter maintenance, a Rapid Re-Housing program, a supportive housing program, housing transition services, and homelessness prevention. The organization was founded in 1990 as a women's shelter and has evolved during the past 30 years into a comprehensive set of supports for clients in the New Haven region. Although New Reach employs a Housing First model—that is, prioritizing moving clients into housing before offering additional supports—a member of the staff noted that the program's goal is "helping [to] stabilize people in housing and stabilize their households. Not just getting them in[to] housing but stabilizing them in the housing and their lives in general."

Overview of New Reach
Program type ▪ Housing support **Geographic scope** ▪ New Haven and Bridgeport, Connecticut **Target population** ▪ People with significant disabilities, mental illness, and substance use disorders ▪ Women and children ▪ Families **Primary housing-related services offered** ▪ Eviction prevention, crisis services, housing services, information and referral, peer support, diversion services, and youth transition **Main funding sources** ▪ Department of Housing ▪ Housing Opportunities for Persons with AIDS program (HOPWA) through the City of New Haven ▪ Corporate sponsors **Number of participants served** ▪ 3,686 individuals served in 2020 ▪ 56 percent of those served are children **Initial year of operation** ▪ 1990 **Main partners** ▪ United Way of Greater New Haven and Department of Mental Health and Addiction Services

BRIEF OVERVIEW OF THE CASE STUDY

New Reach was selected for a case study because of its focus on helping people with disabilities move into housing. Its approach has some unique aspects—including the case management process, collaboration with community partners, and post-transition rent support for 6 months—from which similar programs may draw models and lessons. Although New Reach continues to support clients following their transition into housing, particularly through its integrated care program, this study focuses primarily on New Reach's pre-tenancy services—namely, the ways in which the organization supports clients in transitioning from homelessness into housing. The study draws on the perspectives and experiences of key stakeholders, including program staff, partners, and an individual with program experience and also draws on a review of publicly available documents related to New Reach's mission, history, and funding. Recommendations and lessons learned are drawn from interviews with stakeholders.

2. Program Overview

SERVICES OFFERED AND MODE OF DELIVERY

The services offered by New Reach have evolved significantly over time. Its current pre-tenancy services include the following:

- **Rapid Re-Housing,** which includes short-term rental assistance and related supportive services tailored to each client's needs.
- **SSI/SSDI Outreach, Access, and Recovery Support,** which provides clients (either currently experiencing homelessness or at risk of experiencing homelessness) application assistance for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).
- **Housing navigation,** which includes connecting clients with landlords who have a relationship with New Reach, have vacancies, and are willing to house clients who may have barriers, such as criminal records.
- **Housing application support,** which includes supporting clients to apply for housing waitlists for preferred homes while they are housed elsewhere.
- **Casework support,** which assesses client needs, sets goals, and ensures that needs and goals are met as well as possible.
- **Peer support,** which provides a safe relationship for clients for emotional support and community navigation.

- **A furniture co-op,** which enables clients transitioning from homelessness to furnish their homes. This service includes not only furniture but also commonly needed household items, such as linens, cleaning supplies, and toiletries.

New Reach also maintains roughly 170 Permanent Supportive Housing units as one component of its overall approach. Although the program is still considered Housing First, many program staff indicated that they feel that the current model is more effective in transitioning people into housing (as well as supporting them in maintaining their housing) than past models, which were primarily focused on housing without the additional resources, such as housing navigation or peer support.

TARGET POPULATION

New Reach focuses on serving individuals experiencing, or at risk of, homelessness. Its clients are primarily women and their children. Staff are not limited to serving people with disabilities, but many of their clients have mental health disabilities or substance use disorders and often need education services during and after transitioning into housing (for example, learning how to pay bills, manage money, and attend appointments on time).

STAFFING AND PARTNERS

New Reach has dedicated staff for the various components of pre-tenancy service delivery, including the following:

- **Housing navigators,** who work directly with landlords to help clients locate appropriate housing and advocate for clients who may have barriers to housing (such as criminal records and past evictions).
- **Diversion staff,** who try to divert clients from shelters into housing when possible.
- **Caseworkers,** who provide wraparound support across multiple stages of the housing process.
- **Integrated care specialists,** who encompass recovery and peer support and include individuals with lived experience.

New Reach works with the City of New Haven Disability Services to locate accessible housing. Although New Reach housing units and their offices are accessible, many other units lack the appropriate modifications, which presents an

ongoing challenge for clients with physical disabilities. Program staff noted that accessibility in Connecticut is a particular challenge due to the age of the housing stock.

New Reach also works closely with the Connecticut Department of Housing, which disburses state and federal funds and develops guidelines for various aspects of its program, including rapid rehousing.

Connecticut's Department of Mental Health and Addiction Services (DMHAS) helps to provide client referrals and associated housing voucher programs. This service occurs through a system of coordinated access networks across the state, which connect DMHAS-eligible individuals to community providers. DMHAS coordinates the HUD 811 Program and HUD Continuum of Care Rental Assistance for individuals with mental illness or substance use disorders (Connecticut State Department of Mental Health and Addiction Services, n.d.).

FUNDING

New Reach receives a combination of public funds (72 percent), private funds (14 percent), and earned income (14 percent). The public funds are a combination of federal and state funding, including from the U.S. Department of Housing and Urban Development (HUD), Connecticut Department of Housing, and Housing Opportunities for Persons with AIDS program in New Haven. Private funds are raised via corporate sponsors, partnerships, and individual donors. Earned income is associated with the housing units that New Reach maintains. New Reach staff have noted a greater scarcity of resources in recent years, particularly with private donations, which some believe could be related to the COVID-19 pandemic. These funds support furniture acquisition, gift cards for move-in expenses, and other transition supports.

3. Key Strategies for Connecting Program Participants to Housing

NEW REACH STAFF ENGAGE IN ONGOING ADVOCACY FOR THEIR CLIENTS

> "People with disabilities … sometimes … lack their own voice. They're afraid to speak out about apartment repairs, or habitability issues, or out of fear of retaliation or anything like that. I think a really great practice that's worked well is our service staff stepping in as an educator for both landlords and for clients … of here are the rights but here are the responsibilities and helping to draw lines for landlords of, 'Did you know this practice that you're doing right now is actually discriminatory?'"
>
> **—New Reach Program Staff**

The concept of advocacy emerged across the interviews, highlighting the need to advocate for clients at multiple points in the housing process, teach clients to advocate for themselves (including acquiring an understanding of their tenant rights), and educate landlords and other service providers about client rights and service provider responsibilities.

BUILDING STRONG RELATIONSHIPS WITH LANDLORDS MITIGATES SOME BARRIERS TO HOUSING

By forming relationships with landlords and educating them about the types of services and supports that New Reach provides, staff can mitigate several barriers to housing, such as past evictions or criminal backgrounds. This rapport allows staff to essentially vouch for program participants and provides a track record of success: "If the landlords know you, trust the services, [and] trust the activities, they are more likely to give someone a chance when they're seeing some of those kinds of barriers."

THE HOUSING FIRST MODEL IS SUPPLEMENTED WITH SIGNIFICANT WRAPAROUND SUPPORT, TAILORED TO EACH CLIENT

Although New Reach employs a Housing First model, staff recognize that their approach is not "housing only." Many clients need support to maintain their housing, and although these supports extend beyond the pre-tenancy period, they are critical to program success. In the pre-tenancy period, case managers strive to understand a client's income or earning potential to match them to appropriate housing. Housing

skills education also begins in the pre-tenancy period, if necessary, and includes an active client role in the housing search, housing selection, and completion of related paperwork to lease up a home. Case managers also support clients in negotiating with landlords and touring apartments. Their experience during this process provides additional information about what types of support a client may need post-move-in to maintain housing stability. For the rapid rehousing and integrated care programs, post-move-in engagement with the client lasts anywhere from 3 to 9 months, depending on the client's needs.

PROGRAM STAFF DEVELOPED A WAY TO STREAMLINE THE HOUSING NAVIGATION PROCESS

In response to the challenges of finding appropriate housing, New Reach staff developed a streamlined approach to managing listings. Using the Tableau software program, they pull together listings from multiple websites—including Apartments.com, Zillow Group Inc., and Craigslist—into one tool that removes duplicate listings. Housing specialists use the tool, which includes filters for the number of bedrooms and monthly rent, to find suitable options for their clients; these options are then shared internally. This program saves time when staff are conducting housing searches for their clients and serves to prevent any internal competition for units.

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

Program Outcome
According to the 2020 impact report, ▪ 73 percent of people in New Reach shelters transitioned into housing. ▪ 100 percent of participants maintained their housing after transition.

In addition to formal reporting requirements and an annual impact report, New Reach engages in ongoing formative program evaluation to ensure program quality and identify areas of improvement. A staff member described the process as "track[ing] our data, which includes feedback from our residents, our tenants, [and] our clients. We track that and we listen. If there's something that is not working or that is a barrier, and that's problematic, as long as there's no contractual reason that we're doing it, we change it. We're flexible, and we're constantly looking at our environment. … We know what we're doing. We know how we're doing it. We know if we need to change anything."

CHALLENGES DURING PROGRAM IMPLEMENTATION

Data reporting requirements across various levels of government funding can strain staff capacity

The program receives funding from several sources, requiring staff to manage multiple reporting requirements. Staff responsible for data reporting can spend 25 to 45 percent of their time on these requirements across various levels of government. Although recognizing the importance of program reporting, a staff member explained, "The documentation takes capacity away. … I'm a big proponent of documenting your work. That's non-negotiable. But the way you do it, how efficient the system is, it would be great if our staff could have more client-facing time because we could help a lot more people with the same staff."

An increasingly competitive housing market means that barriers to housing are even more significant

New Reach housing navigators work with landlords to help clients overcome barriers to housing, such as past evictions, but as the housing market has tightened during the past few years, the demand for units has increased, and landlords have more options for tenants. A staff member explained, "Landlords who may have overlooked credit issues or income issues … are now taking a step back on that. For example, still requiring three times the flat rent income even if [the client has] a subsidy—which defeats the purpose of a subsidy."

Policy barriers at multiple levels can affect program implementation

Federal policy requires rent reasonableness. Program staff believe that the fair market rents set by HUD have not kept up with the pace of Connecticut's housing market. A staff member noted, "We project out what the rent is going to be. We have a set number of households we have helped, and we ran out of rental dollars … because everybody's rents increased so much that the amount the subsidy [we were] paying increased, and it is just [that] we ran out of rental money."

State policy in Connecticut allows a landlord to initiate an eviction when the period of the lease is up if they would like a new tenant or would like to raise the rent, regardless of tenant behavior. This action is listed as an eviction for the tenant, which makes renting housing in the future harder for them.

