Vermont's Medicaid Permanent Supportive Housing Program

Stakeholder Engagement Report

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Table of Contents

Background

The Vermont Agency of Human Services (AHS) contracted with the Technical Assistance Collaborative (TAC) to conduct a statewide engagement process to inform the development of the state's new Medicaid Permanent Supportive Housing Assistance Program. Permanent supportive housing (PSH) refers to housing for people with the most complex needs that is affordable; upholds the rights of tenancy via a lease; and offers voluntary, individualized services and supports to help these tenants maintain their housing. PSH is a key evidence-based strategy for ending homelessness and expanding integrated community-based settings for people with disabilities and other chronic and complex conditions.

AHS understands that successful design of this new program requires deep understanding of the needs of the people who will be eligible for, and most in need of, pre-tenancy, community transition, and housing retention services and supports — as well as the systems and providers committed to serving them. Vermont, like many other states, has concluded that its existing services array for individuals experiencing homelessness or housing instability who have the highest acuity needs is not sufficient to help this population achieve and maintain stable housing in the community. The new program is intended to provide additional services and supports, in an effort to improve health outcomes and housing stability by complementing or filling in gaps in what is currently available.

Methodology

To inform this report, TAC conducted interviews with 22 key partners, and held 7 in-person and virtual stakeholder listening sessions with over 100 participants from communities throughout Vermont. In addition, TAC conducted 5 listening sessions with 23 people with lived experience of being unhoused and identifying as having a mental health or substance use disorder (SUD) or other disability, and 1 listening session with 28 family members of people with intellectual and developmental disabilities (I/DD). Please note that additional stakeholders were contacted; however, TAC was not able to connect with all stakeholders who were contacted due to insufficient stakeholder capacity to participate or to provide input.

During these sessions, participants were asked similar questions regarding the strengths, gaps, and challenges in accessing and sustaining housing for families and individuals with disabilities seeking services. They were also asked to share their thoughts about opportunities that the new program may present. Interview guides were designed and used to maintain consistency across the interviews and listening sessions. TAC also developed and disseminated an online survey for providers and a survey for people with lived experience (PWLE) and their family members, to gain input from anyone who was unable to participate in a session. Lastly, TAC hosted two virtual stakeholder sessions with 33 participants to share preliminary findings and provide an opportunity for additional feedback. The full list of participants can be found in Appendix A. The results from the surveys can be found in Appendix B.

The purpose of this report is to provide a summary of stakeholder feedback from the engagement process and recommendations for how to incorporate this feedback into the implementation design.

Current Housing Services and Supports in Vermont

Vermont currently funds a variety of programs that offer housing services and supports to help certain target populations maintain housing stability or transition into permanent housing options. The following is a brief summary of the programs highlighted through the stakeholder engagement process. All of these programs include some or all components of an evidence-based permanent supportive housing model.

The Department of Mental Health (DMH) oversees *Community Rehabilitation and Treatment Services (CRT),* which is a Medicaid program for individuals with Serious Mental Illness that provides a variety of services including care coordination, clinical services including therapy and medication management, community supports, and crisis care for people with serious mental illness. This can include some housing supports for people experiencing homelessness. CRT must be provided by a Designated Agency (DA) or Specialized Services Agency (SSA). DMH provides housing vouchers for a subset of CRT clients to support their transition out of hospital and residential settings. Individuals who are eligible for the Medicaid CRT program or Adult Outpatient Services and are experiencing homelessness may choose to receive services from Pathways Vermont, a Specialized Services Agency that uses a Housing First approach.

The Department for Children and Families (DCF) Office of Economic Opportunity (OEO) provides the *Family Supportive Housing* (FSH) program, which is funded through a combination of Medicaid Targeted Case Management and General Fund dollars. FSH offers intensive case management, transition services, and housing tenancy sustaining services to families with minor children who are experiencing homelessness, want to participate in the program, and are willing to engage with offered services. FSH prioritizes families that have had multiple episodes of homelessness, have an active case with DCF Family Services, and include at least one child under the age of six. Each criterion is weighted equally, and families meeting multiple criteria are prioritized above families meeting only one.

The Vermont State Housing Authority's (VHSA) *A Way Home* is a U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) funded program through the Vermont Coalition to End Homelessness that follows the coordinated entry (CE) PSH prioritization of individuals and families who meet the chronically homeless definition (disabling condition + long-term literal homelessness) or other Dedicated Plus criteria. The program provides housing case management as well as security deposits, property damages, and vacancy costs, and is delivered by specific providers in certain geographic areas. VHSA also provides Shelter + Care serving households that meet the chronic homelessness definition with long-term rental assistance and robust services from local providers in all counties except Chittenden.

The Department of Disabilities, Aging, and Independent Living (DAIL) provides both *Support and Services at Home* (*SASH)* and *SASH for All in Vermont.* SASH is part of the Vermont All-Payer Accountable Care Organization alternative payment model which is a state-federal partnership with the Center for Medicare and Medicaid Innovation that enables Medicare financial support for the program. SASH focuses on older adults and people with disabilities and serves any Medicare beneficiary who lives in a SASH Hub (affordable housing sites across the state used as the locus of coordination), as well as

Medicare beneficiaries living in a community setting near the SASH Hub, by offering a variety of individualized, on-site wellness supports. *SASH for All* is a pilot in one area of the state funded through a federal grant targeting low-income families and children living at affordable family housing sites. It offers individualized support and service planning (care coordination, peer support, health coaching, and motivational interviewing) based on a multifaceted screening assessment, connection to community supports, regular check-ins, and support during transitions. The Vermont Legislature provided $450,000 to DAIL in the 2024 State budget to continue *SASH for All* for year two operations.

Finally, the Department of Corrections provides a couple of programs under its *Transitional Housing* program that offer direct voucher access with supportive housing services that facilitate successful reintegration. Priority is given to individuals being released to the community from incarceration, as well as individuals who are supervised in the community and are at risk of recidivism due to lack of appropriate and stable housing. Services vary depending on location but may include service coordination, substance abuse and mental health support, employment assistance, community referrals, and harm reduction.

In addition, Vermont has two HUD CoCs that apply for federal homeless response funding for their geographic areas, as well as local housing coalitions focused on regional efforts to address homelessness. The CoCs and local housing coalitions use a process called coordinated entry, through which people experiencing or at risk of homelessness can access the homeless system in a streamlined way, have their strengths and needs assessed, and quickly connect to appropriate, tailored housing opportunities and mainstream services.

The Impact of the COVID-19 Pandemic and the Wind-Down of Federal Resources

Widespread flooding in Vermont and the wind-down of the pandemic-era "hotel program" placed substantial additional strain on the state, social service providers, and people with lived experience (PWLE) during the time of the stakeholder engagement process for this report. We share the following background on the wind-down to provide important context for the stakeholder feedback and associated recommendations.

