Housing and Services
Resource Center

Housing & Services Partnership Accelerator (HSPA): Accelerating Housing and Services Partnerships to Advance Housing Stability

January 16, 2025

Facilitator

Ryan Elza, Interagency Housing Innovation & Strategy Lead; Office of Interagency Innovation; Administration for Community Living (ACL)

ACL
Administration for Community Living

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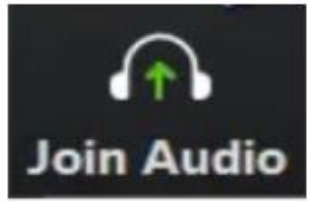
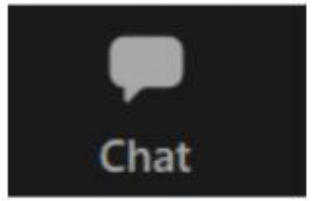
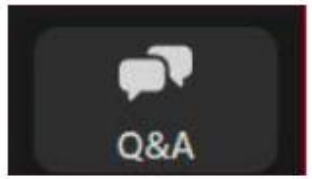


Questions and Comments

- Please actively use chat throughout the webinar, especially for your comments or to connect with other participants.
- To ask a presenter a question, please use the Q&A function.





Or, send your question or comment via email to HSRC@ACL.HHS.GOV

Accessibility

Maximizing view of ASL interpreters

- Enlarge view of ASL interpreter by “pinning” them:
- Click on their video window and select the Pin icon

Screen Reader Users: Reduce unwanted chatter

- Request speech on demand:
- Insert, Spacebar, “S”

Agenda

- **HSPA Overview**
- **A Look Back at 2024 for HSPA States**
- **States Lead the Way: Best Practices, Challenges & Lessons Learned**
  - Maryland
  - North Carolina
- **Q&A**
- **Upcoming HSRC Activities & Closing**

Housing and Services
Resource Center

acl.gov/HousingAndServices #HousingResources

HSRC: Collaboration Among Federal Agencies and Our Networks

U.S. Department of Health & Human Services (HHS)

- **ACL - Administration for Community Living** (Lead Coordinating Agency)
- ACF - Administration for Children & Families
- ASPE - Office of the Assistant Secretary for Planning & Evaluation
- CDC - Centers for Disease Control and Prevention
- CMS - Centers for Medicare & Medicaid Services
- HRSA - Health Resources & Services Administration
- SAMHSA - Substance Abuse and Mental Health Services Administration

U.S. Department of Housing and Urban Development (HUD)

U.S. Department of Agriculture, Rural Development (USDA)

U.S. Department of Energy (DOE)

U.S. Department of Labor (DOL)

U.S. Department of Veteran Affairs (VA)

U.S. Interagency Council on Homelessness (USICH)

Housing

- Continuums of Care
- Public Housing Agencies
- Homeless Assistance Programs
- Multifamily Affordable Housing Owners, Operators, Developers, & Investors
- Landlords

Aging & Disability

- Aging & Disability Resource Centers
- Area Agencies on Aging
- Centers for Independent Living
- Community Care Hubs
- Seniors Centers & Supportive Services
- Assistive Technology Programs

Government

- Federal Agencies
- State Medicaid
- State Unit on Aging
- Housing Finance Agencies
- Municipal & County Government Housing Agencies
- Single State Agency for Substance Abuse Services
- Public Health Agencies
- Cities and Towns

Community

- Community-based Organizations
- Community Action Networks
- Veterans Organizations
- Faith-based Organizations
- Employers & Job Training
- Advocacy Organizations

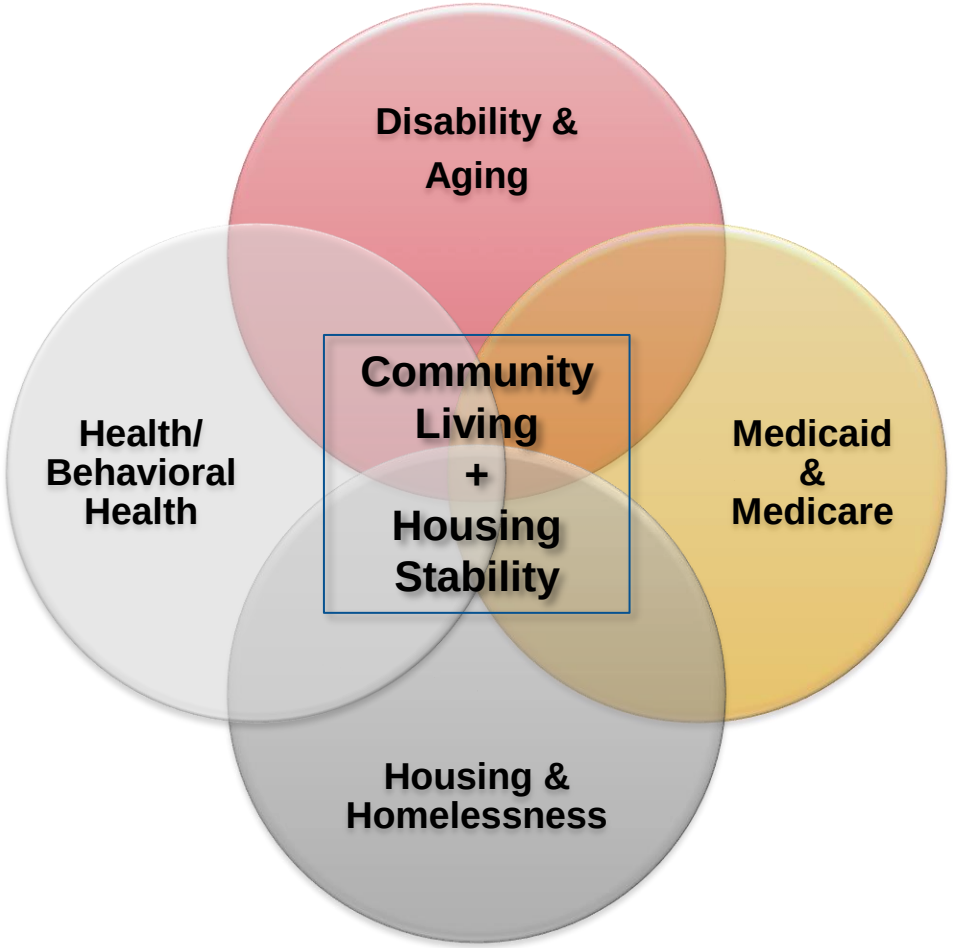
Health & Behavioral

- Managed Care Organizations
- Health Systems
- Hospitals
- Providers
- Federally Qualified Health Centers
- Certified Behavioral Health Clinics
- Behavioral Health Providers