Funding uncertainties affect service delivery

Because nearly 30 percent of New Reach funding comes from non-guaranteed sources, such as private donors and income, some variation exists in available resources, particularly for expenses such as furniture and gift cards. This variation means that not all clients necessarily have the same experience or receive the same services. Some clients may be able to move into a fully furnished apartment, whereas others may need to wait for furnishings and may be provided with interim resources, such as air mattresses. In addition, because New Reach housing comes from multiple sources, decoupling funds and services—which often is required for government reporting—can be hard (for example, determining which source of money allows for rental assistance to be provided).

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

Taking care of program staff is important to provide the best possible services to clients

> "I always put it as a comparison of taking a lion out of the jungle and putting them in a cage. … It was overwhelming. It was a lot to handle. But in order for me to get back into the daily living skills … being a mom and learning how to pay bills, learning how to pay rent and getting a career … I needed to work in collaboration with my caseworker and … thank God I had a caseworker with my housing voucher. I wish that everybody would be able to utilize that … because I needed that structure but not forever."
>
> **—New Reach Program Participant**

As part of its formative evaluation process and to get a sense of staff morale, New Reach engages in staff services at least twice a year and administers both an employee satisfaction survey and a diversity, equity, and inclusion survey at least once a year. One staff member noted, "We listen to our staff; we support our staff. We strive to have our staff paid as professionals because they are—from our peer staff straight up into our chiefs. I think that makes a difference because we're only as good as the quality of the service that our frontline staff are providing." A key lesson for New Reach is that program staff are as important as program services in generating successful outcomes.

Staff should be willing and able to meet clients where they are and respond to the client's current and specific situations and needs

Staff emphasized the importance of treating each client (and their family, if applicable) as a unique person with specific needs. This approach begins with a "triage" by the case manager to assess the client's immediate pre-tenancy needs and build a plan to support their ongoing needs. A former program participant believed that this approach was critical to their success: "[My caseworker] was meeting me where I was at … Just being able to show me how to … have structure in my life … giving me a calendar and saying hey, what's going on? … Why do you miss your appointments so much? … and they supported me."

Although Connecticut practices a Housing First model in terms of funding programs and organizations, Housing First and pre-tenancy services are often not enough to prevent people from recurring homelessness

Across the interviews, multiple staff noted that pre-tenancy education is often insufficient to support individuals with mental health disabilities and substance use disorders to maintain housing. They noted the need for additional education needs, such as paying rent on time, maintaining a clean and quiet apartment, and maintaining personal hygiene. Although case management for two of New Reach's programs—the rapid rehousing and integrated care programs—ends after 9 months or less, peer support staff maintain the relationship and serve as an ongoing connection to both New Reach and other community programs that may benefit their clients.

Valuing the knowledge of individuals with lived experience strengthens service provision

As it continues to expand its integrated care services, New Reach recently began hiring additional recovery workers and peer workers. The target population for filling these roles is New Reach graduates; they have also included graduates on their board. Program staff emphasized the importance of honoring their perspectives and ensuring that graduates are uniquely positioned to deliver client services and provide strong relationships because they can connect with clients through shared experience. Furthermore, staff emphasized the importance of speaking to clients without judgment and helping them to make progress at their own pace, using goals that the clients are setting.

5. Summary

New Reach is a large provider of services to individuals experiencing homelessness or at risk of homelessness around New Haven, Connecticut. Although it does not focus solely on people with mental health disabilities and substance use disorders, those groups represent a large proportion of its clients. New Reach is able to provide targeted and comprehensive support to help clients locate and lease up housing, move into and furnish their housing, develop housing skills, and orient themselves to their communities. The Housing First model is helpful, but staff emphasized the importance of sufficiently intensive additional services to ensure that an individual can maintain stable housing.

Connecticut's Medicaid Money Follows the Person Program

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

The Money Follows the Person (MFP) Rebalancing Demonstration is a federal initiative created under the Deficit Reduction Act of 2005 and expanded by the 2010 Affordable Care Act (Robison et al., 2015). The program is designed to maximize individual preferences, rebalance Medicaid expenditures, and help states transition people needing long-term services and supports from institutional settings into the community. As of 2022, MFP operates in 41 states and the District of Columbia (CMS, n.d.). In 2008, Connecticut was one of the first states to implement its MFP transition program (Robison et al., 2020). Connecticut established a goal of transitioning 5,200 individuals from nursing facilities and other institutions to home- and community-based settings.

The main target group of the program is people with disabilities[46] and older adults who have been institutionalized for at least 60 days. A collaborative team of care managers and transition and housing coordinators guides the transition process. Priority areas include rental assistance for qualified applicants, accessibility modifications, increased access to and use of appropriate assistive technology, and strengthened quality management systems for people living in home- and community-based settings. Consistent with national program rules, enrollees must have been institutionalized for at least 90 days (reduced to 60 days),[47] have Medicaid as the institutional payer, and want to move to a community-based setting (Robison et al., 2015).

Overview of Connecticut's Medicaid Money Follows the Person Program
Program type ▪ MFP Rebalancing Demonstration **Geographic scope** ▪ State of Connecticut **Target population** ▪ People with disabilities and older adults who have been institutionalized for at least 60 days **Primary housing-related services offered** ▪ Rental assistance, transition coordination, housing coordination, housing search, accessibility modifications, installation of appropriate assistive technology, security deposits, household furnishing, and moving expenses **Main funding sources**

[46] This group includes individuals with serious mental illness, substance use disorders, physical disabilities, and intellectual or developmental disabilities.

[47] This requirement was reduced to 60 days as of January 2021 by the Consolidated Appropriations Act of 2021.

- Centers for Medicare and Medicaid
- Connecticut Department of Housing

Number of participants served

- Over 7,000 individuals served since program inception.

Initial year of operation

- 2008

Main partners

- Connecticut Department of Social Services
- Connecticut Department of Developmental Services
- Connecticut Department of Mental Health and Addiction Services
- Connecticut Department of Housing
- Private Case Management Entities: Connecticut Community Care, Incorporated
- Area Agencies on Aging, including Senior Resources, Agency on Aging of South-Central Connecticut; Southwestern Connecticut Area Agency on Aging; and Western Connecticut Area Agency on Aging
- Independent Living Center, including Independence Northwest, Access Unlimited, and Center for Disability Rights

BRIEF OVERVIEW OF THE CASE STUDY

Connecticut's MFP program was selected because of the success of its transition and rebalancing program. The program includes all disability groups and has transitioned more people to the community than all but three other states due to its early start and strong stakeholder support from legislators, policymakers, consumers, and providers (Robison et al., 2015). Connecticut has also leveraged federal matching funds to capture one of the highest per capita amounts for MFP across the states (CMS, 2021b). This case study draws on interviews with key stakeholders (program staff and partners) and one person assisted by the program and aims to provide multiple perspectives on the operations and impact of Connecticut's MFP program. The study highlights critical components of MFP's successful strategies in helping people with disabilities to obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from interviews with stakeholders.

2. Program Overview

PROGRAM PURPOSE AND GOALS

Connecticut's MFP Benchmarks
▪ Transition 5,200 people from qualified institutions to the community ▪ Increase dollars to home and community-based services

- Increase hospital discharges to the community rather than institutions
- Increase probability of returning to the community during the 6 months following nursing home admission
- Increase the percentage of long-term care participants living in the community compared with an institution

The program has two primary purposes: increasing voluntary transitions from institutions to community-based settings and improving the state's home- and community-based services infrastructure. The goal of Connecticut's MFP program is to transition elderly individuals and individuals with disabilities from institutional settings—primarily skilled nursing facilities—to private homes and apartments in the community. MFP is designed to provide maximum independence and freedom of choice about where participants live and how they receive services. In line with its overarching goal, the program has five benchmarks.

SERVICES OFFERED AND MODE OF DELIVERY

Connecticut's MFP program follows a three-phase approach to engage people with disabilities living in institutions, find them housing, and support their move into housing. In Phase 1, Referral and Assessment, the Connecticut Department of Social Services (DSS) receives referrals, either by phone or online, from many sources, including clients, family members, and facility social workers. DSS then conducts an initial screening of the referrals; when eligibility is confirmed, DSS assigns a case to a specialized care manager.[48] The specialized care manager conducts a fully functional and psychosocial assessment of the individual in the nursing facility using a universal assessment tool[49] and puts together a care plan that consists of services to help support clients.

Once the assessment is performed and approved, in Phase 2, the specialized care manager assigns a transition coordinator to further assist with obtaining the needed documentation,[50] delivering services and supports, and identifying housing options. To prepare the transition plan, the transition coordinator collects information on the client's prior living situation and their reason for moving into the institution. Transition coordinators also determine whether clients have family support or a

[48] MFP requires that the participants be covered by Medicaid in the institution for at least the last day before discharge into the community and after a stay of at least 60 days. MFP initially required an institutional stay of at least 90 days. In 2021, the federal law changed, and states could make institutional residents eligible for MFP after 60 days.

[49] The tool, InterRAI, was developed by the University of Michigan; the State of Connecticut adapted it.

[50] Transition coordinators assist clients with getting the necessary documentation, including a photo ID, Social Security card, and birth certificate, which are needed to apply for housing.

home to which they can return. The transition coordinator has a budget of about $2,000 to furnish the home, including furniture and start-up groceries. Program staff noted that the transition coordinator collaborates with other housing staff throughout this process and must communicate effectively to successfully transition a client.

> "My transition coordinator was awesome. She told me about things that MFP does as the transitional coordinator, what happens when someone does transition and gets into an apartment. She asked me 'Is there any furniture that you need?' I needed furniture. I needed a kitchen set. She said, 'Okay, we can provide you with a new couch and table.' She listed up all these items and she asked, 'What do you need out of this?' I was blown away and overjoyed. Then to top it off, she said, 'Write out a grocery list of everything you would want and need.'"
>
> **—CT's MFP Client**

When transition coordinators determine that clients do not have a home to which they can transition, they refer those clients to a housing coordinator, who will meet with them to determine housing preferences in Phase 3. The first step in the housing coordination phase is to determine if clients qualify for the state-funded Rental Assistance Program (RAP).[51] RAP eligibility is like the Housing Choice Voucher program. Once eligibility for RAP is determined, the housing coordinator helps clients search for housing and negotiates with landlords for a price point within the rental subsidy. If a client is found ineligible for RAP after attempting appropriate and reasonable accommodations, the housing coordinator considers other subsidy options, such as project-based subsidy programs and other tenant-based subsidies. In collaboration with the landlord, the housing coordinator also secures an inspection for that unit to pass housing quality standards. The next step in the process is to finalize the lease agreement and ensure that clients understand their tenant rights and responsibilities upon leaving the institution and moving into the community. The final piece of the process, post-lease up before or after move-in, is the necessary modification of the unit to meet the client's needs. After the housing

[51] The state of Connecticut, through a collaboration with DSS and Department of Housing, provides long-term rental subsidies to MFP participants through the state's RAP program. As of July 2022, 1,452 MFP active participants were enrolled in the RAP program.

coordinator obtains authorization from the landlord for the modifications, the transition coordinator works with the vendor to modify the unit.