In response to the pandemic, Vermont used federal resources to decompress its homeless shelters to protect individuals and communities from rapid spread of the virus in congregate settings. Since 2020, the state's "hotel program" has sheltered a significant proportion of the unhoused population in hotel and motel rooms across Vermont. With the wind-down of federal resources, the state began to move people out of the program in June 2023. The wind-down was then halted through new legislation added as an amendment to H.171. However, the new legislation does not direct the state to re-enroll approximately 800 people who lost motel benefits in June, leaving the Emergency Housing program the only option for individuals or families who fell into homelessness after July 1. In addition, the legislation came with new conditions on the vouchers assisting those in the hotel program, such as income contributions, loss of the voucher due to "misconduct," and a requirement to accept within 48 hours any alternative housing placement offered.

Assessment of Stakeholder Perspectives

Stakeholders shared their experiences with services and systems in Vermont; challenges and barriers that will need to be addressed; and current practices and strengths that will contribute to successful implementation of the Program. They shared their perspectives on how the new benefit can best assist individuals to gain access to, and remain successful in, permanent supportive housing (PSH). The following information represents a summary of stakeholders' perspectives gained from various survey methods and TAC's synthesis of themes generated from their responses.

What Is Currently Working for People in Need of Permanent Supportive Housing in Vermont

Vermont has a number of services and programs that help people to access and transition to stable housing:

- The Housing First program was consistently highlighted as an effective approach in Vermont for individuals with high acuity service needs who are experiencing homelessness, due to the level of consistent engagement that people received from the point of identification, and the intensive support with finding and moving into housing and maintaining housing stability.
- The Family Supportive Housing (FSH) program was frequently cited as a successful model of PSH.
- Several respondents shared that landlord mitigation funds (also called risk pools) were an important strategy for securing housing units for PSH programs.
- Where it is allowable, master leasing was highlighted as an effective strategy for securing units for the population, allowing for more flexibility with tenant screening than many private landlords provide. Providers that master lease enter into an agreement with a property owner to lease a property as a single tenant, and then sublease units to clients as occupant tenants. Master leasing provides access to housing for individuals who are not able to secure a lease on their own, due to poor rental histories, criminal convictions or lease violations.
- Financial empowerment services that help people to open savings accounts and incentivize certain financial practices are considered successful.
- Respondents highlighted the *Support and Services at Home* (*SASH)* and *SASH for All in Vermont* programs as being effective for promoting housing stability for the target population.
- Respondents felt that the practices of checking in with tenants at least weekly (or more often, depending on need) and of keeping the caseload ranges manageable for housing retention services are important for PSH success.
- Cross-system coordination of care models, case conferencing, and shared care planning were all cited as effective when they were happening consistently.
- Peer-delivered services and a community hub model in St. Johnsbury were reported by several people with lived experience (PWLE) as the most effective and helpful support to which they had access.

Barriers and Gaps for People in Need of Permanent Supportive Housing

While stakeholders identified many strengths within the service systems, they also identified barriers and gaps that should be addressed in order to assist the target populations to access housing and maintain housing stability.

Ongoing housing retention services are not widely available:

- Many of the current housing services and supports provided through the homeless response system were described as short-term (2 to 3 months). The services that are available are primarily funded by CoC resources, such as rapid-rehousing, grant funding, and Emergency Rental Assistance (ERA) funding and cannot be supported long-term.
- The short-term services were reported as mostly application assistance, security deposit, and benefits assistance, and not as offering support with mental health or substance use disorders (SUDs) — primary factors in maintaining housing stability.
- There is geographical variation in whether any long-term housing retention services are available to people with service needs transitioning into housing.
- The role of the Designated Agencies (DAs) varies, and can sometimes be unclear; DAs are experiencing substantial capacity and staff shortage issues. Some provide longer-term housing supports, several do not, and stakeholders from several regions described the model as "come to us" and not a supportive housing services model.
- Case management caseloads are too high in many programs, with some program caseloads reported to be as high as 80 to 100 individuals at one time.
- Eviction prevention strategies (such as landlord-tenant mediation, access to legal aid/fair housing advocacy, and emergency flex funding) are critical, and lacking in housing retention services. Stakeholders reported frequent no-cause evictions occurring for low-income and vulnerable populations.
- An impetus for the state to pursue the new program was the fact that certain housing-related services and housing options (e.g., Community Rehabilitation and Treatment Services [CRT], Housing First, FSH, and Department of Mental Health vouchers) are only accessible to certain people. Gaps were highlighted for people with serious mental illness who do not want to engage in treatment services; adults with intellectual and developmental disabilities (I/DD) who live with their aging parents due to no other choices in housing options; and people with active substance use disorders (SUDs).
- Family members of Medicaid beneficiaries with I/DD eligible for Home and Community-Based Services (HCBS) reported no real choice of community provider; the DAs are required to work with them, but other private community-based providers are not, and often turn them away.

People who are unhoused, especially those living outside or in their car, who reported not being actively engaged with services/supports or medical care, described a strong need for service engagement:

- PWLE reported feeling stigmatized and retraumatized by an overall lack of humanity in many of the service systems with which they came into contact.

- Negative experiences have led some people who are unhoused to disengage with service systems.
- Several people reported being unsheltered for one to three years while waiting for housing, with little to no engagement from the homeless service system during this time.

There is a severe shortage of housing options for people who are low-income and have disabilities in Vermont:

- A common challenge highlighted was the lack of housing units throughout the state. This has created a high level of competition for available units, increasing overall housing search times.
- Challenges include convincing private landlords to accept rental assistance vouchers and helping clients with low incomes to access affordable housing.
- Family members of Medicaid beneficiaries with I/DD report extremely limited long-term community-based housing options for their loved ones.
- People with lived experience of being unhoused reported poor and substandard housing conditions, which they feel forced to accept due to the lack of housing options.

People who are unhoused need access to mental health and SUD treatment options:

- Respondents reported challenges in accessing residential treatment.
- Some respondents cited low Medicaid reimbursement rates as a driving factor for programs to prefer clients who can pay with their own money or who have private insurance, and a lack of incentives for programs to serve the target population.
- PWLE reported a lack of crisis mental health services and beds.
- Massive workforce shortages were cited as one driving factor.

A strong need was reported for more homeless response system options for people in housing crisis, especially in more rural areas of the state:

- St. Johnsbury stakeholders reported an up-to-two-hour commute to the nearest homeless shelter with no available transportation.
- PWLE reported the need for more than one homeless system provider in their region due to the lack of choice and accessibility it caused for those who did not want to engage with, or were not in good standing with, the current provider.
- Two regions reported no winter warming shelter options.
- The majority of PWLE reported not knowing where to go when they became unhoused and not having a safe place to go during the day while experiencing homelessness.

The lack of transportation options is preventing access to employment, food, and health care, and is exacerbating homelessness.

The benefits cliff[1] is keeping people unhoused and contributing to food insecurity:

- Some PWLE reported not being prioritized or eligible for housing assistance programs and having no other safe housing options that they can afford.
- People with low-wage jobs who are unhoused reported having no viable housing options, and losing benefits, such as WIC and food stamps, due to their limited incomes.

What Success Would Look Like for the New Program

Stakeholders offered multiple perspectives on how implementation of the new Program could benefit people and the system overall in Vermont.