Housing and Services

Housing Alone Is Not Enough

- Some people experiencing or at risk of homelessness need both affordable housing and access to voluntary services to live stably and independently in the community, especially:
  - People with behavioral health needs
  - Older Adults
  - People with disabilities
- Neither the housing system nor the health care system can alone meet these people's needs
- To serve these populations, partnerships among housing, health, and social care systems are key



Housing & Services Partnership Accelerator (HSPA)

Advancing Housing Stability & Community Living

Goal: Support states and communities to accelerate the development and implementation of innovative state strategies to provide housing-related activities and supports to persons with disabilities and/or older adults who are experiencing or are at risk of experiencing homelessness.

Why? The coordination of housing assistance and wrap-around supportive services—such as in the form of supportive housing—is a proven, cost-effective approach to assisting people with disabilities and chronic/complex health conditions to transition from homelessness, exit or avoid institutional settings, and live in the community.

Benefits to State Participants

- Opportunity to develop and expand knowledgebase
- Access to technical assistance to support state activities
- Increased capacity to implement and strengthen strategies for providing housing-related activities, supports, and services
- Implement a whole-of-government approach to address housing stability

Learn More:
https://acl.gov/HousingAndServices/Accelerator

Examples of Housing-Related Services & Supports

Pre-tenancy services,
including transition and navigation services
(e.g., finding and securing housing, one-time transition and moving costs)

Home remediations
(e.g., air ventilation improvements, mold and pest removal)

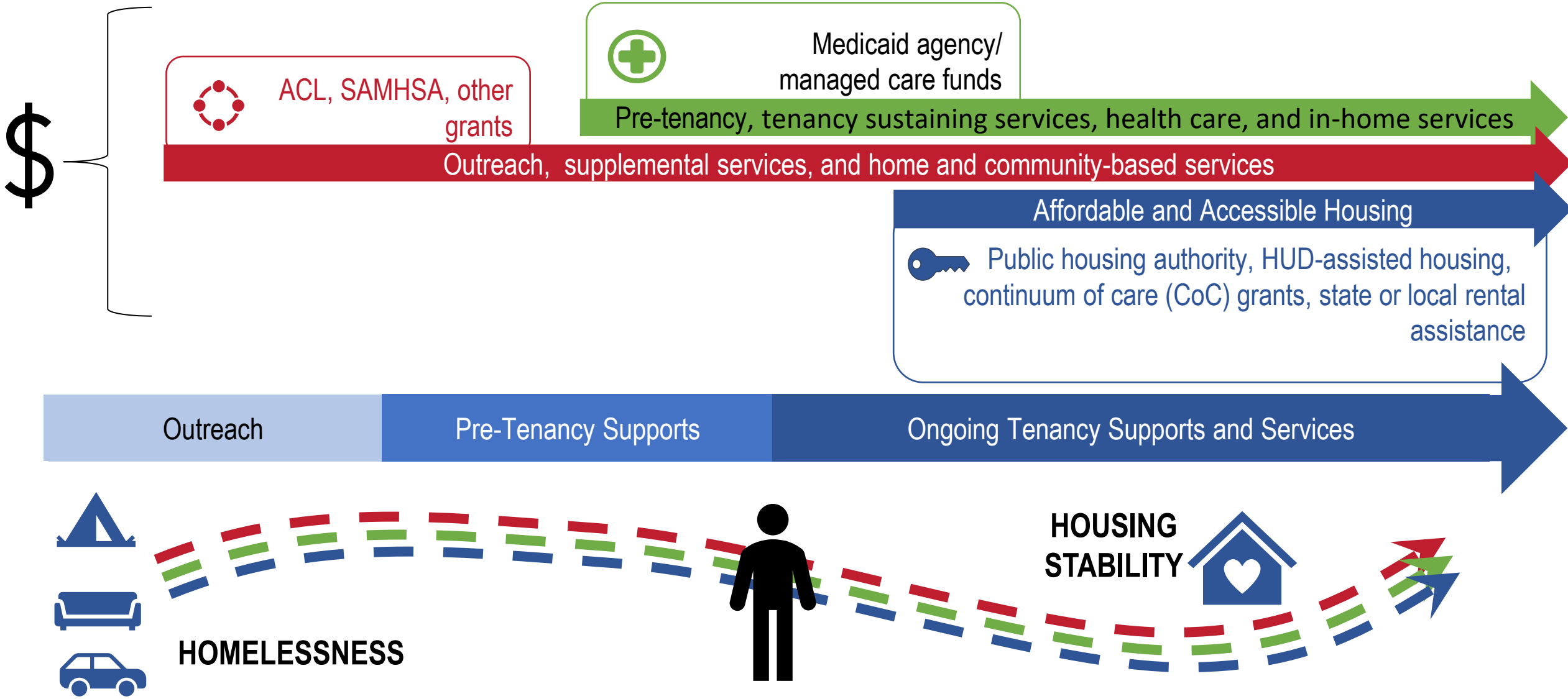
Other supportive services
(e.g., case management, counseling, medication assistance)

Tenancy sustaining services,
including individualized case management
(e.g., linkages to state and federal benefit programs, benefit program application assistance, eviction prevention, tenant rights education)

Home/ environmental accessibility modifications
(e.g., wheelchair accessibility ramps, handrails, assistive technology)

Reference: Coverage of Health-Related Social Needs (HRSN) Services in Medicaid

Housing, Health, & Social Care: Example



Poll #1

Is your state currently covering or planning to cover housing-related services and supports under Medicaid?

- Currently covering under 1915(i) state plan amendment
- Currently covering under an 1115 demonstration
- Currently covering under another Medicaid authority
- Planning to cover under 1915(i) state plan authority
- Planning to cover under an 1115 demonstration
- Planning to cover under another Medicaid authority
- Don’t know/Unsure

Poll #1 Results

Poll #2

How engaged are you in your state's planning and/or implementation related to Medicaid housing-related services and supports?