TARGET POPULATION

Connecticut's MFP program is a cross-disability program for all disability groups institutionalized in nursing homes, rehabilitation hospitals, or intermediate care facilities. Of those the program currently serves, 40 percent are people with physical disabilities, 10 percent are people with intellectual or developmental disabilities, and 10 percent are people with serious mental illnesses. The remaining 40 percent are adults more than 65 years old. According to program staff, although the program does not target people who are homeless, data matching completed by the University of Connecticut Health Center on Aging (n.d.) shows that MFP has served many people who were homeless before institutionalization.

STAFFING AND PARTNERS

Connecticut's MFP program is a collaboration of several agencies advised by a steering committee. The program is operated by the DSS Division of Health Services, which includes the administration and operation of the state Medicaid program. The program also funds certain positions at the state's Department of Developmental Services (DDS) and Department of Mental Health and Addiction Services (DMHAS). Funded positions are filled by staff with specialties and backgrounds related to those agencies, but their primary functions and responsibilities focus on helping individuals transition out of institutions. Although people with physical disabilities are served by DSS, people with mental illness and intellectual or developmental disabilities are served by DMHAS and DDS, respectively. In addition, DSS partners with multiple agencies, including Connecticut Community Care, Inc.; Agency on Aging of South Central Connecticut; Southwestern Connecticut Area Agency on Aging; Western Connecticut Area Agency on Aging; Senior Resources; Independence Northwest; Access Unlimited; and the Center for Disability Rights. DSS contracts with these agencies in different areas, using MFP funds to deliver specialized care management, transition coordination, and, in some cases, housing coordination. Another major partner is the state's Department of Housing (DOH), which serves as the state housing authority. DOH subcontracts the administration of federal vouchers and the state-funded RAP to a private firm, John D'Amelia and Associates, LLC (JDA). DSS also works in close partnership with the University of Connecticut Health Center on Aging, the organization responsible for evaluating the Connecticut MFP demonstration, including the tracking of key data benchmarks.

FUNDING

As in all MFP demonstration states, Connecticut receives federal Medicaid funding for the program. The demonstration provides for an enhanced federal matching rate (75 percent) for 12 months for each person who meets a minimum duration of living in an institution and has transitioned from the institution to the community during the demonstration period. Federal matching funds of 50 percent are also available to support services not allowed by Medicaid that the state provides during the demonstration. Connecticut's MFP program is unique in that the state, through a collaboration with DSS and DOH, receives extra state funds to support rental subsidies for MFP participants through RAP.

3. Key Strategies for Connecting Program Participants to Housing

CONNECTICUT MFP OPERATES A CROSS-DISABILITY PROGRAM

Under federal MFP, states have the flexibility to choose the populations and types of facilities on which to focus their MFP transition efforts. In Connecticut, this process is needs based without recourse to the type of diagnosis or age and focuses on what clients need to be able to function in the community as independently as possible.

CONNECTICUT MFP HAS DEVELOPED EFFECTIVE PARTNERSHIPS AND LEVERAGES STATEWIDE RESOURCES

The program has developed partnerships with housing authorities, landlords, and with local nonprofit organizations. The program's relationship with DOH has been extremely helpful because it not only coordinates access to RAP but it also coordinates access to the state's Security Deposit Guarantee Program. Program staff suggested that, unlike MFP programs in states that use temporary subsidies to stabilize participants, the rental assistance provided under Connecticut's MFP is available long term. Although the housing coordinators' ultimate role is to help the client find housing, staff spend a considerable amount of time working with landlords. To build relationships with landlords and continue building a partnership to acquire more units in the future, staff strive to respond immediately to landlord concerns. Staff also are trained in motivational interviewing to help engage landlords who might be reluctant to take RAP or carry out home modifications. According to program staff, for example, the ability of housing coordinators to describe MFP to landlords and provide assurances about RAP payments and guaranteed security deposits is fundamental to the program's success. Finally, the program has developed relationships with local nonprofit organizations to assist with essential resources needed to facilitate client transitions, including furniture, specialized beds, and specialized chairs, which are not funded under the state's Medicaid

durable medical equipment program. Even during the COVID-19 pandemic, the state was able to transition people as a result of these established relationships.

CONNECTICUT PRACTICES A CULTURE OF TEAMWORK AMONG STAFF AND CONTRACTORS

According to program staff, setting up a team approach has been important to the success of the MFP program. The program uses specialized teams with different experiences and resources to come together to assist clients. Having a team approach—not only within the specialized care manager, transition coordinator, and housing coordinator but also with DSS—has resulted in a streamlined process and higher rates of transitions. Besides sharing the cost of staffing, the team meets twice a month to problem-solve. The team also shares information on clients through My Community Choices, a unified, private website, where every team member can review the status of every case. Finally, DSS and JDA offer informational sessions and quarterly training for team members.

CONNECTICUT IMPLEMENTS A PERSON-CENTERED APPROACH TO SERVICES, IN WHICH CLIENTS' NEEDS ARE CONSIDERED AT EVERY STAGE OF THE TRANSITION PROCESS

The team develops a person-centered service plan for each participant related to his or her post-institutional goals, drawing on a wide range of possible services, such as home health care, case management, and employment supports. During the transition process, the team prepares a transition plan that focuses on the individual, their needs and wants, and their health and medical necessities. Finally, housing coordinators help clients find housing on the basis of client input on housing type and location. The team uses motivational interviewing to identify client goals and tailors the supports provided based on the client's needs over time.

CONNECTICUT ENJOYS STRONG STATE SUPPORT FOR REBALANCING MEDICAID EXPENDITURES TOWARD COMMUNITY LIVING

Program staff highlighted the continued support they receive from the state in terms of favorable policies and funding. MFP is just one component of a governor-level strategic plan (which is updated every 2 years) for rebalancing Medicaid expenditures away from institutional settings toward community living. Also, a state-level, long-term care plan gets updated every 3 years with recommendations and strategies. Program staff also noted that Connecticut's MFP is fully integrated into the state Medicaid system (and is not treated as a separate grant). MFP has been part of Medicaid from its inception, operating as an independent program. According to program staff, "Whether or not the federal government reauthorizes the program, it will continue to operate subject to state appropriations."

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

Connecticut MFP Outcomes as of Q1 2022
▪ Total transitions are 7,033 (compared with a target of 5,200). ▪ Expenditures are 60 percent home- and community-based services and 40 percent institutional services. ▪ 70 percent of people are served in community settings compared with 30 percent in institutional settings. ▪ 33 percent of hospital discharges go to skilled nursing and 67 percent go to community-based settings. ▪ 35 percent of people admitted to a nursing home returned to their community within 6 months.

The University of Connecticut's (UConn) Center on Aging conducts the evaluation of Connecticut's MFP program. The program has five benchmarks, and the evaluation tracks each benchmark differently. Connecticut is the only state that administers the survey at four points in time instead of three (Robison et al., 2015). An additional survey collection 6 months after the transition allows an earlier look at participant outcomes compared to the national evaluation, which requires surveys only before the transition and at baseline (12 and 24 months after the transition). The program has surpassed all its intended benchmarks according to the first quarter of 2022 report. The outcomes achieved are available in the callout box.[52]

CHALLENGES DURING PROGRAM IMPLEMENTATION

Identified Transition Challenges
▪ Lack of accessible units in the state. ▪ Delays in the housing modification approval process. ▪ Eligibility requirements for RAP. ▪ High staffing turnover, leading to heavy caseloads. ▪ Opposition from nursing homes. ▪ Reoccurrence of medical issues.

Despite the success of Connecticut's MFP in transitioning participants out of institutions, program staff identified an array of housing and transition challenges

[52] In 2007, expenditures were 67 percent in institutional services and 33 percent in home- and community-based services.

that have limited the number of people served by the program. Commonly identified housing challenges included a lack of accessible units, delays in the housing modification approval process, and the eligibility requirements for RAP.

Program staff identified the lack of accessible units as a significant challenge. Connecticut historically ranks in the top five states in the country with the oldest housing market. As a result, certain areas in the state have third-floor walk-ups with no elevators or with narrow doorways. Although the program provides for modification expenses, modification may take up to 90 days and further extend transition time. Program staff noted that about 50 percent of MFP participants using rental assistance are waiting to be transitioned into housing due to factors such as accessibility needs.

Although transition and housing coordinators work very hard to establish eligibility for applicants, program staff identified two eligibility requirements for rental assistance that are difficult to overcome: registration as a lifetime sex offender and non-U.S. citizenship.[53] Program staff noted that with the increasing number of people registered as lifetime sex offenders and non-U.S. citizens applying for the program, these requirements render a significant number of applicants ineligible for RAP or other housing programs.

Other important transition challenges that the program staff noted are high staffing turnover, which leads to heavy caseloads; opposition from nursing homes; and recurrence of medical issues among clients. The high turnover rate within the field-staff workforce, including specialized case managers and transition coordinators, creates heavy caseloads for current field staff and could eventually affect the quality of assistance provided and the trust built between the client and staff. Second, program staff indicated that they are experiencing more "pushback," even from nursing homes where they have historically received great support. This pushback usually comes in the form of disagreements between nursing home staff and MFP nurses and social workers around the readiness of residents to leave the institution. Although such disagreements are eventually resolved by the state, this challenge often delays residents from transitioning into the community. Finally, program staff noted that one of the most difficult challenges they face during transition is the reoccurrence of an applicant's medical issue when a lease is executed. This situation can be costly because the state continues to pay for the nursing home and the housing unit.

[53] The head of household, or at least one individual on the application, has to be a legal U.S. citizen to qualify for a RAP certificate.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

> "Because we had that extra lens of what questions we ultimately want to answer, we clearly set out to collect extensive data in the very beginning of the program, and we continue to do that. We are collecting data that is aligned with the future of where we need to be. That data is, today, in a really robust database, and we collect about 800 variables on every single person. To date, Connecticut has sustained every single thing that we set out to demonstrate in the Money Follows the Person initiative."
>
> **—Connecticut's MFP Staff**

Program staff underscored how continuous evaluation and monitoring of changes made through evaluations are essential to the successful implementation of the state's MFP program. Program staff have a process for collecting data on every challenge that clients experience and detailing why transitioning into housing was delayed. For example, staff can analyze data and examine how much time certain criminal background checks add to lease-up time and then target resources to proactively address this barrier. Following are other key lessons that program staff identified:

- Establishing clear partner roles and expected outcomes from the beginning.
- Having a staffing model that allows for continuous and specialized support, including a specialized care manager, transition coordinator, and housing coordinator.
- Having strong partnerships to foster a network of high-support agencies that are willing to come together and be part of a coordinated working group.
- Establishing good relationships with landlords by providing both security deposits and guaranteed rental payments.