- Addressing urgent issues in substance use and mental health care for the target population.
- Clear program guidelines and guidance on how people can access the Program.
- A program that fills the gaps in the current state structure, and creates alignment and synergy with existing housing services programs.
- Using data to inform priorities and set performance metrics and revisit them regularly.
- Helping eligible individuals develop independence and be able to identify housing stock in the community that they can eventually "move on" to.
- Providing adequate wages and hazard pay for staff delivering the services.
- Successful engagement, referral, and tenancy for the eligible population.
- Utilizing the Program services to leverage more affordable housing partners and units for people who are unhoused.

Biggest Concerns Regarding Implementation of the New Program

Stakeholders also identified a number of issues within the current system that if not addressed will present challenges to successful implementation of the new program:

- Workforce capacity issues related to staff turnover, wages, and vacancies.
- A serious lack of housing stock and affordable housing options.
- Ground-level, grassroots housing providers with deep knowledge and experience with the population will be left behind as they lack the infrastructure to be able to bill Medicaid.

[1] The "benefits cliff" refers to the sudden and often unexpected decrease in public benefits that can occur when individuals or families have small increases in income and become ineligible to continue receiving benefits despite being unable to sustain their basic needs.

- Concerns about too many qualifying criteria and parameters on what can be provided, a complicated and inaccessible application process, complicated billing processes, and excessive reporting and data collection.
- The lack of these services or a structure to support the program in some areas of the state. There is also concern that there won't be enough staff to support the program.
- Respondents expressed concerns about access for people living with complex mental health needs and those with the highest needs overall.

The Biggest Opportunities for the New Program

Stakeholders shared a variety of perspectives on what they see as the biggest opportunities the new Program brings to the state. The common themes were as follows:

Expanding the Housing First program and trauma-informed care:

- Respondents stressed the need to expand and sustain successful PSH models.

Building upon SASH and the "SASH for All" site-based models to deliver PSH.

Helping more families and individuals with complex barriers to be housed:

- Assisting those who are falling through the cracks.
- Supporting people trying to reenter the community from incarceration.

Setting rates and caseloads that will address burnout and overloaded case managers.

Addressing gaps in the system for people in SUD recovery. Respondents highlighted the following:

- Role of recovery housing
- Need for more harm reduction housing
- Urgency of addressing SUD issues

Enhancing System and Service Coordination

There were a variety of ways in which stakeholders raised the need for better system and service coordination at both the state and local levels.

Several respondents cited the need for stronger coordination across providers/systems doing similar work (e.g., domestic violence, Community Action Agencies, Designated Agencies, homeless services providers). Multiple agencies duplicate certain efforts, which can be confusing for people being served.

- There is a need for more collaborative efforts across organizations and sectors.
- Joint care planning and case conferencing were raised as critical strategies.

- A general lack of understanding of who is eligible for what program, and how to navigate the various systems and programs, was frequently noted.

Respondents reported the need for better state-level coordination and communication to address homelessness as it relates to contracting, eligibility criteria, program standards, data collection and sharing, and quality assurance:

- Respondents requested stronger coordination on housing solutions across state agencies.
- Funding for housing programs was described as a patchwork and siloed in the state.

Family members of people with I/DD reported no organized, centralized, state-level process or system for coordinating referrals for community-based housing options for people with disabilities.

Suggestions for Delivering the New Medicaid Program

Stakeholders provided suggestions that they thought were key to implementation of the new program:

Several respondents highlighted ground-level, grassroots housing/homeless organizations as the most experienced with the target population and most appropriate providers to be delivering the new housing services; however, several of these providers shared challenges and barriers to starting to bill Medicaid directly.

Several providers expressed significant concerns if a fee-for-service payment model was adopted, due to the administrative burden — and requested a per member per month (PMPM) rate:

- Several non-Medicaid providers requested an intermediary option for purposes of managing the Medicaid billing requirements.
- Small organizations don't have clinicians and don't fit the "medical model," and stressed that flexibility will be key to success.

Respondents cited the need for Medicaid reimbursement for peer support, (e.g., mental health, SUD, and housing/homelessness).

Providers highlighted the importance of appropriate caseloads and the need for adequate rates to support the benefit.

The FSH program approach has been successful at enrolling providers in Medicaid with minimal challenges.

- FSH has a simple payment methodology with one Current Procedural Terminology (CPT) code and one PMPM payment. The program uses general fund dollars to fill in the gaps (e.g., families not eligible for Medicaid).
- FSH has a preferred provider network, and providers cover certain catchment areas.

Federally Qualified Health Centers (FQHCs) were highlighted as potential providers of the new housing services that could partner with current housing agencies and embed staff in their buildings.

Prioritization of the New PSH Assistance Program

Given the cap on the program and need to establish a waitlist, respondents were asked how they thought the program should be prioritized. The following themes emerged:

Strong concerns about crime, violence, drug use, and deplorable conditions in hotels and on the streets were reported by PWLE and provider staff, and should inform the prioritization strategy:

- PWLE expressed fear of staying in the hotels, which are deemed not appropriate shelter options due to safety issues and the likelihood of exacerbating SUDs and criminal justice involvement.
- People who are unsheltered or living in hotels reported repeated assaults, victimization, and criminalization of their homelessness.
- Families with children living in hotels were repeatedly raised as the most vulnerable populations in need of prioritization.
- Individuals who are unhoused for long consecutive stretches or have had multiple stays should be considered for prioritization.

The majority of respondents expressed that coordinated entry (CE) systems should be used to prioritize eligible individuals and families who are experiencing homelessness with the following requests:

- Address the discrepancy between the CE list and unit availability, since many have housing histories or criminal histories that prevent them from receiving housing vouchers.
- Allocate additional funding for housing units with prioritized referrals from CE.
- Prioritize those experiencing chronic homelessness, and with the longest periods of homelessness for the PSH Assistance Program.
- Respondents noted that CE can be difficult to navigate or access, especially for those with the most complex needs, and that lack of stable phone access exacerbates access issues.

Respondents identified multiple populations likely to fall through the cracks:

- Domestic violence victims.
- Parents who disengage from systems due to fears of losing their children.
- People who are unhoused and employed in low-wage jobs were identified as ineligible for many housing supports but having no other housing options.

People with high rates of inpatient psychiatric visits and a high level of care needs were flagged as an important population to prioritize.

Training and Quality Assurance

Respondents expressed the need for the state to support training and technical assistance and to promote consistency across PSH programs.

FSH was cited as an effective model of quality assurance for PSH and for bringing consistency to training and data collection:

- Training is required for FSH providers and they must also participate in a mandatory quarterly community of practice meeting.
- The monthly payment rate allows for staff to engage in onboarding requirements and training. Every program is expected to have a line item for Training & Technical Assistance.

Respondents shared that PSH providers need more expertise on the model, and training on fair housing, understanding resources and benefits, and disabilities.

Strategies to Address Equal Access to Services and Supports for Disenfranchised Populations

Respondents reported some diversity, equity, and inclusion (DEI) efforts related to PSH, but they are varied and inconsistent across the state, especially as they relate to analyzing data.