- Very engaged
- Somewhat engaged
- Not at all engaged
- Not applicable
- Other, explain in chat

Poll #2 Results

A Look Back for HSPA States

HSPA State Participants & Medicaid Authorities for Coverage of Housing-Related Services & Supports

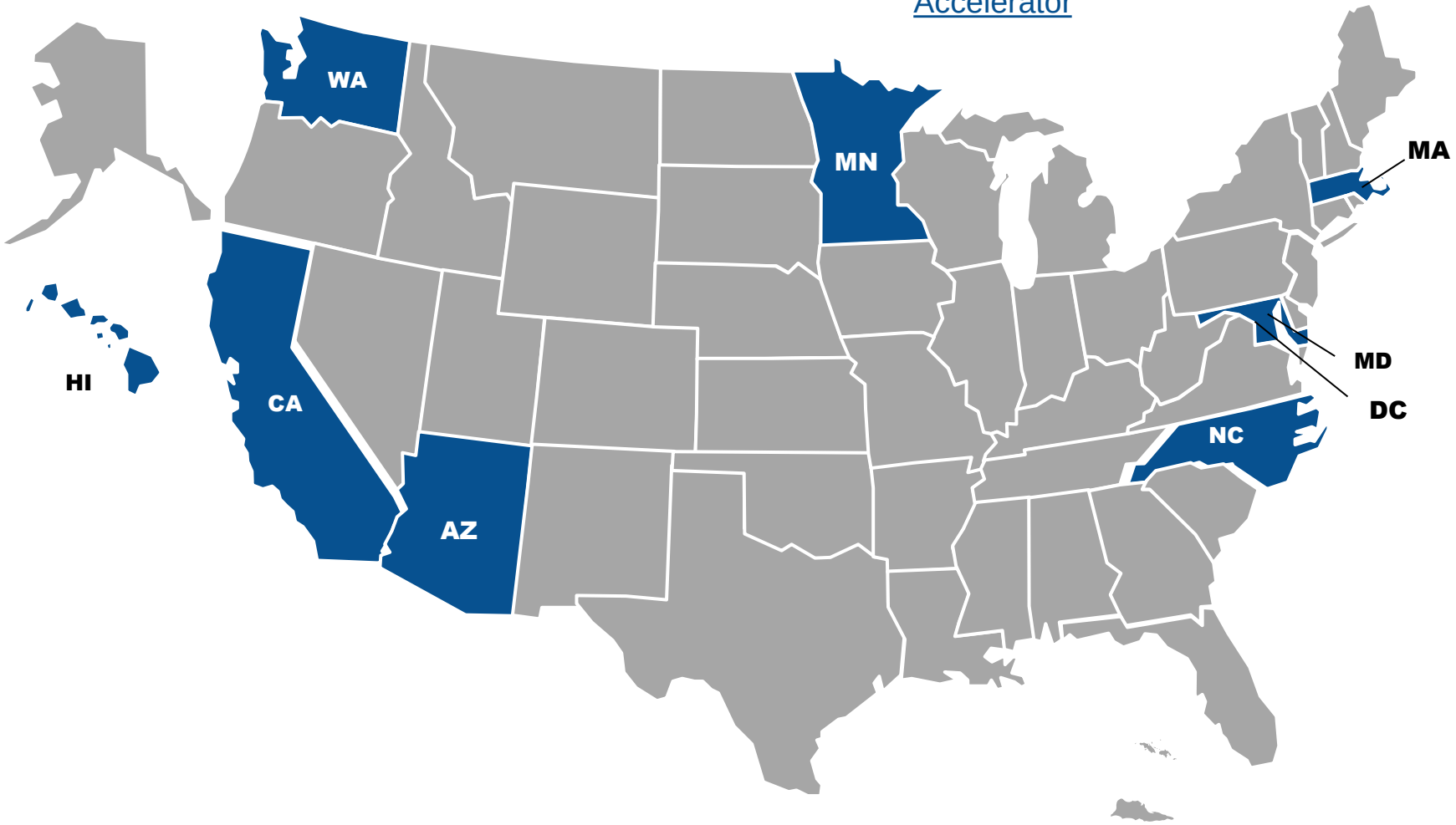
2024 Housing and Services Partnership Accelerator

1115 Demonstrations

- Arizona
- California [w/1915(b)]
- Hawaii
- Maryland [pilot]
- Massachusetts
- North Carolina [pilot]
- Washington

1915(i) SPAs

- District of Columbia
- Minnesota



HSPA TA Components & Timeline

State Kick-Off Webinar

January 2024

State TA Needs Assessments

1:1 State Coaching

February/March - December

Peer-to-Peer Learning Sessions

-Partnerships (March)

-Braiding Funding

-Implementation of Braiding Funding (May)

In-Person Meeting

-All State Panel & Topical Roundtable Discussions

-Data Strategies Peer-to-Peer Learning Session

(June 26-27)

Peer-to-Peer Learning Sessions (con't.)

-Provider Capacity (July)

-Aligning Payment Models & Reimbursement (August)

-Working w/Managed Care (September)

-Scaling Affordable & Supportive Housing Models (October)

-Close Out Session (December)

Final Learning Webinar

January 2025

ACL
Administration for Community Living

State Priority Goals/TA Focus Areas

Strengthening/expanding state/local partnerships between Medicaid, housing, aging & disability sectors, to better meet housing, health & social care needs

Arizona established partnerships with **PHAs** in cities where the highest eligible population for Housing and Health Opportunities (H2O) program reside, created **PHA/Medicaid** roundtable discussions, and established data sharing agreements with all 3 **CoCs** in Arizona. They are also working with the City of Pheonix and **AAAs** for a pilot program referring members to City of Pheonix's HCV program.

Hawaii continued collaboration with their **CoCs** and expanded participation by other stakeholders and partners through weekly meetings.

North Carolina brought **housing partners** together to identify funding streams, services, eligibility criteria which aided in disaster recovery efforts.

State Priority Goals/TA Focus Areas

Braiding & aligning housing & services resources to maximize federal/state/local investments

California developed a plan to leverage HUD Mainstream Vouchers and create awareness of housing subsidy resources available.

Massachusetts held interviews with PSH providers about service funding and strategies to develop a workplan for disseminating successful strategies and overcoming barriers and developing a complete PSH statewide inventory.

Washington worked with its partners to identify a pathway for short- and long-term partnerships to leverage HRSN rental assistance with more permanent housing subsidies.