5. Summary

Connecticut's MFP is one of the few grantees that have achieved more than 100 percent of their annual transition goals. According to program staff, the success of the program in transitioning people with disabilities from institutions into the community stems from strategies such as the program's cross-disability approach; effective partnerships with the state housing department, landlords, and community

organizations; strong state support for rebalancing toward community living; and an individualized approach to services based on a standardized and comprehensive assessment of applicants' functional needs. Key lessons from implementing Connecticut's MFP program underscore the importance of establishing clear partner roles and expected outcomes from the beginning, having a staffing model that allows for continuous and specialized support, having a network of high-support agencies, and establishing good relationships with all stakeholders, including landlords.

Alliance of Disability Advocates

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

Alliance of Disability Advocates (Alliance), formerly Universal Disability Advocates, is a Center for Independent Living program in Raleigh, North Carolina, that primarily serves five counties in the state: Durham, Franklin, Johnston, Orange, and Wake. However, staff noted that they often receive consumers from other parts of the state. Alliance was established in 1999 to assist people with significant disabilities[54] to live as independently as possible in the community of their choice. Centers for Independent Living act as advocates for community inclusion, providing services to empower people with disabilities to live independently in their communities. Centers for Independent Living were created under the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act (29 U.S. Code § 796),[55] to offer services that are designed, directed, and delivered for people with disabilities by people with disabilities. Such programs are required to have at least 51 percent of all staff and their board of directors be people with disabilities. Staff indicated that Alliance exceeds this requirement.

Overview of Alliance
Program type: ▪ Center for Independent Living **Geographic scope:** ▪ Five counties in North Carolina **Target population:**

[54] *Individual with a significant disability* means an individual with a severe physical or mental impairment whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited and for whom the delivery of independent living services will improve the ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment, respectively. 29 USC § 705 (21) (B).

[55] The Cornell Law School Legal Information Institute defines terms in these acts: https://www.law.cornell.edu/uscode/text/29/796a#3.

- People with significant disabilities
- Centers for independent living refer to program participants as "consumers"

Primary housing-related services offered:

- Information and referral, reentry, community inclusion, and advocacy

Main funding sources:

- Federal Center for Independent Living Grant
- North Carolina Council on Developmental Disabilities Grant
- Other federal, state, and local grants

Main partners:

- North Carolina Targeting Program, North Carolina Department of Public Safety, local reentry commissions, CASA, and the Green Chair Project

BRIEF OVERVIEW OF THE CASE STUDY

This case study draws on interviews with program staff and two persons assisted by the program and aims to provide multiple perspectives on the operations and impact of Alliance's housing-related services. The case study highlights critical components of Alliance's successful strategies in helping people with disabilities to obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from interviews with stakeholders. The case study has limited data on program participants and performance because the research team lacked access to relevant Alliance program documentation or performance reports. Information about program services, partners, key strategies, challenges, and lessons learned is limited because the research team was unable to interview key program staff.

2. Program Overview

PROGRAM PURPOSE AND GOALS

Alliance's goal is to help individuals with disabilities to live as independently as possible in the community of their choice. This case study focuses on Alliance's approach to housing-related services for participants, referred to as "consumers" in Center for Independent Living programs.

SERVICES OFFERED AND MODE OF DELIVERY

As a Center for Independent Living, Alliance offers the following core services: information and referrals, independent living skills training, peer support, transition support and assistance, and advocacy. In addition, Alliance offers services related to reentry for people who have been incarcerated and for disaster response. Following

are the details of the services offered to help consumers overcome barriers when accessing housing assistance.

- **Information and Referral Services:** Alliance collects and maintains information on resources in each of the areas served by the organization. For housing, staff noted that Alliance primarily serves as one of the community referral organizations for North Carolina's Permanent Supportive Housing Targeting Program, which serves low-income individuals with disabilities by providing access to properties supported by the Low-Income Housing Tax Credit through a partnership between the North Carolina Department of Health and Human Services and North Carolina Housing Finance Agency.[56] Staff also noted that Alliance provides information and referrals to other housing programs, including the U.S. Department of Housing and Urban Development's (HUD) Housing Choice Voucher (HCV) program and Court Appointed Special Advocates (CASA),[57] a nonprofit organization based in North Carolina that provides affordable housing in Chapel Hill, Durham, Raleigh, and surrounding areas. In addition to housing-related referrals, Alliance refers its consumers to other agencies and programs for financial assistance. For example, it refers consumers to the Green Chair Project, a nonprofit organization based in Raleigh, North Carolina, that provides home furnishings to individuals facing challenges, such as homelessness, crisis, or natural disasters.[58]
- **Reentry:** Alliance received grant funding from the North Carolina Council on Developmental Disabilities to help improve transition outcomes after incarceration for individuals with intellectual or developmental disabilities through systems advocacy and information and referral services.[59] Through this grant, Alliance works with local reentry commissions, the North Carolina Department of Public Safety, and other partners (for example, the Dunn Rotary Club of North Carolina and local employers) to provide independent living, employment, and housing-related services. Consumers in the Alliance reentry program often are referred to the Targeting, HCV, and CASA programs for housing assistance.
- **Advocacy:** Alliance helps individuals with disabilities develop effective communication skills to empower them to access both housing and necessary support services. Alliance case managers, known as community inclusion

[56] For more information about the North Carolina Targeting Program, see https://www.ncdhhs.gov/divisions/aging-and-adult-services/permanent-supportive-housing.
[57] For more information about CASA, see: https://www.casanc.org/.
[58] For more information about the Green Chair Project, see: https://thegreenchair.org/.
[59] For more information about the North Carolina Council on Developmental Disabilities grant initiative, see https://adanc.org/wp-content/uploads/NCCDD_Initiative_-Justice_Release_Reentry_Reintegration_2020.pdf.

specialists, work one-on-one with consumers to develop needed communication skills.

TARGET POPULATION

Alliance provides services to individuals of all ages with all types of significant disabilities. Although Alliance does not target a specific disability type, staff mentioned working with several populations, including people with serious mental illness, physical or sensory disabilities, and intellectual or developmental disabilities.

STAFFING AND PARTNERS

The Alliance staffing model includes administrative staff, including the executive director, program directors, managers, and staff who take on a case management role. The different roles that support housing-related case management include the following:

- **Community inclusion specialists** are case managers who work one-on-one with consumers to provide them with resources and services, such as benefits counseling, housing information and referrals, peer support, employment services and referral, and independent skills training.
- The **information and referral services manager** is usually the first point of contact for consumers when they call or are referred to Alliance for services. This staff member confers with consumers to understand their needs and then directs them to the appropriate community inclusion specialist.
- **Program managers and directors** supervise community inclusion specialists and provide overall leadership for Alliance programs.

FUNDING

Alliance is funded primarily through the federal Center for Independent Living grant. Staff reported that Alliance also receives grants from other federal, state, and local government agencies and private donors. For example, staff reported that Alliance received a North Carolina Council on Developmental Disabilities grant and funding from a local transportation company for its travel training program.

3. Key Strategies for Connecting Program Participants to Housing

> "[I was in an apartment that] was 500, I think 525 square feet, to right now I am in a 2 bedroom with a 2 bath at 1,100 and something square feet. And I needed that extra space due to my medical equipment. And [my case manager] also helped me get a two-bedroom instead of a one-bedroom because I had a reasonable accommodation from my doctor. But [my case manager] also helped me along the way with another reasonable accommodation."
>
> **—Alliance Consumer**

INDIVIDUALIZED PLAN

Staff reported that community inclusion specialists work with consumers to develop individualized plans designed to identify needs, barriers, and challenges to independent living. Community inclusion specialists then work one-on-one with consumers to set goals and address barriers and challenges, such as lack of housing, independent living skills, transportation, and employment. Staff noted that the achievement of goals is consumer driven (that is, the consumers determine how and when they want to achieve their goals).

PARTNERSHIPS WITH OTHER ORGANIZATIONS

Staff noted that partnerships with other organizations in the community have helped Alliance to leverage its limited resources to provide comprehensive services to more consumers. For example, staff noted that the Green Chair Project has been instrumental in helping Alliance consumers obtain needed furniture for their homes once they have secured housing assistance.

COMMUNITY INCLUSION

As a Center for Independent Living, Alliance facilitates community inclusion (for example, helping individuals with disabilities gain independence and participate in their communities) for its consumers by training them how to navigate public transportation, providing information on community resources, and offering employment counseling, among other services. One staff member noted that "It's not just about placing that person in the community … you got to think about the community that you're placing that person in."

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

Alliance staff reported that they use an online database, known as CILSuite, to store and track consumer information and services. The database collects information, such as consumer names, addresses, date of birth, county of residence, public assistance being received, and services being provided to the consumer. Alliance staff shared that the program collects the following outcome measures: the number of housing goals set by consumers and the number of housing services provided to consumers (for example, filling out housing applications with consumers, referring consumers to available housing options, and locating home modification resources).

Staff expressed that, as of October 2022, their consumers had received 128 housing services. They also noted that 24 new housing goals were set by their consumers in 2022. Nonetheless, they clarified that this number is not reflective of the number of consumers seeking to find housing because some consumers set their housing goal many years ago and are still working toward finding affordable housing.

Staff reported that the reentry program, which began in 2020, had served 146 consumers, exceeding a target goal of 120 consumers.

CHALLENGES DURING PROGRAM IMPLEMENTATION

Staff reported that a limited number of housing units and vouchers are available under North Carolina's Targeting program, HUD's HCV program, and CASA. This shortage results in long waiting periods, often lasting years, for consumers to receive housing once Alliance refers them to various agencies or organizations. Staff also reported that limited resources, such as funding, were a significant barrier to the provision of housing-related services.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

Staff noted the following lessons learned:

- Having partnerships to be able to leverage resources and better serve consumers is important.
- Policymakers must understand the needs of formerly incarcerated individuals who have disabilities. This understanding allows funding to be directed toward initiatives that will help them integrate into society and avoid recidivism.

- Being honest and transparent with consumers regarding services available to them and the challenges and barriers they might face when trying to seek these services is important (for example, long waiting lists for housing assistance due to the limited availability of housing units).