- Some respondents felt that the CE system is the most notable equity strategy currently in place.
- Respondents reported inequitable treatment of people with disabilities, especially serious mental illness and SUDs.
- The need for funding for translation services was repeatedly cited as an equity issue.
- Small agencies don't have capacity to focus on equity data and outcomes. State funding connected to intentional deliverables around health equity was recommended.
- One homeless services provider was undertaking a DEI initiative using mobile outreach vans to engage hard-to-reach people.
- The provider qualifications for the new Program were raised as an equity issue with concern that the bachelor's degree requirement for case management will exclude staff who bring critical life and work experience.

Alignment of Peer Support Services with the New Program

Multiple respondents, including many PWLE, emphasized the importance of lived experience in service provision.

- Intentional peer support was highlighted as an effective model for PSH that is not widely available.
- Respondents expressed a need for statewide training and professional development of a peer support workforce.

Recommendations

TAC offers the following recommendations for how to incorporate stakeholder feedback into the design of the new Medicaid PSH Assistance Program. These recommendations are based on TAC's in-house subject matter expertise and on our experience with and knowledge of evidence-based and national best and promising practices for permanent supportive housing (PSH).

Prioritizing Individuals Experiencing Homelessness

For initial implementation, TAC is recommending that the state of Vermont demonstrate and build the initial infrastructure for the Medicaid PSH Assistance Program by prioritizing eligible members who are experiencing homelessness. As noted above, a strong theme in the stakeholder feedback was the dire circumstances many individuals and families experiencing homelessness are facing, especially individuals and families living in the hotel program, people who are unsheltered, and those fleeing domestic violence. Prioritizing program recipients based on these risk criteria during initial implementation of the pilot will provide a clear baseline for understanding and evaluating the impact of the Program and for measuring outcomes related to addressing homelessness. TAC is aware that efforts are underway to modify coordinated entry (CE) and also to incorporate people at risk of homelessness for prioritization. As the Medicaid PSH Assistance Program becomes fully operational and CE is revised, individuals at risk of homelessness should also be considered for prioritization for a certain portion of the new Program.

At the same time, it will be critical for AHS to maintain current pathways to PSH, for example, supports for people transitioning from institutional settings through the Department of Mental Health (DMH). People exiting institutional settings will continue to need access to PSH to be supported successfully in the community, and are not prioritized for PSH through the CE process for people experiencing homelessness. Vermont should also consider expanding the DMH initiative to include those transitioning from criminal justice settings. TAC also strongly recommends building upon or utilizing the existing state pilot funding for people with intellectual and developmental disabilities (I/DD) to test and evaluate if modifications or enhancements to the supportive services are needed for those who would choose to live in PSH.

System and Service Coordination

Individuals and families in need of PSH often touch multiple systems, and require a multisystem, coordinated response for successful outcomes. Cross-system coordination and resource deployment are key elements of effective state programs.

Leveraging Resources and Braiding Funding Sources

- Continue the expansion of PATH at the DMH to support street outreach and mobile mental health, substance use disorder (SUD), and medical services to pair with the Program.
- Partner with "SOARing in Vermont" at DMH to ensure there are staff in every region to support expedited access to SSI/SSDI income benefits for people with disabilities who are unhoused.
- Partner with VT Health Connect to determine eligibility for Medicaid.

State-Level Interagency Collaboration and Coordination

- Create a cross-agency working group, or build upon an existing one, to focus on interagency coordination on supportive housing, including but not limited to contract alignment, performance metrics, requests for proposals (RFPs), and other funding opportunities.
    - Create a Medicaid PSH Assistance program implementation working group for providers and other major stakeholders, managed by the State, to foster strong communication, collaboration, consistency, and coordination of the Program.
- Build upon or support local or regional multidisciplinary care coordination teams designed to identify and manage high-need members across a variety of providers, settings, and systems of care, with an emphasis on using community resources.
- Partner with Continuums of Care (CoCs) to conduct data-matching with the Homeless Management Information System (HMIS) to better understand the profile and scope of the target population, and to help confirm which beneficiaries are currently experiencing homelessness, among other potential cross-system data strategies.

Training and Quality Assurance Practices

- Designate an agency and role to create a centralized system of training and quality assurance for the Program.
- Require and offer regular training on providing culturally sensitive, trauma-informed care, Housing First, harm reduction, and effective assertive engagement practices.
- Establish uniformity in data collection and disaggregate data by race, ethnicity, and other demographics to assess equity in who is served by the Program and their outcomes.
- Support providers in reaching fidelity to PSH principles and standards.
- Ensure that staff at all levels of the Program are trained in housing resources and how referrals are made to the appropriate program. Create clear educational materials explaining the different housing support services/eligibility and the pathways to access them (e.g., Community Rehabilitation and Treatment Services [CRT], Housing First, Medicaid PSH).

Prioritization and Waitlist Structure and Processes

The following recommendations build upon the consistent themes in the stakeholder feedback to use the existing CE systems in the state and avoid creating another system/process for prioritization of the Medicaid PSH Assistance Program, and to focus on people experiencing long-term homelessness with the most chronic and complex needs.

Prioritize Referrals from the Homeless System and Align with the CE System Matching and Prioritization Process for PSH during Initial Implementation of the Program

- Create a referral process to the Medicaid PSH Assistance Program for eligible individuals and families experiencing homelessness identified by other systems.
- Establish in-house case managers at the State to provide conflict-free case management (to promote individual choice and independence in services and providers). Consider dedicating each case manager to a particular geographic area to allow for regional coordination and collaboration with local community partners — including CoCs and CE systems — on referrals,

eligibility, intakes, and other functions. This practice could be operationalized within current structures, such as the Vermont Chronic Care Initiative.

- Case managers can help decrease the administrative burden of ground-level agencies and frontline staff (e.g., by streamlining Medicaid and service eligibility processes and by managing the waitlist and referrals to Medicaid PSH providers). They can also partner with housing retention staff to assist with determining next steps in connecting individuals with services. Case managers may also serve as points of contact between CE systems and their members with complex needs who are experiencing homelessness, and participate in case conferencing and housing match meetings as needed. State case managers may also assist in prioritization of the benefit by identifying individuals who are homeless but have not engaged with the homeless response system.
- As the Medicaid PSH Assistance Program becomes fully operational and CE is revised, individuals at risk of homelessness should also be considered for prioritization of the new program.

Provide Capacity-Building Support for CoC service providers of PSH to Become Medicaid-Funded Housing Service Providers

Scope of Services

- Clearly define and require assertive engagement as part of housing retention services for all eligible participants, including those who don't currently want services.
- Ensure that financial literacy/empowerment supports are included in housing retention services.
- Incorporate a Housing First model into the service requirements.
- Require that service planning be reviewed and revised every six months.

Medicaid Benefit Design

Reimburse Providers via an Alternative Payment Arrangement other than Fee-For-Service

- A bundled rate will be administratively less complex for new providers.
- The alternative arrangement can include reimbursement for multiple services, including peer support.
- Staff must be trained to appropriately document and report their delivery of services.

Rate(s) Must Support an Array of High-Quality Services

- Develop adequate rates that incentivize providers to pay staff a living wage.
- Assess and, if appropriate, mirror the bundled rate paid for similar services in the Family Supportive Housing (FSH) and Housing First programs.
- Rate(s) should support services provided where members are physically located (i.e., in the community, travel to get to member), and ensure adequate supervision and training, as well as allowing for care and services coordination functions.