North Carolina developed a statewide permanent supportive housing framework as a part of their strategic housing plan.

State Priority Goals/TA Focus Areas

Preparing to launch & integrate new 1115 health-related social needs (HRSN) housing supports (e.g., one-time transition/move-in costs, Medicaid transitional rent assistance) with other Medicaid & non-Medicaid services & supports

The **District of Columbia** submitted its application to CMS for 1115 demonstration coverage of HRSNs, leveraging the HSPA to learn from and connect with other states.

Minnesota developed priorities for ongoing enhancements across benefit access, technical assistance, training, and benefit design.

Maryland successfully expanded its Assistance in Community Integration Services (ACIS) program, resulting in standing up a Medicaid billing methodology, as well as an 1115 demonstration amendment submission for increased spaces.

Arizona's Housing and Health Opportunities (H2O) Program went live on 10/01/24.

State Priority Goals/TA Focus Areas

Building provider capacity to deliver & receive reimbursement for housing-related services & supports under Medicaid

Arizona identified various reimbursement approaches to help inform their program model.

Hawaii expanded their community outreach efforts, including taking site visits to Kauhale on Oahu and Maui.

Massachusetts worked to clarify misunderstandings regarding eligibility and the enrollment process for providers that did not have the capacity internally.

Minnesota incorporated their lessons learned from the HSPA into community engagement work, legislative proposals, and a request for rate setting and service design assistance to inform the future direction of the benefit.

State Priority Goals/TA Focus Areas

Working with managed care entities to align requirements, simplify processes & lessen administrative burden on providers

Arizona established a 3rd Party Administrator to contract with providers and administer their benefits.

California developed a plan to create awareness of housing-related supports and services available across Medi-Cal Managed Care Plans, social service agencies, aging and disability networks, and HUD PHAs.

North Carolina worked with managed care organizations to identify service gaps and how to leverage resources across various agencies and programs.

State Priority Goals/TA Focus Areas

Developing payment/reimbursement models, billing strategies & state infrastructure that support quality service delivery

District of Columbia completed a crosswalk of the cross-payer service array and the eligibility criteria to identify gaps in services, challenges with implementation, and opportunities for alignment with their new HRSN housing benefit under their pending 1115 renewal.

Maryland's program expansion planning resulted in standing up a Medicaid billing methodology effective 01/01/25.

State Priority Goals/TA Focus Areas

Accessing & integrating data to support alignment of housing/services eligibility & improve care coordination

Arizona established data sharing agreements with all 3 **CoCs** in Arizona. AZ Medicaid match is now occurring with members in HMIS.

Hawaii continued collaboration with their **CoCs** mapping housing resources and funding infrastructure to identify housing pathway for Medicaid members.

Massachusetts completed analysis from 11 CoCs across the state and various other streams to develop a complete PSH statewide inventory.

Challenges

- The number of PHAs within the state and the need for states to have individual discussions with each of the PHAs.
- The process for aligning referral and application processes/requirements for each PHA requires a considerable amount of time and resource capacity.
- Incorporating health resources into the existing housing system requires a deep focus on stakeholder engagement and identifying best practices.
- Lack of understanding of each partner's limitations and program implementation timelines can result in disrupting goals and plans for service delivery. There is a need to develop a solid understanding of partner agency plans and timelines before setting long-term agendas for programs.
- Some supportive service streams remain underutilized due to a lack of understanding of the eligibility and enrollment processes – a capacity that does not always exist internally among many providers.
- Identifying and ensuring integrity of various cross-agency priorities can be a challenge and requires continued engagement to meet and overcome barriers with solutions that meet the needs of all of the partners involved.

Lessons Learned

- Understanding the programs and resources available through HUD (PHAs and CoCs), AAAs, CILs, and other partners to connect to housing, health and social care services allows for the mapping and braiding of resources for the most effective use of federal, state, and local resources.
- Increased standardization across HRSN services allows for more consistent delivery in local areas.
- Collaboration is critical among key stakeholders who can influence resource allocation.
- Flexibility and agility in program design and implementation, as well as the involvement of key stakeholders from the onset of program design, is critical for sustainability.
- Ongoing technical assistance and training is key to developing and maintaining a provider network that is inclusive of agencies that otherwise do not bill Medicaid for their services.
- Simplifying the eligibility determination process and associated administrative work is key to establishing a timely and responsive benefit.
- Partnership takes time and continued engagement. Formal partnerships with MOUs and other agreements create a sustainable partnership that can develop and adapt over time.
- The existing infrastructure has the capacity and the desire to connect systems if the work is done to map and plan the appropriate coordination solutions.

States Lead the Way: Best Practices, Challenges & Lessons Learned

Maryland

Leveraging HSPA to Support Maryland's First Permanent Supportive Housing Strategy and Scale Up of Housing-Related Services

Maryland
DEPARTMENT OF HOUSING
AND COMMUNITY DEVELOPMENT
Jacob R. Day, Secretary
Julia Glanz, Deputy Secretary

dhcd.maryland.gov

PERMANENT SUPPORTIVE HOUSING FUNDING MODEL

Low Income Housing Tax Credit (LIHTC)

- **Primary source of development financing for affordable rental housing in the United States**
  - The **9% credit** is limited and is allocated through competitive process
  - The **4% credit** is a noncompetitive source and is not limited

- **How the LIHTC funds projects**
  - IRS allocates credits to state governments, generally a state housing agency
  - The housing agency awards the credits to housing developers through competition
  - Selected developers generally sell the credits to private investors to obtain funding (equity)
  - Once the housing project is built and occupied, the investors are able to claim their tax credits and use them to offset their tax liability.