5. Summary

Alliance promotes independence by providing people who have significant disabilities with independent living skills, information and referrals, peer support, reentry service, transition support, disaster response, and advocacy. Alliance has successfully helped people with disabilities obtain and move into housing through strategies, such as partnering with other community organizations, developing individualized plans, and facilitating community inclusion for its consumers. Lessons learned from implementing these strategies emphasize the importance of partnerships, honesty, and transparency when servicing consumers with disabilities.

Lifetime Independence for Everyone Inc.

1. Introduction

BRIEF OVERVIEW OF THE PROGRAM

Lifetime Independence for Everyone Inc. (LIFE Inc.) was established in 1988 in Lubbock, Texas, to assist people with significant disabilities.[60] LIFE Inc. is a Center for Independent Living (CIL) program with two locations in Texas: the main location is in Lubbock, and a satellite center, called Disability Connections, is in San Angelo. CILs are a key component of the Administration for Community Living's Aging and Disability Networks that work to provide support to older adults and people with disabilities. CILs act as advocates for community inclusion, providing services to empower people with disabilities to live independently in their communities. CILs were created under the Rehabilitation Act, as amended by the Workforce Innovation and Opportunity Act (29 U.S. Code § 796),[61] to offer services that are designed, directed, and delivered by individuals with disabilities. CILs are required to have at least 51 percent of all staff and the board of directors consist of people with disabilities. According to their Project Performance Report, LIFE Inc. exceeds this requirement: 95 percent of LIFE Inc.'s staff members and 71 percent of its board of directors are people with disabilities as of 2020.[62]

Overview of LIFE Inc.
Program type ▪ Center for Independent Living **Geographic scope** ▪ Two regions of Texas **Target population** ▪ People with significant disabilities ▪ CILs refer to program participants as "consumers" **Primary housing-related services offered** ▪ Information and referral, relocation, youth transition, peer support, and payee services **Main funding sources** ▪ Federal CIL Grant ▪ Texas Health and Human Services **Number of participants served**

[60] Federal law: 29 USC § 705 (21) (B) the term *individual with a significant disability* means an individual with a severe physical or mental impairment whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited and for whom the delivery of independent living services will improve the ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment, respectively.

[61] The Cornell Law School Legal Information Institute defines some of the terms in this act: https://www.law.cornell.edu/uscode/text/29/796a#3.

[62] LIFE's 2020 CIL Project Performance Report was provided by the executive director to the research team and is available upon request.

- 568 people with disabilities served in 2020

Initial year of operation

- 1998

Main partners

- Neighborhood House, South Plains Homeless Consortium, and Open Doors Life Center

BRIEF OVERVIEW OF THE CASE STUDY

This case study draws on interviews with key stakeholders, including program staff, partners, and a person assisted by the program and aims to provide multiple perspectives on the operations and impact of LIFE Inc.'s program. The study highlights critical components of LIFE Inc.'s successful strategies in helping people with disabilities obtain and move into housing, including service delivery approaches, tools, staffing, and partnerships. Recommendations and lessons learned are drawn from interviews with stakeholders.

2. Program Overview

PROGRAM PURPOSE AND GOALS

LIFE Inc. strives to help people with disabilities reach their individual goals while empowering them to live as independently and successfully as possible on their own. This case study focuses on LIFE Inc.'s approach to coordination and transition into community-based housing for participants, referred to as consumers in CIL programs.

SERVICES OFFERED AND MODE OF DELIVERY

LIFE Inc. offers the following independent living core services: information and referral, independent living skills training, peer support, advocacy, and transition services. LIFE Inc. also provides the following services to help consumers overcome barriers when accessing housing assistance.

- **Advocacy:** LIFE Inc. provides advocacy for its consumers by helping people with disabilities navigate the complex housing system of regulations "that may impede access to benefits for which one may be eligible. During this process, consumers are encouraged to become their own best advocates by exercising their civil rights against unfair and discriminatory practices."[63]

[63] See the LIFE Inc. website at https://www.liferun.org/our-services.

- **Information and Referral Services:** These services provide people with disabilities and their families with comprehensive information on the community resources available, such as transportation services, accessible housing, and adaptive equipment. Although not all information and referral services are related to housing, program staff identified these services as a key aspect of pre-tenancy support because staff help consumers locate housing using these services. Information and referral services are highly individualized to the consumer and help them navigate when applying for assistance, such as housing choice vouchers (HCVs), Mainstream Vouchers, and Section 811 Supportive Housing for Persons with Disabilities program. In addition, staff can help consumers locate and apply for rental housing assistance and provide education on engaging landlords and understanding tenant rights and responsibilities.
- **Relocation Services:** LIFE Inc.'s relocation services are operated through multiple contracts and focus on transitioning people with disabilities from long-term care facilities into a community-based setting of their choosing. Their Home by Choice program specifically serves individuals seeking to transition out of long-term care facilities into the community by assisting with locating housing, finding transportation options, and securing grants for covering moving expenses, deposits, household items, and other related costs.
- **Purchased Services:** LIFE Inc. provides purchased services to consumers in need of adaptive equipment, including equipment to make housing more accessible, such as grab bars or railings.
- **Payee Services:** As an approved representative payee of Social Security benefits,[64] LIFE Inc. can manage benefits and receive and disburse funds in a way that maintains the client's necessities, such as housing, utilities, food, adaptive equipment, and access to funds for personal needs. Although payee services are not strictly related to housing, staff mentioned that these services help consumers manage their funds so they can make rent and utility payments.

[64] The representative payee is a designation by the consumer approved by the Social Security Administration that identifies another person or entity to manage Social Security benefits on behalf of the consumer. The funds belong to the consumer, and consumers may redesignate their representative payee at any point.

TARGET POPULATION

LIFE Inc. provides services to individuals of all ages with all types of significant disabilities.[65] Although no specific disability type is targeted, staff mentioned working with several populations, including people with serious mental illness, physical or sensory disabilities, and intellectual or developmental disabilities.

STAFFING AND PARTNERS

LIFE Inc.'s staffing model includes administrative staff, such as the executive director and program directors, and staff that take on a case management role. The different roles that support housing-related case management include the following:

- Independent living specialists who work directly with consumers to supply them with resources, such as SNAP benefits and transportation services, while helping them navigate the housing process. They also provide followup services to the consumer.
- Independent living services coordinators who perform the same duties as a specialist but are also involved with purchasing services.
- Relocation specialists who work with people transitioning out of an institutionalized setting into the community.
- Community integration specialists who provide additional followup care to ensure that those housed continue to be successful in the community. This specialist also addresses issues that consumers face in their transition from an institutionalized setting into the community.
- The payee representative who is responsible for financial and benefits management for people in the payee program.

Program staff emphasized the importance of having good relationships with other organizations in the community to connect consumers as needed. These relationships are discussed in more detail in the Key Strategies section.

FUNDING

LIFE Inc. is funded primarily through its federal CIL grant and a base grant funded through the Texas Health and Human Services (HHS) agency. Funds provided by Texas HHS include core CIL funds and Money Follows the Person (MFP)

[65] An in-depth discussion is available in the Key Strategies section.

Demonstration funds. Staff mentioned these funding sources during interviews and described receiving program-specific funding, such as the funding LIFE Inc. receives as a transition assistance services provider in Texas; this funding allows LIFE Inc. to serve Medicaid-eligible people transitioning from nursing homes into the community. In addition to LIFE Inc.'s core funding, the program receives service funding by billing Medicaid managed care organizations as a Medicaid provider.

3. Key Strategies for Connecting Program Participants to Housing

STAFF COLLABORATION TO ENSURE THAT CONSUMERS' NEEDS ARE MET

> "[My case manager] does anything that she's able to do. She makes the calls … cross networking as well. If I had questions, she would look up answers, and if she did not know, she'd refer me to certain other organizations."
>
> **—Life Inc. Consumer**

Staff with different roles often collaborate, and more experienced staff act as a resource, providing vital knowledge about available resources in the community. Staff share past contacts that have been helpful, minimizing the time spent searching for available resources and connecting consumers with resources more quickly. For example, staff developed a list of property owners and landlords who are willing to work with their consumers.

STAFF EMBEDDED IN THE COMMUNITY TO INCREASE AWARENESS OF SERVICES AVAILABLE AND INFORM SERVICE DELIVERY

Staff are assigned to a significant "systems area" in their community, such as a homeless coalition board, the alcohol and drug abuse council, and meetings of the regional transportation council. Staff attend meetings for their respective systems area, participate in community discussions, and share that information to ensure that other program staff are knowledgeable about the community circumstances that may affect service delivery. Sharing this information also helps to develop relationships with community partners.

RELATIONSHIPS IN THE COMMUNITY HELP STAFF BECOME AWARE OF RESOURCES AVAILABLE IN THE COMMUNITY

Program staff emphasized the importance of having good relationships with other organizations in the community to connect consumers as needed. Staff mentioned partnerships with organizations providing energy assistance, such as Neighborhood

House, and organizations that work with the homeless population, such as the South Plains Homeless Consortium and Open Door. These community relationships help staff become knowledgeable about which resources are available and willing to work with their consumers. That knowledge is used to develop strong partnerships with a network of high-support agencies that are willing to come together and be part of a coordinated working group as needed.

BUILDING RELATIONSHIPS WITH HOUSING AUTHORITIES, PROPERTY OWNERS, AND LANDLORDS HELPS OVERCOME BARRIERS RELATED TO THEIR RELUCTANCE TO RENT TO THOSE RECEIVING ASSISTANCE

Staff noted a list of housing properties and landlords with whom they have relationships. They also have a general sense of which landlords, who were identified through advocacy activities, are willing to work with their consumers. These contacts were noted to be more willing to accept consumers using housing vouchers or rental assistance. Due to these established relationships, property owners will sometimes waive eligibility requirements that would otherwise deem a consumer ineligible, such as background checks or income requirements. LIFE Inc.'s staff also act as a point of contact for the property owners if they are having issues with a tenant. In addition, LIFE Inc.'s Social Security Representative Payment Program helps to persuade property owners or landlords to waive income requirements. This waiver is possible because staff can provide reassurance that rent payments will be made by the representative payee as long as the consumer does not choose to withdraw from the Representative Payment program.

WRAPAROUND SUPPORTS BASED ON A NEEDS ASSESSMENT HELP CONSUMERS LIVE INDEPENDENTLY

Services are structured to address any area of a consumer's life that keeps them from successfully living independently. LIFE Inc.'s executive director developed an at-risk assessment that consumers complete at intake. This assessment is designed to examine all significant areas of need that may affect their ability to live independently, including age, housing status, housing utility management, housing accessibility, past institutionalization, informal supports, formal supports, medical needs, current medical providers, medication management, and transportation. This evaluation helps LIFE Inc. staff provide holistic support to each consumer.