Caseloads Must Adhere to Best Practice

- HUD Guidance recommends caseloads of 1:10 or 1:20 for housing retention services, depending on the acuity of individuals served.

Establish Partnerships to Support Service Delivery by Providers who Do Not Have the Infrastructure to Bill Medicaid

- This could include, but should not be limited to, partner agreements with Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Clinics (CCBHCs).
- Allow options that address the request for an "intermediary" for billing.

Provider Qualifications

The Medicaid PSH Assistance provider agency must commit to achieving PSH quality standards and to participation in fidelity reviews, and have experience providing services to persons with mental health disorders and/or SUDs. Provider agencies must have at least two years of experience providing pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness, including those experiencing chronic homelessness.

System Issues that will Impact Program Success

The new Medicaid PSH Assistance benefit has the potential to achieve positive outcomes for many of Vermont's most vulnerable residents. However, the benefit alone will not be successful unless ancillary issues within the service system are addressed.

Improve Access to Decent, Affordable, and Accessible Housing

In addition to this Stakeholder Engagement Report, TAC is producing a comprehensive inventory of current supportive housing resources in Vermont; a report on best practices and national standards based on research conducted in this field; and an analysis and recommendations on how to implement these standards in Vermont in a manner that supports an effective and coordinated system for accessing supportive services, rental assistance, and housing options.

TAC's Housing Best Practices Report will address these strategies:

- Increase rental assistance resources for the target population.
- Increase production of integrated PSH units.
- Ensure the alignment and coordination of housing and services for the target population.

Improve Access to Mental Health and Substance Use Disorder Services

- Use data to assess capacity needs and waitlists at the Designated Agencies and support quality assurance processes.
- Provide service standards and quality assurance measures for the housing supports offered at Designated Agencies
- Develop a specific SUD treatment strategy for people who are unhoused that addresses inpatient detox and residential treatment service capacity. The strategy should also address inadequate transportation, stigma, and other barriers to accessing outpatient treatment, including medication for opioid use disorder.

- Ensure direct coordination and partnership with CCBHCs, the 988 crisis line, and mobile crisis response planning and implementation.

Implement Strategies and Incentives to Expand the Workforce

- Explore strategies being used to expand the behavioral health workforce across the country, such as expanding the types of providers that can bill for services; using inter-professional consultation codes; establishing new partnerships with educational centers, for example, community colleges; engaging in outreach to recruit more staff; and expanding coverage for and/or access to telehealth services in Medicaid. Financial incentives such as instituting prompt payment policies and student loan repayment programs are being used nationally to help grow the workforce.[2]
- Coordinate with the current mental health peer certification planning in the state.
- Incentivize hiring PWLE in an array of positions, including for pre-tenancy and tenancy sustaining services.
- Partner with community colleges to develop job training pathways for PWLE and non-degree individuals.
- Work with providers to ensure that PWLE aren't being prevented from filling such roles by job qualifications and human resource policies related to criminal histories, flexible hours, or part-time hours.

Transportation Options

- Develop additional transportation options for people who are unhoused, such as establishing agreements with ride-hailing services. Create a centralized and coordinated inventory of options and a strategy for quickly connecting people with transportation options.
- Expand mobile phone access for Medicaid beneficiaries.

Community Supports

- Ensure drop-in centers are visible and accessible in every region to provide a safe space and access to basic hygiene supplies/amenities for people who are unhoused.
- Increase access to safe spaces to build community and social support that offer a central location for connecting people to resources, such as the SSI/SSDI Outreach, Access, and Recovery (SOAR) program and other supports.

Meaningfully Partner and Build Trust with People with Lived Experience

- Develop a formal consumer advisory board made up of PWLE that will meet regularly to provide guidance and advice to the state. Ensure members are compensated for their time and expertise.
- Ensure current complaint processes are known and accessed, and that this input is considered. Develop an independent, accessible ombudsperson or point person to oversee the process of investigating and responding to complaints from people served by social service programs.

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[2] Saunders, H., Guth, M., & Eckart, G. (2023). A look at strategies to address behavioral health workforce shortages: Findings from a survey of state Medicaid programs. San Francisco, CA: KFF

- Partner with the CoCs to conduct quarterly homeless outreach events to engage and maintain up-to-date information on people who are unsheltered and entered into the Homeless Management Information System (HMIS).

Benefits Cliff

- Explore state strategies to mitigate the impact of the benefits cliff, such as implementing grace periods, bridge funding, or time limit extensions to state administered programs, and federal benefits when possible, to give individuals and families reasonable opportunity to establish more permanent solutions for the loss of resources.

Conclusion

Vermont's Medicaid Permanent Supportive Housing (PSH) Assistance Program has the potential to expand much-needed services for individuals and families, and can serve as a foundation for expansion of PSH throughout Vermont.

At TAC, our experience has shown us that diverse stakeholder input is essential for implementing systems change, and for designing services and programs that work for people. The commitment of AHS to a comprehensive stakeholder process has afforded key representatives across multiple systems and services the opportunity to inform the development of a program and delivery approach that will be successful. Over the course of a few months, TAC was able to connect with over 195 stakeholders in Vermont. Through these conversations, we learned a great deal about the strengths, challenges, and opportunities for the relevant systems, as well as the experiences of the people who sit within and are impacted by these systems. The lack of housing stock, affordable housing options, and workforce capacity are primary challenges that must be tackled for the new Program to ultimately succeed. Vermont has considerable assets for addressing these challenges, including state leadership and innovation, peer and provider leaders, quality programs, resource investments, and passionate community members committed to permanent housing solutions for people in need.

Appendix A: Interview Participants

Individuals

Angela Smith-Dieng, Department of Disabilities, Aging, and Independent Living (DAIL)

Cherry Sullivan, Upper Valley Haven

Christy Durgin, Upper Valley Haven

Conor O'Dea, Department of Vermont Health Access (DVHA)

David Riegel, Agency of Human Services (AHS)

Jennifer Garabedian, DAIL

Jennifer Hunter, Support and Services at Home (SASH)

Julie Abrahamson, DAIL

Kana Zink, Vermont Department of Health (VDH)

Karim Chapman, Life Intervention Team

Keith Grier, Washington County Mental Health Services (WCMHS)

Lily Sojourner, Office of Economic Opportunity (OEO) Family Supportive Housing

Lindsay Mesa, Pathways Vermont

Liz Genge, SASH

Liz Sanderson, VDH Division of Substance Use (DSU)

Molly Dugan, SASH

Renee Weeks, Agency of Human Services

Sarah Phillips, OEO Family Supportive Housing

Sue Graff, AHS

Trish Singer, Department of Mental Health (DMH)

Wendy Trafton, Agency of Human Services

Will Eberle, Recovery Vermont; Vermont Association for Mental Health and Addiction Recovery (VAMHAR)

Listening Sessions

Rutland Homeless Continuum of Care

Angus Chaney, Homeless Prevention Center
Anne Filskov, Community Health Centers of the Rutland Region (CHCRR)
Anni Savage-Prusaczyk, DVHA
Carol A Hilliker
Carrie LaFrancis, Rutland Regional Medical Center