Low Income Housing Tax Credit (LIHTC)

- **Affordable housing projects must meet one of the following three criteria:**
  - At least 20 percent of the project's units will be occupied by tenants with an income of 50 percent or less of area median income (AMI)
  - At least 40 percent of the units will be occupied by tenants with incomes averaging no more than 60 percent of AMI
  - No units will be occupied by tenants with income greater than 80 percent of AMI

Low Income Housing Tax Credit (LIHTC)

- **9% credits are very competitive, so states often require additional criteria and incentives to leverage something from developers, e.g. affordability, accessibility, permanent supportive housing**

- **Each allocating agency issues a LIHTC Qualified Allocation Plan (QAP) that outlines the application process, eligibility priorities and project selection criteria used to award federal tax credits within the jurisdiction**

- **Maryland LIHTC Program**
  - Competitive 9% LIHTC allocation of $16.5M
  - 4% credit projects funded by tax-exempt bonds are accepted on a rolling basis throughout the year
  - Policy Guidance - Tenant Selection Plans
  - Existing Scoring Priorities:
    - Community Context
    - TOD
    - Income Targeting
    - Family Housing

Establishing Permanent Supportive Housing as a Maryland Priority

- Moore-Miller administration released the first State Plan in over a decade, establishing priorities, systems transformation, and initiatives with clear metrics for determining success. Two major metrics are reducing homelessness overall and ending chronic homelessness by 2035.

- DHCD launched new Division of Homeless Solutions in January 2024 to elevate issue of homelessness, create clear leadership on the state's strategy, and increase strategic cross-sector collaboration through the Maryland Interagency Council on Homelessness.

- To achieve an end to chronic homelessness by 2035, the state must increase PSH capacity by a **minimum** of 500-600 units annually for the next 10 years

Permanent Supportive Housing Needs

	Chronically Homeless (all ages)	Rising Senior (55-64)	Senior (64+)
FY23 Annual Total	4,383 (16% of all homeless)	4,813 (15% of all homeless)	1,925 (6% of all homeless)
Adult-Only Households (1-bedroom units)	3,813 (87%)	4,716 (98%)	1,905 (99%)
Families with Children (2+ bedrooms)	570 (13%)	97 (2%)	20 (1%)

- **Income** – 68% of chronically homeless households have **zero cash income**. 95% are under 15% Area Median Income.
- **Accessibility** – 67% of chronically homeless households have permanent physical disability and 25% are age 55+
- **Housing First & Service Needs**
  - 48% of homeless households have at least one criminal case. 27% of these households were eligible for expungement for all cases.
  - 69% of chronically homeless households have mental health diagnosis and 40% have a substance use disorder
- **Geographic Diversity** – Every CoC has a minimum of 50 chronically homeless individuals in need of PSH, with greater needs in urban/metro areas

Prior PSH Strategy/Efforts

- Increases in PSH are largely driven by HUD CoC funding and Housing Choice Vouchers with a homeless preference at local level
- No clear state budget or program to holistically and adequately fund PSH at the scale needed – small programs embedded in multiple agencies with varying target populations and capacity
- Philanthropic commitments limited due to permanency of funding needs
- Launch of Medicaid 1115 Housing and Tenancy Supportive Services waiver in 2017 created opportunity for county governments and Continuums of Care to pair Medicaid-funded services with permanent housing to create PSH
- 2019 LIHTC round included a PSH set-aside that resulted in one project being awarded, creating 35 PSH units

2025 QAP Timeline

January - June	August - September	November-December	January 2025	2028-2029
Research & Plan Development • Chronic homelessness needs analysis • Unit affordability and services gap analysis • Research & consultation with experts and other states • Listening sessions • Partner/funder engagement	**1st Draft QAP Released - Link** • 30 day public comment period	**Public Hearing & Final Draft** • Governor signs plan after public hearing	**Competitive 9% QAP Round** • Approximately 90 days from QAP effective date to application due date	**Units Placed in Service and Available for Leasing**

2024 Final QAP Strategy

- **9% Competitive Round Projects**
  - Set-aside for 2 permanent supportive housing projects (higher density of PSH)
  - All other projects have a required homeless preference for 15% of units

- **Both 9% Competitive Round and 4% Projects**
  - If state has rental subsidy and supportive services funds available for PSH, projects must accept them

- Places burden on state to secure rental subsidies to cover affordability gap - critical for volume of units state needs to create

- State matches projects to local supportive services provider participating in Medicaid 1115 waiver pilot for housing-based case management/tenancy support services, and/or contracts with supportive services provider directly

Funding and Partner Roles

State

- Administer state project-based rental assistance (PBRA)
- Secure vouchers from PHAs
- Match PBRA, vouchers, and other subsidies to properties
- Match supportive services providers participating in Medicaid 1115 waiver to properties (annual expansion of services)
- Review/enforce property compliance with tenant selection, CoC referrals, troubleshoot slow referrals and vacancies
- Track housing outcomes through homeless services data warehouse

Property/Manager

- Develop quality and accessible units
- Accept referrals exclusively from CoC
- Low-barrier tenant selection plan
- Completion of state-provided training and learning collaborative
- Proactive tenancy problem-solving (avoid eviction as a solution)
- Provide office or meeting space on-site, if possible, for case management

Continuum of Care

- Ensure accessible Coordinated Entry assessment and prioritization process that can screen for eligibility for PSH requirements and/or general homeless preference
- Timely referral of prioritized households for vacancies at lease-up and turnover
- Collaborative move-on support or program transfers with service provider

Service Provider

- Leveraging/match of other funds to fill gaps in activities not eligible for Medicaid reimbursement (with DHCD support)
- Comprehensive, proactive supportive services provided through voluntary participation

Policy & Program Design Factors

- **Eligibility Criteria** - Less restrictive/specific than HUD definition of chronic homelessness
  - Include individuals in transitional housing or exiting from institutions with prior long-term homelessness
  - Definition of disability
  - Lower third-party documentation requirements and breaks in homelessness

- **Referral Coordination** - Solving access challenges for disabled individuals who are homeless but not engaged with a CoC service provider and in Coordinated Entry

- **Quality Supportive Housing** - Owner/property manager/service provider learning collaborative, technical assistance, and ongoing annual training. Assessments for fidelity to quality supportive housing model.