USING CONSUMERS' EXISTING SOCIAL CAPITAL HELPS BUILD TRUST IN THE PROCESS AND SERVICES RECEIVED

Staff stated that obtaining permission to talk with a family member or close friend who will be present throughout the housing process can help communicate expectations more effectively to the consumer. When providing relocation and

transition services, the first approach also is to see if the consumer has a family member with whom he or she can live, either permanently or while they are on a waitlist for low-income or accessible housing.

NEARBY HOUSING AUTHORITIES CAN HELP MITIGATE BARRIERS RELATED TO LONG WAITLISTS

Staff shared that they encourage consumers at their main center in Lubbock to apply to other nearby rural housing authorities outside city limits that have shorter waitlists. Staff noted that some of these housing authorities overlap to include Lubbock County and have much shorter waitlists compared with the City of Lubbock's waitlist. Staff shared, "We encourage our consumers to be open to possibly making the short-term sacrifice of living in a rural area to achieve a long-term goal. As we all know, having housing assistance has a massive impact on quality of life for those living on low incomes."

4. Program Outcomes and Lessons Learned

PROGRAM EVALUATION EFFORTS AND OUTCOMES

Program Outcomes
▪ 568 people with disabilities were served in 2020. ▪ 72 consumers received housing, home modifications, and shelter services, and 51 consumers received transition services in 2020.

LIFE Inc. uses a data collection system designed to identify progress made toward its program goals, such as the number of consumers served, amount of money expended, number of events hosted in a certain timeframe, and event attendance. Staff shared that they have a work plan that includes monthly goals that must be met to sustain their base grant and other grant funds. Benchmarks are determined by the Texas State Plan for Independent Living. The plan outlines target activities and objectives for CILs but does not provide benchmarks for individual CILs. Instead, the plan implements benchmarks at the state level, with a targeted number of activities completed by all CILs in the state combined. These benchmarks include targets for the number of outreach activities; dissemination activities; advocacy activities in different areas, such as policy, transportation, and housing; toolkits distributed; new funding sources; and CILs using assessment tools. During 2020 and 2021, LIFE Inc. facilitated all activities targeted by the State Plan for Independent Living.

Program staff identified several success stories about how their various services have enabled persons with disabilities to overcome barriers and secure housing. In 2020, 72 consumers received housing, home modifications, and shelter services; 51 consumers received transition services; 38 consumers were informed of and assisted in applying for Section 8 housing; and 155 individuals were relocated from nursing facilities into a community-based setting through LIFE Inc.'s contracts with five managed care organizations.[66] Of those relocated, less than 4 percent have returned to nursing facilities.

Success Story
Ms. V. began receiving services at LIFE Inc. while in an abusive relationship, reporting that she was often homeless and sometimes "engaged in dangerous and illegal activities to have enough money." LIFE Inc. staff served as her advocates and assisted her in accessing resources. LIFE Inc. also serves as her Social Security representative payee, ensuring that rent and utilities are paid on time. LIFE Inc. staff assisted her in applying for a housing choice voucher in getting the required documents for application. LIFE Inc. worked with a newly built, subsidized apartment complex to obtain a unit for Ms. V. As a result of these services, Ms. V. has a different life in a new apartment and has enough funding left each month to live comfortably. —LIFE Inc.'s 2020 CIL Project Performance Report

CHALLENGES DURING PROGRAM IMPLEMENTATION

Implementation challenges

Staff explained that their community has limited to no accessible housing units, and most consumers with physical disabilities required home modifications to make the unit accessible. Another barrier stated was the identification requirements needed to lease up housing. These requirements often cause challenges because many consumers do not keep track of their identifying documents and do not have the money needed to obtain additional copies.

Contextual challenges affecting program implementation

People need transportation to search for housing, obtain required identification documents, and attend medical appointments. However, staff noted that people with disabilities often lack access to personal transportation, public transportation options are limited, and those few available options are often time consuming and unreliable. In addition, staff mentioned that rental rates have increased because of

[66] LIFE Inc.'s 2020 CIL Project Performance Report was provided by the executive director to the research team and is available upon request.

the Lubbock center's proximity to Texas Tech University; property managers can charge higher rents to college students during the academic year. In addition, landlords assume that students may damage units and ask for higher rents and higher security deposits.

LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

> "What works today might not work tomorrow, so just knowing the little things going on around and being aware can help me address those strategies and improve upon them."
> **—Life Inc. Program Staff**

Staff emphasized that addressing multiple areas of need related to housing barriers is essential to the success of their program. Additional lessons learned during the implementation of the program include the following:

- Having a staffing model that allows for continuous, specialized support through all stages of the housing process is essential to ensure that consumers' needs are met.
- Having staff who are flexible and willing to adapt to new strategies or approaches is key to serving a consumer's individualized needs and goals.
- Having strong partnerships with a network of high-support agencies that are willing to come together and be part of a coordinated working group as needed is essential to program success.
- Establishing a good relationship with landlords through outreach and providing them with a point of contact for consumers help to mitigate some hesitance from landlords to rent to consumers.
- Being aware of a consumer's history—including criminal record and rental history—at the outset is important in ensuring that potential barriers may be addressed directly.[67]
- The factors that cause an individual to be at risk of being institutionalized are often the same ones that keep them from independent living.

[67] It is important to note that using criminal history to screen, deny lease renewal, evict, or otherwise exclude individuals from housing may be illegal under the Fair Housing Act.

- The person receiving services from LIFE Inc. and interviewed for this case study recommended more collaboration across systems to build consistent information and eligibility requirements across organizations and agencies.

5. Summary

LIFE Inc. promotes independence by providing people who have significant disabilities with advocacy, information and referral, relocation, youth transition, peer support, and payee services. LIFE Inc. employs several strategies in successfully helping people with disabilities obtain and move into housing, including collaborating with staff, embedding staff in the community, building relationships in the community, using wraparound supports to address needs in multiple domains, and leveraging a consumer's social capital to build trust in the processes and services. Lessons learned from implementing these strategies emphasize the importance of high levels of collaboration among staff, strong community relationships and involvement, and the adoption of an individualized approach to services.

Appendix B: Approach to the Research Team's Systematic Literature Review

Literature Review

The research team employed a multistep literature review process to describe the relevant U.S. Department of Housing and Urban Development (HUD) programs and services. The literature review process consisted of the following steps:

1. Searching literature using approved search terms, including soliciting seminal literature from HUD subject matter experts and reference lists.
2. Reviewing and screening identified literature using inclusion and exclusion criteria.
3. Reviewing full-text literature.
4. Summarizing, synthesizing, and interpreting final literature.

The following sections provide details regarding the research team's approach to searching databases for peer-reviewed literature, state and federal government reports, and organization websites, including the process for screening and reviewing the identified literature and synthesizing and interpreting the included literature.

SEARCHING LITERATURE

In consultation with the Contracting Officer's Representative (COR), the research team developed initial search terms (such as the specific program names "Mainstream" and "NED") to limit the search and submitted them as part of the Literature Review Search Terms deliverable to HUD for review and approval. The list of search terms includes programs suggested by HUD and the U.S. Department of Health and Human Services (HHS) staff during the kickoff meeting, such as the Medicaid Money Follows the Person (MFP) Demonstration, the Medicaid Innovation Accelerator Program, and the Medicaid Home and Community-Based Services Waiver programs. The research team developed the search terms to identify detailed information on the services and intended beneficiaries of the selected HUD-funded programs and to estimate the effectiveness of these programs on participants' employment and earnings. The research team used the approved search terms and criteria to search for state and federal government reports and peer-reviewed literature.

Peer-Reviewed Literature

The research team searched four electronic databases for peer-reviewed literature in December 2021 and January 2022: Academic Search Complete (ASC), PubMed, Web of Science, and JSTOR. These databases catalog a wide array of peer-reviewed journals that publish content related to well-being and housing support programs. Searches were restricted to articles published or written in the past 10 years (2011 or later) with research conducted in the United States and available in English. See **exhibit B.1** for the search terms used for the peer-reviewed article search.

Exhibit B.1: Housing Search Assistance for Non-Elderly People with Disabilities Search Terms

Search Terms										
DISABILITY		**SERVICES/ PROGRAMS**		**SERVICES/ PROGRAMS**		**SERVICES/ PROGRAMS**		**TYPES/ SETTINGS**		**LANGUAGE**
disabilities (disab*) non-elderly disabilities (NED, non-elderly disab*)	AND	housing (hous*) rental lease (leas*) supportive housing transition move-in	AND	locator search voucher subsidy	AND	services assistance support	AND	mental intellectual developmental physical autism nursing homes institutional settings homeless	AND	English
OR										
Money Follows the Person (or "MFP") Non-Elderly Disabled (NED) Voucher Program Mainstream Voucher Program Innovation Accelerator Program New Jersey Bridgeway Rental Subsidy Home and Community-Based Services (or "HCBS" or "HCBS waivers" or "1915 waiver") New York Olmstead Housing Subsidy Program Section 1115 Demonstrations Section 811 Project Rental Assistance Program										

Exhibit B.2 provides the specific number of papers returned for each of the four databases searched before removing duplicates. In total, the preliminary searches initially identified 347,668 articles. The research team decided to exclude JSTOR after initial searches, given the high volume of returned results. After repeating the process without JSTOR, the research team checked 2,279 papers for duplication. After removing duplicated articles, 488 papers remained.

Exhibit B.2: Number of Papers Returned by Databases Searched

Database	Date of Search	Number of Papers Returned (Before Duplicates Removed)
Academic Search Complete	12/15/2021–1/05/2022	403
JSTOR	12/22/2021–1/06/2022	345,389*
PubMed	12/27/2021–1/05/2022	1,467
Web of Science	12/28/2021–1/05/2022	409
Total number of papers before duplicates were removed for ASC, PubMed, and Web of Science:		2,279**
Total number of papers after duplicates were removed for Academic Research Complete, PubMed, and Web of Science:		488 **

*The research team met with the COR to discuss the issue of the high volume of search returns. The research team and the COR agreed to drop JSTOR and concentrate on the results from the other three databases.
**This number included results from only ASC, PubMed, and Web of Science.

Government and Organization Reports on Their Websites

In consultation with the COR, the research team identified websites that contain the most relevant reports for HUD housing assistance and HHS housing-related services that are not published in journals. The research team used the search terms in **exhibit B.1** to search state and federal government and organization reports whenever possible. However, the availability of search fields and filters in the federal and state websites varied considerably. The research team reviewed the publication pages of databases that did not have search functionality for reports. **Exhibit B.3** provides the specific search strategy used to search each website for state and federal reports.