Dan Thompson
Dori Beardsley, BAYADA Home Health Care
Elizabeth Eddy, BROC, Community Action in Southwestern Vermont
Jamie Bentley, Rutland Regional Medical Center
Jane Bourhill, VDH
K. Pelletier
Kathleen Boyd, Rutland Regional Medical Center
Kevin Loso, Rutland Housing Authority
Kimberly Mayo, Rutland Mental Health Services
Louisha Coppins
Marissa Reed
Mary Cohen, The Housing Trust of Rutland County
Merideth Drude, DVHA
Richard Gallo, Office of Veterans Affairs
Stephen Box
Terry Williams, State Senator

Rutland Mental Health and Intellectual/Developmental Disability (IDD) Providers

Anne Filskov, CHCRR
Carrie Cole
Carrie LaFrancis, Rutland Regional Medical Center
Dori Beardsley, BAYADA Home Health Care
Kevin Loso, Rutland Housing Authority
Louisha Coppins
Morgan Blanchard, Rutland Regional Medical Center

Virtual Statewide Listening Session

Angie Harbin, Downstreet
Christine Hazzard, Burlington Housing Authority, BHA
Daniel Blankenship, Vermont State Housing Authority, VSHA
Eli Ferree, Homeless Healthcare Program, Community Health Centers of Burlington
Jake Harrelson, Pathways Vermont
Leah Sare, Vermont Housing and Conservation Board (VHCB)
Patricia Singer, DMH
Tyler Strange, VHCB
William Vilardo, Vermont Veterans Committee

Burlington Listening Session

Alison Calderara, Capstone Community action
Alyssa Peteani, Vermont Housing Finance Agency, VHFA
Emily
Henri June Bynx
Jason Brill, Veterans Affairs (VA) Burlington Community Based Outpatient Clinic (CBOC)
Linda Amante, Chittenden Community Action

Lindsay Mesa, Pathways Vermont
Louise Masterson, Institute for Community Alliances (ICA)
Marcella Gange, Burlington Community and Economic Development Office
Meghan Morrow Raftery, ICA
Mike Ohler, Burlington Housing Authority (BHA)
Molly Dugan, SASH
Sarah Russell, Burlington Community and Economic Development Office
Sarita Austin, State Representative
Stephanie Bixby, BHA
Thomas Moore, Community Health Centers of Burlington
Tiffany Bluemly, State Representative
Will Towne, Spectrum VT

Brattleboro Housing Services Committee Listening Session

Addison Worsman, Groundworks
Alli Briggs
Amy Goldberg, **Vermont** Department of Children and Families Economic Services Division
Biz Youth Services
Camilla Tarmy, Health Navigator
Celestin Nkusi
Cheryl Jackins, Pathways Vermont
Christine Levy
Ciarra Monty, Southeastern Vermont Community Action
Collette Gangloff, Early Education Services
Cori Gauthier, Family Supportive Housing Coordinator
Dan Handy, Groundworks
David and Doreen
David DeAngelis, Brattleboro Housing Partnerships
Emilie
Greg Leduc
Hayley Rowland, Health Care and Rehabilitation Services (HCRS)
Heather Cutler, AIDS Project of Southern Vermont
Jasmine Martin, Winston Prouty Center
Jennifer Hunt, Groundworks
Jess Guardado, Groundworks
Jessica
Julie Parker, VT Blueprint for Health
Katherine Cummings, Brattleboro Memorial Hospital (BMH)
Katrina Gragen, Winston Prouty Center
Lesa Trowt, VT Department of Corrections
Lindsay Mack
Lori Lintner, Senior Solutions VT
Lucy Tell, Brattleboro Housing Partnerships
Malcolm Hamblett, Chester Baptist Church
Margaret Lewis, The Gathering Place
Negina Azimi, Ethiopian Community Development Council (ECDC) Multicultural Community Center
Nkisha Taylor

Patricia Singer, DMH
Ruben Garza, United Way of Windham County
Sue Graff, AHS
Susan Howes, Southeastern Vermont Community Action (SEVCA)
Suzanne Tremblay, SaVida Health
Taylor Emery, RN, BMH
Teresa Morrison, BMH
Tim Guarente, Groundworks
Tricia
William Vilardo, Vermont Veterans Committee

Brattleboro Groundworks Case Management Listening Session

Addison Worsman
Cora Cobane
Dan Handy
Hannah Macon
Miranda Neizer

St. Johnsbury Homeless Continuum of Care Listening Session

April Kelly, Northeast Kingdom Community Action (NEKCA)
Barbara Edelman, NEKCA
Becca Lewis, NEKCA
Belinda Webster, NEKCA
Carly Nichols, VA
Casey Winterson, NEKCA
David Riegel, VT Agency of Human Services
Diana Gibbs, Northeastern Vermont Regional Hospital (NVRH)
Erica Beer, NVRH
Heather Lindstrom, VT Dept of Health
Jenna O'Farrell, NEKCA
Jodi Wheeler, HOPE
Judith Jackson, Community Member
Maryellen Griffin, Legal Aid Society
Robert Little, RuralEdge
Star Barden, NEK Youth Services
Tin Barton-Caplin, VT Dept of Health

State Community Rehabilitation and Treatment (CRT) Program Directors Meeting

Attended a regular convening of CRT Program Directors hosted by Vermont Care Partners: Vermont Council of Developmental and Mental Health Services.

People with Lived Experience and Family Members

People with Lived Experience

Twenty-five people with lived experience were interviewed through five listening sessions and two key informant interviews across the state.

VT Developmental Disabilities Housing Initiative (DDHI) Listening Session

Twenty-eight family members of people with Intellectual and Developmental Disabilities (I/DD) participated.

Feedback Sessions on Preliminary Findings

Feedback Session on Preliminary Findings October 10, 2023

Alison Harte
Anera Foco
Angie Harbin
Cherry Sullivan
Daniel Blankenship
Eli Feree
Elise Shanbacker
Jennifer Hunt
Jessie Butterfield
Jon Hoover
Juliet Emas
Kathrynn Titus
Kim Fitzgerald
Lindsay Mesa
Maryellen Griffin
Michael Redmond
Rick Morse
Sadie Fischesser
Star Barden
Taylor Thibault
William Vilardo

Feedback Session on Preliminary Findings October 13, 2023

Leah Burdick
Leah Sare
Lindsay Thrall
Emily Cindy Wood
Rewa Worthington
Erin Oalican
Ashley Lowe
Robyn Stattel

Michael Ohler
Emily Taylor
Shannon Bradley
Adnan Duracak

Many thanks to those who coordinated with TAC to make the listening sessions possible, and all of the stakeholders who gave their time to help inform this report. A special thank you to Juliet Emas, Executive Director of the St. Johnsbury Community Hub, and Lisa Marie, community member in Brattleboro, for all of their support and coordination.