- **Participant Choice & Housing First** - Planning for tenant mobility and relocation needs

States Lead the Way: Best Practices, Challenges & Lessons Learned

North Carolina

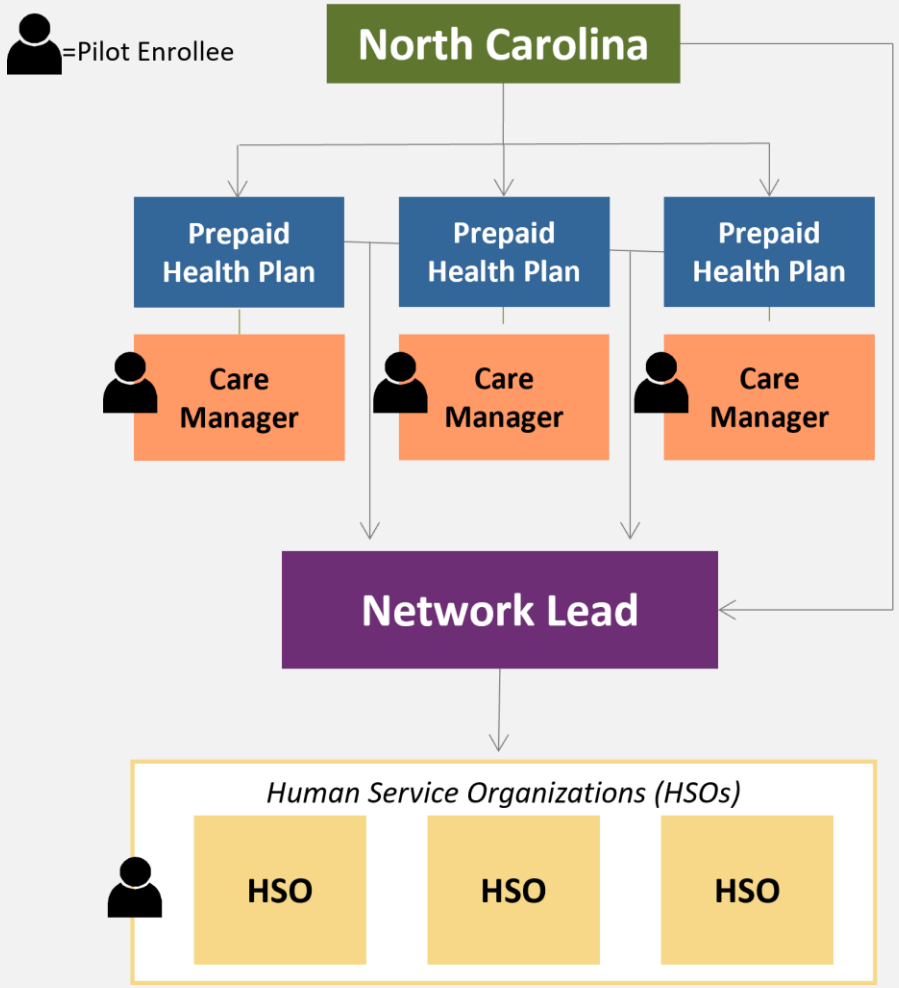
The overarching goal with HSPA was to connect siloed programs.

The team identified areas where programs can connect:

- Front end eligibility and referral
- Identifying and addressing service gaps by mapping current services provided by each program
- Cross-program provider training, certification, TA, and quality assurance
- Expansion of affordable housing resources for all three programs
- Cross-agency governance structure to oversee future work

Healthy Opportunities Pilots: How Do They Work?

Sample Regional Pilot



HOP Overview

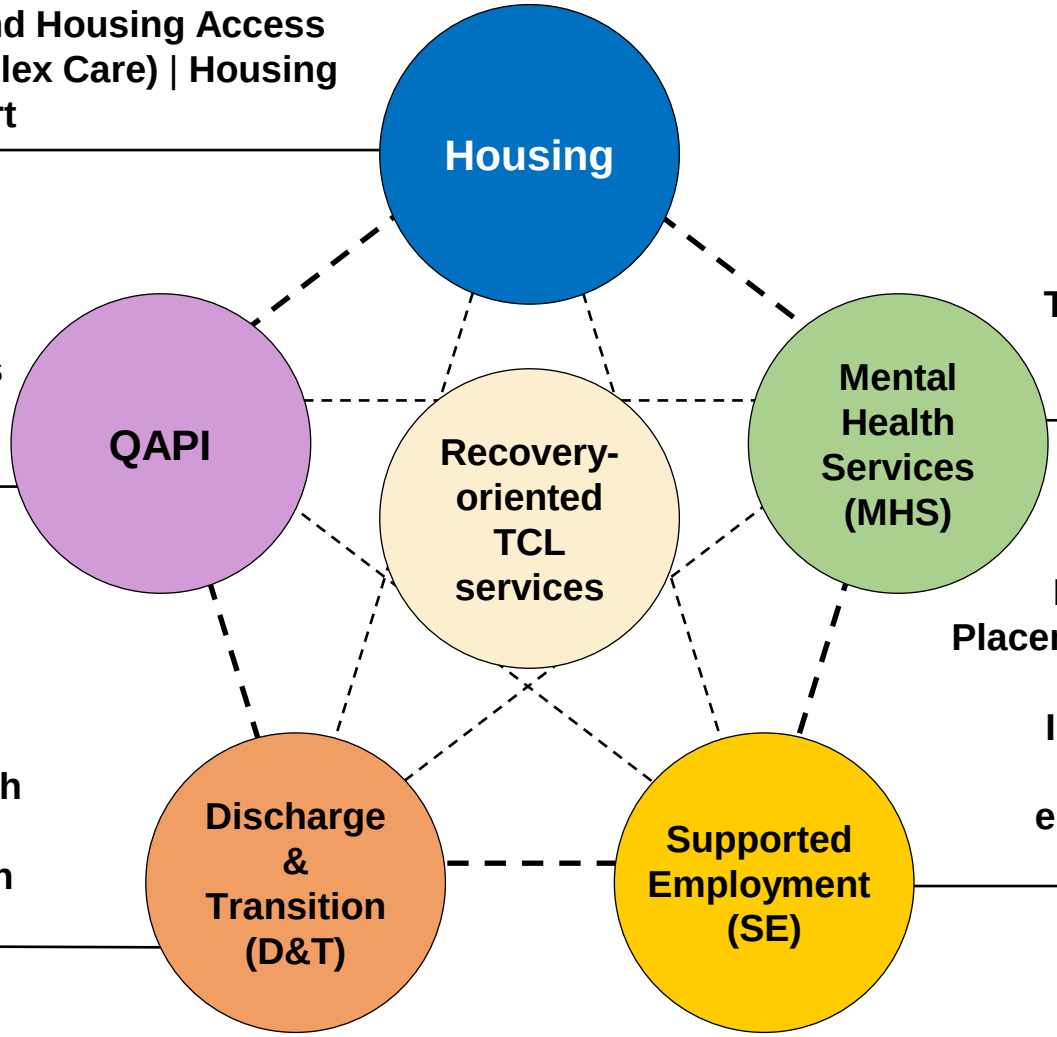
- **NC's 1115 Medicaid transformation waiver** authorizes the use of state and federal Medicaid funding for the Healthy Opportunities Pilots
- **Pilot funds are used to:**
  - Pay for **evidence-based, federally-approved, non-medical services** defined and priced in NC DHHS' Pilot fee schedule
  - **Build capacity of local community organizations** and **establish infrastructure** to bridge health and human service providers
- **Pilot Vision and Goals:**
  - Integrate evidence-based, non-medical services into Medicaid to:
    - **Improve health outcomes** for Medicaid members
    - **Promote health equity** in the communities served by the Pilots
    - **Reduce costs** in North Carolina's Medicaid program
  - **Evaluate** which services are highest value & impact for which populations
    - CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback, concluding in a summative evaluation
  - Create **accountable infrastructure**, **sustainable partnerships** and **payment vehicles** that support integrating highest value non-medical services into the Medicaid program sustainably **at scale**