Exhibit B.3: State, Federal, and Organization Websites Searched

Organization Websites	Search Strategy
Administration for Community Living (ACL)	Publications pages
ADvancing States	Publications pages
Bazelon Center for Mental Health Law	Publications pages
Centers for Medicare and Medicaid Services (CMS)	Publications pages
Corporation for Supportive Housing (CSH)	Publications pages
GovInfo	Search terms
HHS Office of the Assistant Secretary of Planning and Evaluation (HHS ASPE)	Search terms
HUD Office of Policy Development and Research (HUD PD&R)	Search terms
Independent Living Research Utilization (ILRU)	Publications pages
Interagency Autism Coordinating Committee (IACC)	Publications pages

National Association of State Mental Health Program Directors (NASMHPD)	Publications pages
Substance Abuse and Mental Health Services Administration (SAMHSA)	Search terms

In total, the research team initially identified 428 reports (before removing duplicates). **Exhibit B.4** provides the number of items returned for each website.

Exhibit B.4: Number of Papers Returned for State and Federal Government and Organization Reports

Database	Date of Search	Number of Papers Returned (Before Duplicates Removed)
ACL	1/25/2022	29
ADvancing States	1/27/2022	0
Bazelon Center	1/20/2022	37
CMS	1/24/2022	1
CSH	1/27/2022	0
GovInfo	1/31/2022	0
HHS ASPE	1/27/2022	21
HUD PD&R	1/28/2022	56
ILRU	1/21/2022	62
IACC	1/21/2022	44
NASMHPD	1/21/2022	178
SAMHSA	1/21/2022	0
Number of papers before duplicates were removed:		428
Total number of papers after duplicates were removed:		422

REVIEWING AND SCREENING IDENTIFIED LITERATURE

The research team reviewed 58 articles from federal reports and 135 articles from peer-reviewed literature databases.

The research team then screened and reviewed this list of articles (with abstracts) using a standardized procedure. Using inclusion and exclusion criteria (see **exhibit B.5**), at least one trained team member reviewed the title, abstract, or both components of every publication identified through the peer-reviewed literature and state and federal government report searches.

Exhibit B.5: Inclusion/Exclusion Criteria for Literature Review

Component	Inclusion Criteria	Exclusion Criteria
Housing and Housing Services Programs	▪ Money Follows the Person ("MFP") ▪ Non-Elderly Disabled Voucher Program ("NED Voucher") ▪ Mainstream Voucher Program ▪ Innovation Accelerator Program ▪ New Jersey Bridgeway Rental Subsidy ▪ Home and Community-Based Services ("HBCS waiver"/"1915 Waiver") ▪ New York Olmstead Housing Subsidy Program ("Olmstead Housing Subsidy") ▪ Section 1115 ▪ Section 811 ▪ Similar housing services programs	▪ Non-housing or housing services programs
Population	▪ Non-elderly adults (ages 18–60)	▪ Children and teens (ages 0–17) ▪ Elderly adults (ages 60+ years)
Unit of Analysis	▪ Individual (adults) ▪ Family/Household ▪ County ▪ Census tract ▪ State ▪ Region	▪ Country
Topics of Interest	▪ Economic well-being ▪ Social well-being ▪ Quality of life ▪ Life satisfaction ▪ Self-sufficiency ▪ Permanence ▪ Affordability	▪ Any outcomes not related to the housing services programs

Component	Inclusion Criteria	Exclusion Criteria
Type of Data/Analysis	▪ Observational ▪ Qualitative ▪ Program evaluation ▪ Experimental	▪ Commentaries ▪ Thought papers ▪ Raw data without analysis (for example, financial data, infographics, caseload data, participation rates) ▪ Infographics ▪ Caseload data ▪ Participation rates ▪ Systematic review ▪ Meta-analysis
Type of Publication	▪ Reports to Congress ▪ Federal reports ▪ State reports ▪ Policy issue/briefs ▪ Promising practices ▪ Scholarly journals	▪ Letters to the editor/opinion ▪ Blogs ▪ Websites/webpages ▪ Dissertations/thesis ▪ Books ▪ Contingency funds award ▪ Success story ▪ Working papers
Publication Date*	▪ 2011 or later	▪ Before 2011
Country	▪ United States	▪ Any other country
Language	▪ English	▪ Any language other than English

* The Publication Date was applied only to peer-reviewed literature.

REVIEWING FULL-TEXT LITERATURE

The research team systematically tracked all literature reviewed and the reasons for exclusion when applicable. When the title or abstract met the inclusion criteria (on the basis of **exhibit B.5**), the team flagged it for a full-text review. For articles or reports that met the inclusion criteria for a full-text review, the research team extracted the following information, when available, to facilitate a final decision about inclusion.

- Citation
- Included housing assistance and housing-related services program(s)
- Population (and subpopulations of interest—for example, type of disability, housing situation before housing assistance receipt, race/ethnicity, sex, income, geography, and other community characteristics)
- Data source(s)
- Unit of analysis
- Services and methods of service delivery
- Challenges and barriers identified
- Main theme
- Study design/methods and included variables
- Findings, outcomes, and impacts
- Study implications and areas of gaps
- Suggestions for future research

Reviewers resolved any differences through discussion or consultation with another research team reviewer. For example, if one reviewer thought a paper warranted a full-text review but the other reviewer excluded the same paper, those reviewers would discuss their reasoning for their decisions and arrive at a consensus. If the reviewers could not reach an agreement, they consulted a third reviewer. The screening and full-text review results, including the summarizing, synthesizing, and interpreting of the literature results, are reported in the main body of this report.

Appendix C: Master Case Study Discussion Guide

SEMI-STRUCTURED MASTER INTERVIEW GUIDE AND QUESTIONNAIRE

Housing Search Assistance for Non-Elderly People with Disabilities

INTERVIEWER: Thank you for agreeing to participate in this interview. My name is _____, and I am a senior researcher with 2M Research, the policy research firm contracted by the U.S. Department of Housing and Urban Development (HUD) for this study. I am joined by my colleague,_____, who will help take notes during the interview.

I will start by briefly introducing the study, obtaining consent, and making sure we cover any questions you have before beginning the interview.

The purpose of this study is to identify promising strategies and approaches used by various organizations, such as public agencies or nonprofits, to assist non-elderly people with disabilities overcome challenges in obtaining and moving into housing.

For this study, we are conducting nine case studies of successful programs and approaches that we identified. Specifically, we are interested in understanding how [PROGRAM NAME] is being implemented, including the purpose of the program; target population; housing-related services provided, such as housing location or navigation services and housing transition services; and any notable program successes and challenges. In addition, we are interested in understanding the major characteristics of the program and any recommendations to policymakers and local housing and other service agencies on how to improve or expand the program. The research team will use the information to develop a case study of your program that we will then provide to you to review for accuracy. Our discussion should last approximately 1 hour.

Permission to Record

Before we begin, we would also like to have your permission to record the conversation to ensure that our notes are accurate and complete. We will not share the recording with HUD, and we will delete it at the end of the study.

Do we have your permission to record this interview?
□ Yes
□ No

- If interviewee(s) agrees to be recorded:
  - Thanks. Now, we are going to turn on the recorder **(TURN ON RECORDER)**. Can you please confirm that you have agreed to be recorded?
- If interviewee(s) declines:
  - Okay, that is not a problem.

Consent to Participate (Other than Individuals with Lived Experience)

We hope you will be candid in the information you provide. We will aggregate information about your program and comments from staff members within the case study. We will conduct all analyses using a de-identified data file and will not share your identity. You can refuse to answer any questions you do not want to answer. Your participation in this study is voluntary, and you may stop at any time. There will be no negative consequences if you choose to stop or if you choose not to participate. We will only use your responses to this interview for research purposes, and they will NOT be used for compliance monitoring. Would you still like to participate in the study?

Consent to Participate (Individuals with Lived Experience Only)

We would like to interview you as an individual who has been a beneficiary of the [PROGRAM NAME] to learn about your experiences, both the good and the bad, with the program. We hope that you will be open about your thoughts and about your participation in the [PROGRAM NAME]. The information you provide is important to improving services that support people to obtain and use housing assistance. We will make every effort to protect your privacy. Your name or other identifying information will not be used in reporting what we have learned during this interview, and we will combine your responses with the responses of others participating in interviews (if possible) as part of this study. However, because program staff referred you to participate in this discussion, it is possible that they may be able to identify your experiences described in the report.

If you have questions about this study, please email Dr. Hiren Nisar, the study's principal investigator, at hnisar@2mresearch.com, or Teresa Souza, social science analyst at HUD, at Teresa.Souza@hud.gov.

Do you have any questions before we begin?

Section 1. Respondent and Organization Background (All Respondents)

I would first like to understand a bit about how you have been involved in your organization/agency's efforts to address the barriers faced by people with disabilities in securing housing.

1. Please start by telling us a little bit about yourself as it relates to your involvement with [PROGRAM NAME]. What is your role in supporting [PROGRAM NAME]?

   Probe: How long have you been in this role?

   Probe: What services do you support?

2. Can you provide an overview of your organization/agency?
   Probe: Type, size, and what participants you serve, and range of services the agency provides.
   - How long has your agency been working on the [PROGRAM NAME]?
   - Probe for detailed information on types of participants, as well as whether the program serves only individuals, or individuals and their families

Section 2. Program Purpose and Goals (Program Staff Only)

3. Can you provide an overview of the [PROGRAM NAME]?
4. What do you perceive to be the main purpose or goals of the [PROGRAM NAME]?
5. What were the circumstances that led to your organization/agency's current efforts to help people with disabilities in securing housing?

Section 3. Program Services (Program Staff and Partners Only)

Next, we would like to understand the key services provided under your program. We are interested in learning about housing location or navigation services and housing transition services that help people with disabilities apply for and use housing assistance. We provide examples of these types of services in the next question.

6. What services does your organization/agency offer to people with disabilities who need housing assistance?
   Note for Interviewer: Probe for the types of services listed here, as well as any additional services not listed that they may identify.
   - Types of housing location or navigation services—
     - Help individuals understand and locate affordable housing in their community.
     - Help individuals locate housing accessible to people with disabilities.
     - Assist with transportation to view housing options and neighborhoods.
     - Help individuals complete and submit housing applications.
     - Help individuals meet housing eligibility requirements.
     - Help individuals appeal rejections by property owners.
     - Help individuals pay security deposit requirements.