Appendix B: Online Survey Results

Survey for Providers and Other Agency Partners: 18 Respondents

1. **Demographics**
    - 77.78% Female; 11.11% Male; 11.11% Non-binary
    - 100% White
    - Age Range: 27.78% = 25-34; 27.78% = 35-44; 16.67% = 45-54; 27.78% = 55-64
2. **How do you relate to Vermont's new Medicaid Permanent Supportive Housing (PSH) Assistance Program?**
    - 83% Providers
    - 6% Program Administrators
    - 11% Other (coordination roles)
3. **In what part or parts of Vermont do you operate?**
    - Newport and St. Johnsbury districts = **35.29%**
    - Barre and Hartford districts = 23.53%
    - Brattleboro and Springfield districts = 17.65%
    - Not applicable = 17.65%
    - Statewide = 11.76%
    - Rutland and Bennington districts; St. Albans and Morrisville districts = 0%
4. **Does your organization provide Permanent Supportive Housing (PSH)?**
    - Yes = **38.89%**
    - No = **38.89%**
    - Other = 22.2%
5. **Does your organization use demographic information to determine if all Vermonters have equal access to PSH programs?**
    - Yes = 16.67%
    - No = 27.78%
    - Not Applicable (N/A) = **50%**

6. Does your organization measure differences in outcomes based on demographic information for those being served with PSH?

- Yes = 22.22%
- No = **38.89%**
- Not applicable (N/A) = 33.33%

7. Do you participate in your homeless Continuum of Care's Coordinated Entry System (CES)?

- Yes = **83.33%**
- No = 0%
- Other = 16.67%
    - We are a referral partner but our local continuum does not allow us to participate in housing retention team meetings
    - Not directly, we refer folks to NEKCA for coordinated entry
    - N/A

8. Are you a Medicaid provider?

- Yes = 27.78%
- No = **50%**
- Other = 22.22%
    - One member of the Healthworks team is a Medicaid provider
    - Yes, but only for two assisted living residences
    - No, but we bill Medicaid for services
    - Some of our services are Medicaid billable

9. If Yes, how likely is your organization to deliver the PSH Assistance Program?

- Very likely = 20%
- Somewhat likely = 20%
- Neither likely nor unlikely = 10%
- Somewhat unlikely = 20%
- Very unlikely = 10%
- Other = 20%

10. If No, how likely is your organization to become a Medicaid provider to deliver the new PSH Assistance Program through Medicaid?

- Very likely = 13.33%
- Somewhat likely = 6.67%
- Neither likely nor unlikely = 6.67%

- Somewhat unlikely = 20%
- Very unlikely = **33.33%**
- Other = 20% (I'm not sure if NEKYS can?)

11. Please indicate any challenges to enrolling as a Medicaid provider. Check all that apply.

- New to billing Medicaid = 11.11%
- Lack the necessary infrastructure = 27.78%
- Lack the necessary staff to create and submit claims = **38.89%**
- Other = 27.78%
- Not applicable (N/A) = 33.33%

12. Please indicate any supports your organization would need to enroll as a Medicaid provider to deliver the new PSH Assistance Program services. Check all that apply.

- Funding to support infrastructure = **55.56%**
- Training and technical assistance = **55.56%**
- Additional staff for billing = 44.44%
- Not applicable (N/A) = 33.33%

13. Based on your experience, how will we know whether the new PSH Assistance Program is successful?

- Housing retention rates go up over time (measure successful tenancy after placement in affordable housing).
- If we find landlord willing to rent to our clients and they remain housed.
- We are implementing Outcomes Tracker to measure outcomes for residents in our resident support program, which provides service coordination but does not provide direct services. This system is not an EMR but could allow us to report on outcomes such as housing retention, access to services, etc.
- Set clear and realistic outcomes and indicators to gauge progress in regular intervals. It will take multiple years for outcomes to become clear.
- Our PSH program has 3 primary goals; housing retention, resident stability, and developing independence. We measure how well we reach those goals through a variety of metrics including lease violations, rent, community engagement, engagement in services, and connection to community resources.
- Firstly, by the number of enrollees. Secondly, by the number of those housed and then by those retaining housing after a determined period of time.
- More people will be housed and housed more timely. Providers will help people complete applications and collect documents needed for applying. Affordable units will be available. Vouchers or income-based units will be available. Leading housing organizations will more directly support clients around housing needs.

- If people (who are eligible) to receive housing assistance are aware and able to receive assistance.
- Decreased number of long-term households on coordinated entry list and decreased time long-term households are on CE lists.
- No more homeless folks.
- When people are housed permanently.
- It would show based on reporting requirements. Depends on what outcomes are reported on.
- Reporting.
- How many folks who remain successfully supported and housed.
- Whether or not people remain successfully housed at intervals thereafter.

14. Do you feel the current programs and services are meeting the needs of individuals in PSH?

- Yes = 35.29%
    - In my experience with the population served, there is adequate access and resources for PSH; It seems that current programs meet the needs of individuals in PSH when they are enrolled; I think the referral process is sufficient; FSH (Family supportive housing) is the only example of a true successful program.
    - Lack of housing availability is making this very hard to do.
    - I do think that overall it is but there is always room for more support.
- No (please explain) = **52.94%**
    - No, lack of access to SUD or MHD treatment, or tenant is unwilling to seek treatment.
    - I have had several clients refuse services, their symptoms escalated and as a result they lost their housing. Housing and services need to be closer connected.
    - We house many extremely vulnerable households who are not able to live independently, are chronically in eviction or at risk of eviction, and who need additional services to remain stably and successfully housed and often to have chronic mental and physical health conditions adequately addressed. Most of these residents are either unwilling or unable to access services. There are simply not enough services to serve everyone in the existing "scattered site" or integrated PSH model, and for those residents who are unwilling or unable to access services this way, we need an entirely new model for co-located housing and service, which currently doesn't exist outside a few group homes in Addison County. Co-located housing and services would enable more assertive engagement with noncompliant residents and increase the likelihood that services are available when and where they are willing and able to engage with them.
    - Need more trained mental health support persons that can work where people live with maximum flexibility.
    - We are not able to have the staffing level we would like to have due to limited funding.

- No, hundreds of people have been homeless despite getting significant wraparound services to support complex needs including housing navigation by the local DAs with limited success due to limited units. Accessing supportive services through Nursing Homes, CCH's, Intensive Residential Recovery Homes, Therapeutic Recovery Residences, and Adult Family Care Homes is just as limited.
- The existing programs are not sufficient to meet the demand for PSH in Vermont.
- There isn't enough housing.
- There is not enough affordable, accessible housing.

- Other (please specify) = 23.53%

15. What are the biggest barriers to moving people quickly into PSH?

- Identifying housing units = **88.89%**
- Obtaining necessary documentation to determine eligibility = 50%
- Housing location = 27.78%
- Unit quality/Housing Quality Standards (HQS) inspections = 22.22%
- Maintaining engagement with the individual = 44.44%
- Lack of support services = 44.44%
- Other = 27.78%
    - VSHA housing voucher application approval delays; It takes too long to process paperwork.
    - "PSH" as such just doesn't really exist in Addison County. Extremely vulnerable clients are moved directly into independent housing at which point the services either stop following them or the participant stops engaging, leaving the landlord to pick up the pieces.
    - The application process is difficult for people exiting homelessness. They have to complete applications for the property manager and the provider of rental subsidy. With supporting documents this can exceed 30 pages of forms and documentation.
    - Available housing units/beds/discrimination around MH [mental health] issues and complex needs.