TCL Framework – Key Priority Areas and Functions

The Transition of Community Living (TCL) Settlement Agreement between North Carolina Department of Health and Human Services (NCDHHS) and the USDOJ created six pillars that provide the TCL framework. Discharge and Transition (D&T), and Admission and Pre-Diversion are both captured in one pillar, given Adult Care Home (ACH) focus overlap.

Increasing Transitions | Expand Housing Access and Retention (includes Complex Care) | Housing Pilot | Strengthen Peer Support

Measure Review, Quality Assurance and Performance Improvement (QAPI) Cycles, & Consulting for all Pillars | Analysis and use of data for Continuous Quality Improvement (CQI)



Tenancy Support (includes Peer Support) | Community Integration | Person-Centered Plans | Network Adequacy

NC CORE standardization | Individual Placement and Support (IPS) Provider Rate adjustment | Service Providers with Integrated Behavioral Health (BH) and Employment | Executive leadership engagement and ownership | Targeted Employment Outreach

Tailored Stratification for In-Reach & Transition | Streamline Resolution of Barriers | Transition Team Monitoring

TCL implementation requires collaborative, cross-agency efforts for timely success *(e.g., regular twice/week Pillar meetings, division updates)*

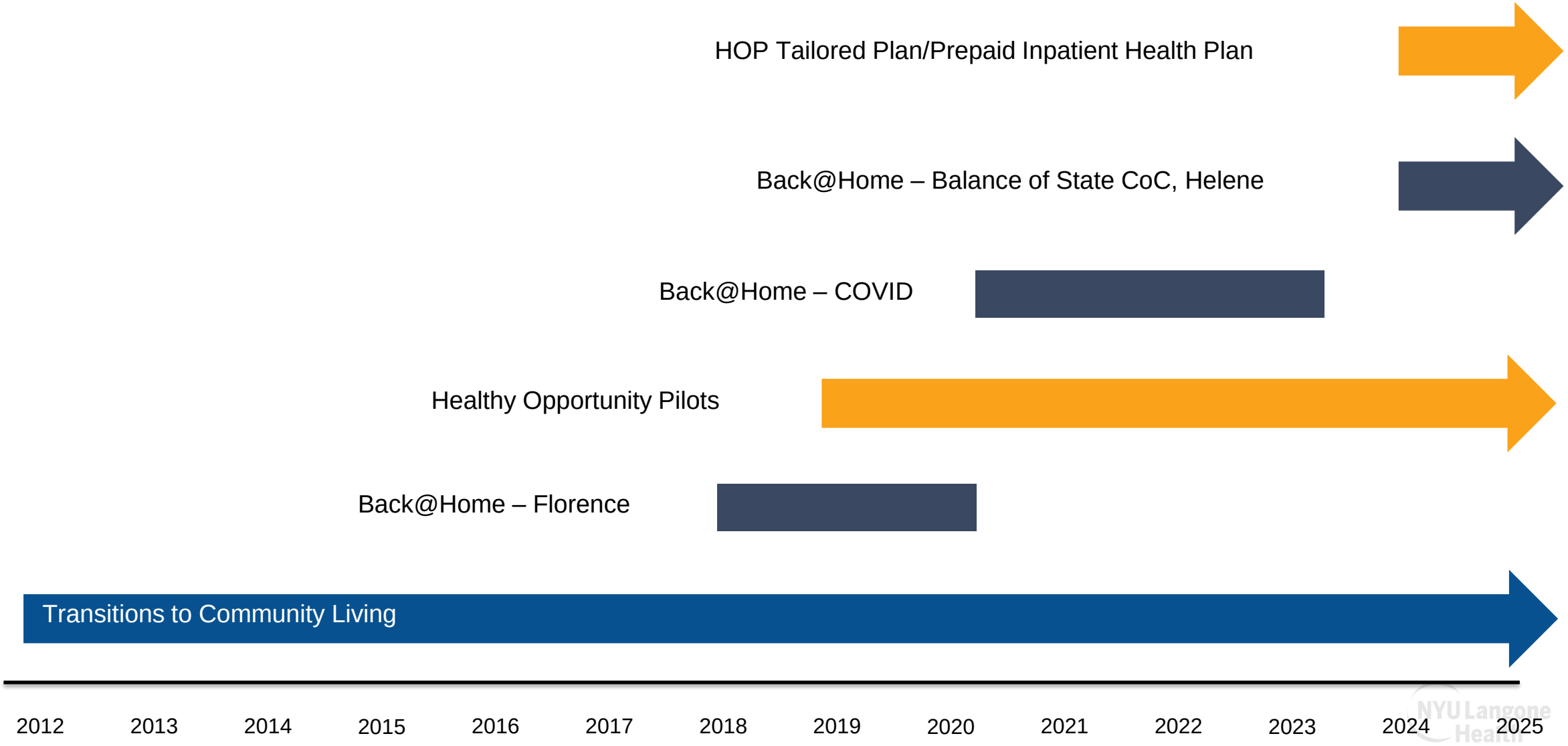
Back@Home Overview

- Provides financial assistance and housing stabilization services, enabling households to obtain and maintain housing

- Braids together funding from Continuum of Care Special NOFO funding, Emergency Rental Assistance, State Fiscal Recovery Funds, and soon, Rapid Unsheltered Survivor Housing

- Innovations in design:
  - Centralized financial assistance and property provider recruitment
  - Mirrors HOPs payment for housing stabilization services using a PMPM model
  - Scalable as new funding is added to the program

Building Upon Innovation



Impacts of the Programs in North Carolina

- Healthy Opportunity Pilots
  - $85 per member per month reduction for those receiving HOP services comparing HOP and non-HOP counties
  - Reductions in emergency department utilization and hospitalization

- Transitions to Community Living
  - 84% participants retaining housing
  - Went from 1,000 annual admissions to adult care homes to 65 or less annual admissions for people with severe and persistent mental illness (SPMI)

- Back@Home
  - 464 households housed as of January 9, 2025 (almost a full year)
  - Quickly able to scale up to assist households in disaster shelters after Hurricane Helene

HSPA advanced our work as a state.