  - Other services?
- Types of transition services—
  - Assist individuals in procuring furniture or household goods.
  - Assist with physical move to the new property, including packing, transportation, and unpacking.
  - Accompany individuals on their move-in day.
  - Assist with move-in paperwork, inspections, and obtaining keys to the building.
  - Ensure needed medical equipment is delivered and set up prior to move-in.
  - Set up community services, including establishing a healthcare provider, transfer of prescriptions to a community pharmacy, applying for food and utility assistance benefits.
  - Orient individuals to a new neighborhood.
  - Other services?

Probe: Which of these types of services are provided earlier on?

7. What services are not currently offered by your organization/agency that you believe should be offered?
   Probe: How would these additional services help your organization/agency better serve its clients? Why do you think these services are not offered by your organization/agency?
8. Can you tell us about your main partners, their roles in supporting participants, and the services they help provide?

Section 4. Program Implementation (Program Staff, Partners, Service Providers Only)

Next, we would like to understand in more detail **how each of the services you identified** in the previous set of questions is offered. Specifically, we are interested in understanding who provides the services, the number of people that benefit from the service, the funding used, and how it helps participants apply for and use housing assistance.

Note to Interviewer: Cycle through the questions in this section for each type of service that the respondent identified in the previous section.

9. How is your organization/agency structured to provide [TYPE OF SERVICE]?
   - Can you discuss the staff involved in providing this service to your target population?
     Probe: Staff expertise, caseload, and adequacy of staff to meet the needs of participants.
     Probe: Which partners are involved in providing this service?
10. What are the population groups that your organization/agency targets for [TYPE OF SERVICE]?
    Probe for the following population groups:
    - People with physical disabilities (mobility, visual, or hearing disabilities)
    - People with intellectual or developmental disabilities
    - People with serious mental illness

- People moving out of institutional settings, such as nursing homes or intermediate area facilities for individuals with intellectual or developmental disabilities
- People experiencing homelessness or at risk of homelessness

11. Are there certain groups that are harder to serve or reach in the provision of this service?
    - **[If yes]** What are these population groups?
    - **[If yes]** What makes it difficult to reach and serve these population groups?
    - What approaches has your organization developed to reach these harder-to-serve populations?
        - Of these approaches, which have been most successful in reaching harder-to-serve populations?
12. How many people benefit from this [TYPE OF SERVICE] per month or year?
13. How are program participants connected to housing-related services?
    - How do you identify/recruit participants to receive a service?
    - **[If applicable]** How are outreach services to participants organized and administered?
    - How are program participants screened/assessed?
    - How are participants prioritized (e.g., vulnerability tools)?
    - What resources are available to participants to find/locate housing and services?
14. In general, how do the housing resources and services available compare with the demand for those services and resources (i.e., supply-demand)?
    - What approaches or processes has your organization/agency used to ensure critical needs for participants are met?
    - Does your organization/agency prioritize a particular target population for this service?
15. How long does it typically take an individual to receive [TYPE OF SERVICE] from the agency?
16. How is this [TYPE OF SERVICE] funded?
    Probe: Source of funding; and amount of funding spent on service either per participant, per month, or per year.
17. Can you give me specific examples of how this [TYPE OF SERVICE] has helped participants?

Section 5. Context and Policies Affecting Implementation (Program Staff, Partners, Service Providers Only)

18. What state or local policies have been most helpful with the design or implementation of your organization/agency's strategies and efforts?
    a. How have the policies facilitated the successful implementation of your program?
    b. How have the policies hindered (negatively impacted) your program?
    c. Would you recommend any specific policy that will help improve your program?

Section 6. Major Program Results, Outcomes, or Impacts (Program Staff and Partners Only)

19. What specific outcomes or benchmarking goals does your organization/agency have for the program?

Probe: Transition goals, people who remain stably housed, social well-being, return to homelessness or institutions.

20. How do you monitor or track the program outcomes?
21. How have each of the performance outcomes been met by the program?
22. **[If monitored]** What are the most recent impacts of the [PROGRAM NAME]? Are there any reports or documents you can provide to the study team?

Section 7. Successful Strategies and Major Challenges (Program Staff, Partners, Service Providers Only)

23. What are the successful strategies that have helped your program achieve its goals and helped the people you serve find and move into assisted housing?
    a. What are the most successful components of your organization/agency's approach to reduce these barriers?
    b. Why do you think that these strategies have been successful?
24. What might make the approaches or strategies even more successful, or how could they be improved?
    - What would be needed to make these changes?
25. What have been the biggest challenges to your organization/agency in offering these services/implementing these approaches?
    - What can policymakers do to help your program be more successful?

    Probe: Coordination, resources, policies, political will or buy-in, staffing, other.

26. What barriers remain in trying to house people with distinct types of disabilities?
    Probe for the following target population groups of the program:
    - People with physical disabilities (mobility, visual, or hearing disabilities)
    - People with intellectual or developmental disabilities
    - People with serious mental illness
    - People moving out of institutional settings, such as nursing homes or intermediate area facilities for individuals with intellectual or developmental disabilities
    - People experiencing homelessness or at risk of homelessness

Section 8. Recommendations for Program Improvement and Sustainability (Program Staff, Partners, Service Providers Only)

27. Do you think the strategies and approaches we have discussed today would be suitable for another housing assistance program and target population group (if applicable)? Why or why not?
    a. What considerations should be made before adapting the approach to another program and/or population group?
28. What have you learned from implementing these strategies (lessons learned during implementation)?
    - Are there things you would do differently? *Why?*
29. Do you believe the strategies we have discussed today are sustainable? Why or why not?
    a. **[If no]** What would help make them sustainable?

b. **[If yes]** What would be required to ensure these strategies are sustained?

30. Can you describe any ways in which the [PROGRAM NAME] could be improved to address the barriers and challenges people with disabilities face when securing housing?
    Probe for the following examples, if needed:
    - Searching for housing using housing assistance.
    - Leasing up housing using housing assistance.
    - Move into housing using housing assistance.
31. What other strategies would you recommend to effectively serve more non-elderly people with disabilities looking to use housing assistance?
32. Can you share with us any materials, resources, practices, and tools that are integral to the success of this program and may help other housing and service agencies improve their assistance to people with disabilities?

Specific Questions for Individuals with Lived Experience

Thank you for taking the time to speak with us today. We are talking to you because we understand that you have received services from [ORGANIZATION NAME] under [PROGRAM NAME] and are interested in understanding your experiences searching for assisted housing and how the services you received from the [PROGRAM NAME] were able to help you. We appreciate that, for a variety of reasons, it may not be easy to recall or recount all of this information. Please feel free to let me know if you would like to skip any of the questions I ask, for any reason. Our goal is to learn what about your experience was positive and how it may help others in a similar situation as you, and what you may like to see changed or improved in the future.

We are going to start with questions about your search for assisted housing and your engagement with [PROGRAM NAME]. Then, I will ask you in a bit more detail about your current home, and the experiences you had receiving services from [PROGRAM NAME] and, if applicable, from other organizations. I will also ask you about any recommendations you may have, based on your experiences, to improve the delivery of services you received from the program. Is there any part of this structure with which you are not comfortable? We can skip those sections if you like.

1. Can we start with what led you to search for assisted housing?

   Probe: What was your housing situation prior to receiving services from [PROGRAM NAME]?

2. How did you hear about this [PROGRAM NAME] or [ORGANIZATION NAME]?
   Probe: recruitment/referral source—person, agency, location.
3. Please tell me about the services that the [PROGRAM NAME] offered you to help you locate and move into assisted housing.

Probe for the types of services listed here, as well as any additional services not listed that the referring program offered the participant:

- Types of housing location or navigation services—
  - Assistance with understanding and locating affordable housing in their community
  - Assistance with transportation to view housing options and neighborhoods
  - Assistance with completing and submitting housing applications
  - Assistance with meeting housing eligibility requirements
  - Assistance with appealing rejections by property owners
  - Assistance with paying security deposit requirements
  - Other services?
- Types of transition services—
  - Assistance with procuring furniture or household goods
  - Assistance with physical move to the new property, including packing, transportation, and unpacking

- Assistance with move-in paperwork, inspections, and obtaining keys to the building
- Assistance with delivery of equipment and setting up prior to move-in
- Assistance with setting up community services, including establishing a healthcare provider, transfer of prescriptions to a community pharmacy, applying for food and utility assistance benefits
- Assistance with getting oriented to a new neighborhood
- Other services?

Probe for the types of services the participant used or did not use and why.

4. Can you describe the process you went through while looking for and leasing up assisted housing?

Probe: Had you been seeking assisted housing prior to becoming involved with [PROGRAM NAME]? If so, how did [PROGRAM NAME] impact that process? What do you believe to be the key impacts of [PROGRAM NAME] during your housing search/transition?

5. **If the participant was housed through [PROGRAM NAME]** (based on responses to questions 3 and 4):
    a. What type of housing do you live in?
    b. How did you select your home?
    c. What is the length of the lease? Is it renewable, and for how many terms?
    d. What, if any, help did you receive when moving in?
    e. Are you still in the same housing as accessed by the [PROGRAM NAME]?
    f. Would you change anything about your current housing?
6. **If the participant was not housed through [PROGRAM NAME]** (based on responses to questions 3 and 4):
    a. How did you find your current home?
    b. Would you change anything about your current housing?
7. Now, I would like to ask you a little more about what you think of the services you receive(d) from the [ORGANIZATION NAME] under [PROGRAM NAME].
   For each service received by participant:
   Can you please tell us:
    a. Where do/did you receive this service?
    b. How easy is this service for you to access?
    c. What, if anything, makes it hard for you to receive this service?

Now, I would like to ask you a little more about what you think of the overall services you receive(d) from the [PROGRAM NAME].

8. What do/did you like about the [PROGRAM NAME]? What was/has been the most helpful about the [PROGRAM NAME]?
9. What do/did you not like about the [PROGRAM NAME]? What services would have been helpful for you to find and move into housing?
10. How do you think the [PROGRAM NAME] could be improved?

Probe: services, coordination of services, communication, etc.

11. Is there anything else you would like to share about your experience with the [PROGRAM NAME] that we have not asked yet?
12. Apart from the services you have received from this [PROGRAM NAME], have you received services to help you locate and transition to housing offered by other programs and organizations?

    If yes, probe for: Which programs/services?

    If no, probe for: What other services, either from the referring program or from other organizations, would have helped you while you were participating in this program?

Closing

Those are all the questions we have for you today. Now we would like to give you an opportunity to share anything else you think would be helpful for us to know regarding the [PROGRAM NAME].

We would like to thank you for taking time to speak with us today. Your answers have provided us with valuable insights about the program. Should you have any additional thoughts you would like to share, please feel free to contact us at the email addresses provided.

Appendix D: References

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