16. What are the biggest barriers to expanding the capacity of PSH to meet the need in your community/service area? (check all that apply)

- Lack of funding for services = 66.67%
- Lack of staff resources = 77.78%
- Lack of available affordable housing units to pair services with = **100%**
- Lack of leadership and/or community buy-in for PSH = 22.22%
- Other (please describe) = 5.56%

17. How are Peers/People with Lived Experience currently included in service delivery for the populations that may be eligible for this Program?

- Many service coordinators working at housing agencies have lived experience with being unhoused.
- We have a peer support lead embedded within the Healthworks ACT [Assertive Community Treatment] team. I have not observed clearly identified peer support systems within other organizations or at PSH sites I frequent.
- Unknown. We don't have strong partnerships at the leadership level among housing and service providers that would enable us to speak the same language, learn about each other's systems, and develop the capacity and buy-in to develop a collaborative model with formal and consistent components like peer support. Peer support may be a part of the models of service providers who are providing services to our residents, but we just don't know because we don't partner at that level with those agencies.
- Support services from the community.
- Housing stock is almost non-existent — we need the stock.
- There is a lack of services for these individuals in our area.
- All of our housing programs require people to be HUD 1 homeless. HUD 1 homeless are generally people who have dual diagnosis from the above list.
- Our programs work with all families regardless of their barriers and work to connect them to services need to be successfully housed.
- We employ people with lived experience in all areas of care and supports.

18. Please indicate whether any of the following approaches are currently underutilized in PSH from your experience:

- Housing First = 47.06%
- Trauma informed care = **58.82%**
- Harm reduction = 47.06%
- PSH standards and fidelity = 35.29%
- Racial equity = 29.41%
- Not sure = 35.29%
- Other (please specify) = 11.76%
    - State subsidy rates remain below market rates for housing.
    - Systems for voucher approval and recertification are not trauma-informed and beyond client capabilities.
    - There isn't formal agreement on what the "Housing First" model actually entails so it's hard to comment on this one. We see folks being offered housing without conditions but then they stop engaging and instead of Housing First it becomes "Housing Only" which just leads back to eviction and the revolving door of coordinated entry

19. Given that the new PSH program may have an enrollment cap, are there certain considerations that should be factored into who is prioritized for the services?

- Families with children should be prioritized.

- Asylum seekers.
- Individuals with the longest period of homelessness.
- Individuals that have been in the hotel program for either long consecutive stretches or have had multiple stays should be considered for prioritization.
- The state should prioritize developing a PSH site in every county, and must partner with VSHA to align prioritization with who is eligible for vouchers. For example, families are prioritized for vouchers, but the CE list is full of individuals who need PSH and also frequently have housing histories or criminal histories that prevent them from receiving Section 8 vouchers, so someone has to figure out who is going to pay the rent.
- Those who don't have access to PSH through other means/programs.
- CRT clients, young adults up to age 30 with mental health/substance use services, people with high rates of inpatient psychiatric care.
- Perhaps setting age-specific caps to provide equal opportunity across age demographics (x number of youth under the age of 25, x number of households that are 25-45, etc.).
- Level of care need
- Chronic homeless — been homeless for more than 3 years.
- Those with no other familial or community supports should be considered first. People who are frequently arrested due to mental health issues.
- All the recent housing programs are for families. Single individuals are most often overlooked.
- Engagement should be a consideration.
- Those who are not eligible or have no other housing options.
- Violence/sexual conviction history & engagement.

20. Are there certain populations that have less access to PSH today?

- Black, Indigenous, or People of Color (BIPOC) = 42.86%
- Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual (LGBTQIA) = 28.57%
- Refugees = 42.86%
- People who speak English as a second language = 42.86%
- Other (please specify) = 64.29%
    - Those with active substance usage
    - People with mental illness and substance use disorders
    - Youth
    - People who are coming out of incarceration

21. Please describe any strategies used to prevent or overcome the racial disparities in who is unhoused in Vermont.

- Refugees are often excluded from housing subsidy eligibility.
- CE list does not specify race or gender.
- I can't really say that I have seen any active strategies used to prevent racial inequity.
- We have looked at our application data to identify racial disparities but our applicant pool generally reflects the demographic composition of Addison County (though not necessarily the composition of who is poor in Addison County; we don't have that data or at least haven't obtained it if it is available) which leaves us with too small a sample size to draw conclusions about whether racial disparities in who is offered housing and who is not is even a problem. Our staff take Fair Housing Training as continuing education, in order to make sure our policies and practices are nondiscriminatory.
- Race and/or ethnicity are not used as a factor in who is selected to apply for PSH program.
- There really are none. It is a big gap and that has shown itself in PIT [point-in-time] data.
- On-the-ground case work; more accessibility to resources; you have to know what is available and where to look; many people are unaware of what is available to them.
- A scoring and individual interview situation that does not include race as a factor.
- Education around DEI [diversity, equity, and inclusion] work for both our agency and community partners.
- Awareness, acceptance, DEIB [diversity, equity, inclusion, and belonging] work, and trauma-informed care.

22. What do you see as the biggest opportunities with the new Medicaid PSH Assistance Program?

- Staffing to provide services and billing
- Trying out new models for actual PSH as it is practiced in other states on the leading edge of this policy area.
- Flexible payment and delivery mechanism that can help scale successful existing programs such as SASH, SASH for ALL, Housing First, Pathways.
- Increased funding and staffing.
- Serve clients who might not be otherwise served in other capacities.
- Creation of more units.
- Expanding services and offering more PSH for long-term households.
- Housing our homeless.
- Hoping to help more get housed a soon as there is enough housing.
- Possible expansion to include people who need to leave incarceration but cannot due to no approved residence.
- Assistance for every person not just households with youth.
- Helping more families with complex barriers to be housed.

- To assist those who are falling through the cracks.
- Create housing retention supports.

23. What are your biggest concerns for the new Medicaid PSH Assistance Program?

- Bureaucracy associated with Medicaid is an administrative burden that many small housing agencies cannot absorb.
- That it won't involve the housers and won't result in any greater collaboration between AHS and the housing community than currently exists. I'm also concerned that Addison County isn't seen as a priority and won't benefit at all from this program, or a small program will be allocated to the Designated Authority and maybe expand a group home but offer no other real change or progress for our community.
- There will be too many qualifying criteria and parameters on what can be provided, the duration of services and payment model. Services need to happen in housing through trusted relationship building.
- Excessive reporting and data collection.
- Staffing capacity and housing availability.
- Access for people living with complex mental health needs.
- Concerned about the application process and how complicated/lengthy/inaccessible for most applicants it will be.
- Not enough funding, staff, or housing available.
- The "voucher" ends before a suitable apartment can be identified...Lack of housing is huge in the state.
- The lack of these services in the NEK [Northeast Kingdom].
- Not being implemented in a thoughtful way.
- There won't be enough staffing support.
- Appropriate level of funding.

Survey for People with Lived Experience and Family Members: 10 Respondents

Given the small number of respondents, the results are not included in the report, in order to protect the identities of the respondents.