- Provided the team with space and accountability to get the work done which allowed the team to prioritize the work.
- Despite different perspectives, the team was able to get above the jargon and see the commonality in the programs.
- Built relationships among program leadership and staff
  - Newfound appreciation of peer group at the state level
  - Provided cross-fertilization of the programs and added intention to the work
- Provided immense learning from HSPA peer group and allowed us to benchmark our work against a peer group of states
- Completed services and eligibility crosswalk, PSH framework, and have recommendations for next steps in each of the 5 areas identified to connect the programs.

Questions for States

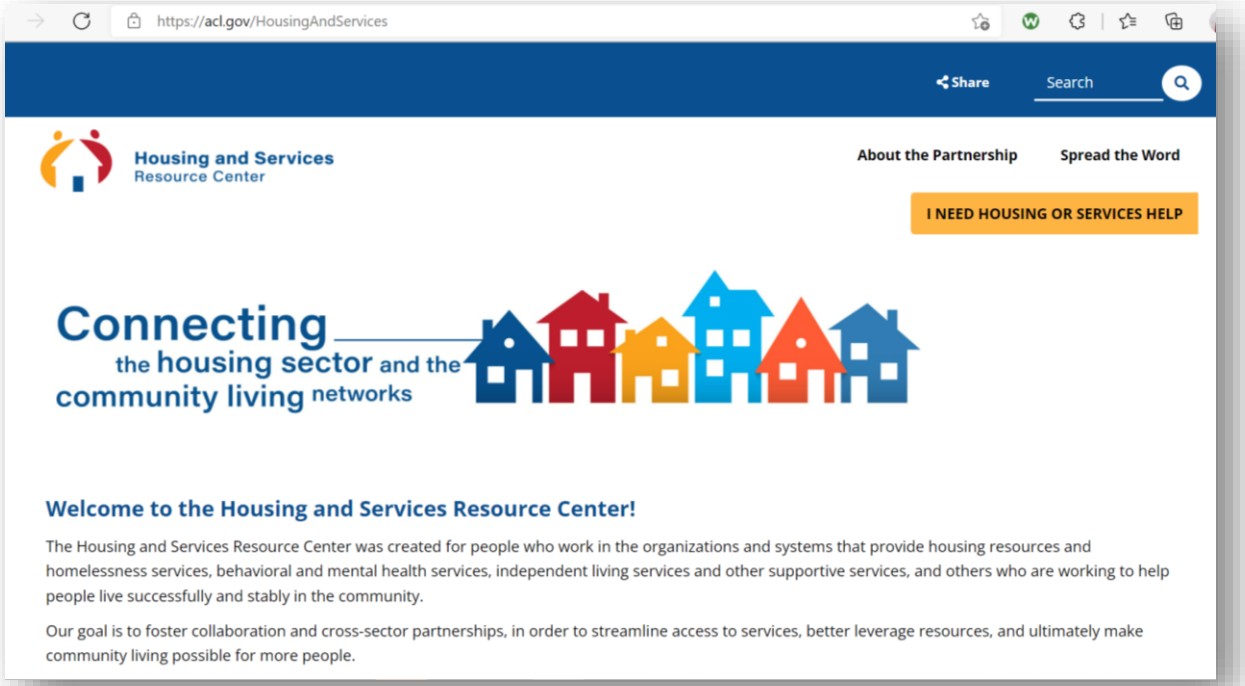
Help Us Improve

Please complete our short feedback form at:

https://www.surveymonkey.com/r/BXJHV5H

HSRC Website

- Slides, recording, and transcript from today will be posted on the HSRC website.
- For that and other helpful links to resources, please visit: https://acl.gov/HousingAndServices



Connecting the housing sector and the community living networks

Focus Areas

Explore accessible, affordable, fair housing; homelessness; supportive services; tribal housing; and transitions

Models

Use these guides, examples, practices, and more to help you build, adapt, and grow partnerships across sectors

Tools

Find tools to support action, including data, reports, directories, training, toolkits, and funding information

What's New

Check this page regularly for our latest news and updates on webinars, tools, and technical assistance

acl.gov/HousingAndServices

Housing and Services Partnership Accelerator Webinar Series: Emerging Findings on Strengthening Housing, Health, and Social Care Partnerships

Session Name	Description	When
Housing and Services Partnership Accelerator National Webinar	Select HSPA states will share best practices, challenges, and lessons learned as they develop and implement effective partnerships and innovative solutions to advance housing stability. Presenters will briefly review federal collaborative efforts and describe the individualized technical assistance and facilitated peer learning opportunities offered to states through the HSPA. Participants will learn about the growing array of HSPA and related HSRC resources to support state and local efforts to align housing, health, and social care.	**View recording and materials on HSRC website. – Emerging Findings: Session 1**
Accelerating Housing and Services Partnerships to Advance Housing Stability: Area Agencies on Aging (AAAs)	Discover how a local AAA delivers various supportive housing services and partners with their local public housing authority.	**View recording and materials on HSRC website – Emerging Findings: Session 2**
Accelerating Housing and Services Partnerships to Advance Housing Stability: Centers for Independent Living (CILs)	Learn how independent living community organizations provide housing-related services and support to people with disabilities.	**View recording and materials on HSRC website – Emerging Findings: Session 3**

Housing and Services
Resource Center

ACL is here to help you and your staff!

Email us at hsrc@acl.hhs.gov

- We want to learn about your **partnerships and innovations.**
- We have **technical assistance** available.
- We welcome subscribers to the **HSRC Listserv** (18,000 and growing).
- Visit the HSRC hub at acl.gov/HousingAndServices.

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