Housing and Services
Resource Center

HSRC National Webinar

January 16, 2025 | 3:00 - 4:30 pm ET

RYAN ELZA (ACL):

It's 3:00 and we have a great webinar today, so we'll get started and welcome to the fourth webinar in the Housing and Services Partnership Accelerator webinar series highlighting insights and innovations and cross sector innovation throughout there the first cohort of our 12-month accelerator program. My name is Ryan Elza. I'm the interagency housing innovation and strategy lead for the Administration for Community Living. Which is an operating division of the U.S. Department of Health and human services and I'll be serving as our facilitator today. We would love for you to introduce yourself in the chat, so please share your name, your organization and where you are joining us from today. And next slide please.

First a few housekeeping notes, use your computer speakers or dial in with the phone number in your registration email. Please note that all apartments are polluted. Please use the chat in the webinar to make comments or connect with other apartments to ask a question that might be answered during the Q&A presentation section of our presentation today use the Q&A function in Zoom. Don't put your questions in the chat use the Q&A function. This will allow presenters to find your question and you can send the questions to the HSRC@acl.hhs.gov, someone will be monitoring the inbox throughout the webinar. And note this event is recorded and by staying to participate you are agreeing to participate in the recording. Next slide.

A few notes on accessibility. We have ASL interpreters pinned throughout the webinar. So, enlarge the view of the interpreter, you can click on their window and select the pin icon to maximize your view. For screen readers if you would like to reduce unwanted chatter you can request speech on demand and the spacebar and letter S on your keyboard. Next

slide. And here is our agenda for today. First, we are going to provide a background and overview of the accelerator. Then we'll take a look back at the 2024 accelerators activities and focus areas and then hear from two of our of 2024 participates states Maryland and North Carolina and then we'll are time for questions and answers with our representatives and please use the Q&A function to ask questions. And we'll get to as many as we can. And then we'll finish with upcoming activities and resources to inform your work to strengthen, housing, health and care partnerships. Next slide, please.

The Housing and Services Partnership Accelerator is an activity of the housing and services resource center or HSRC. The HSRC was launched by the U.S. department of Health and Human Services and the U.S. department of Housing and Urban Development in 2021. The HSRC has a cross sector of private and public partnership between the organization and systems that provide housing and homelessness resources and health care services and independent living service and other services part of the HSRC is part of an interagency initiative to streamline access to affordable housing and the services that make community living possible. Our partners launched the accelerator in partnership with states and communities to help align housing, health, and social care. Next slide, please.

In its three years of existence the HSRC has grown to a cross sector of federal team led by ACL. And in close partnership with the U.S. department of Housing and Urban Development. Next slide, please.

But the HSRC and the accelerator are far from insular federal convenings, we partner with states Tribal Nations and organizations local governments, disability and aging agencies and organization, homeless advocates, substance use disorder and mental health providers, homeless Continuum of Care and housing providers and developers and faith-based organizations. There's a wide array of agencies and organizations that deliver housing and health care and social care services and it's important for all states and communities to consider partnership across sectors with these agencies and organizations especially those that are directly delivering services to people at risk or experiencing homelessness, older adults and people with disabilities to achieve community living and housing stability. Next slide, please.

As you know the lack of affordable accessible housing is a primary cause of homelessness and many people experiencing homelessness are people with disabilities or older adults or people with behavior health needs. For them housing alone is not enough to live stably housed in the community without wrap around supports we'll never achieve our goal of housing stability or helping individuals achieve or maintain independence and full community participation. To full strengthen cross sector partnership the HSRC alongside

the federal partners launched the Housing and Services Partnership Accelerator. Next slide, please.

The goal of the accelerator is to support states and communities to accelerate the develop and implementation of innovative state strategies to provide housing related activities to provide support of people with disabilities or at risk of experiencing homelessness. And we know the coordination of housing assistance and wrap around, and supportive systems is an effective approach to assisting older adults, people with disabilities, individuals with chronic and chronic health conditions transition from homelessness, exit or avoid institutional settings and live full and independent living within the community. Next slide, please.

Access to safe housing, healthy food, transportation and other basic needs can have a significant impact on a person's health, their ability to maintain their health coverage, and their connection to their health care providers. In November 2023, CMS provided guidance on opportunities to cover clinically appropriate supports that address health related social needs and framework of support that CMS allows under Medicare and children's health insurance program or CHIP authority. And this builds on previous guidance and builds on policy from section 1115 demonstration for states to partner to partners to realize this opportunity. This innovation connects the goal of connecting people with intervention and housing and local social service agencies to improve access for individuals with specific clinical conditions. On this slide you can see examples of housing related supports and services. Such as case management. Pre-tenancy services that include housing navigation. Application for finding and securing housing. Sustaining services. That includes things such as linkages to state and federal benefit programs. Applications. Eviction prevention. And tenant rights. And home remediation and home accessibility modifications such as wheelchair ramps and assistive technology. With our TA we are helping states to find solutions to the challenges how to operationalize these supports. Next slide, please.

This illustration will give you a high level sense how housing, health, and social care partnerships can support an individual with exiting homelessness. The top arrow showing the funding streams that can be braided together to provide a seamless set of supports for individuals in the community. Green is the Medicare or managed care funding for not only health care but pre-tenancy and it's sustaining services as well as in-home services. In red, we have grants. And other types of funding sources from agencies such as ACL, SAMHSA and other sources that community providers can use to provide outreach to people unhoused and provide an array of supplemental services and home and community-based services. In blue you'll see an array of rental assistance that might be available such as a

housing voucher or rental assistance from a housing authority. A Continuum of Care, a state rental assistance or other supports. And all three supports ideally are available and coordinated as an individual journeys from a homelessness to housing stability and the line is dashed because it should be modified to the vim's preference and needs.
And this model exudes with cross sector collaboration to so the period of homelessness is brief and one time. Next slide, please.
So now we would like to do a couple quick polls. And if we could bring up the poll, please. So our first question is we want to know for you in your states is your state currently covering or planning to cover housing-related supports and services under Medicare? So the first response is currently covering under 1915(i) state plan amendment. The second response option is covering under an 1115 demonstration. Third is currently covering under another Medicare authority. Fourth option is planning to cover under a 1915(i) state plan authority. And then the 5th option is planning to cover under an 1115 demonstration. 6th is planning to cover under another Medicare authority. Or our last option is don't know. Or you are unsure. We'll give it one second. Why don't we go ahead and show the results. Um, so a lot of folks are unsure what housing related supports might be covered at your state level. And my colleagues would be happy to share some resources in the chat. So you might be able to find out what housing related supports and services might be covered in your state. So our next poll. Next slide. Please. Is how engaged are you in your state's planning or implementation related to Medicare housing related supports and services? So are you very engaged? Somewhat engaged. Not at all engaged. Not applicable because they are not currently being implemented in your state. Or other. Feel free to explain in the chat. And we'll give folks a minute to respond. And let's bring up the results, please. We have a good distribution we have 11% who are very engaged. 27% are somewhat engaged. 29% are not engaged at all. And we have 19% of folks who say it's not applicable. Okay. Let's move on. So let's go to our next slide, please. So now we are going to take a look back for our accelerator states. So next slide. Please. To be eligible to participate in the accelerator, states have to have an approved 1115 demonstration of an 1915(i) state amendment that included coverage of housing related supports and services. Through a competitive process, 8 states and the District of Columbia were selected to participate in the yearlong accelerator. These states formed multisector teams to bring together aging and disability, housing and homelessness, health, including behavioral health, and social care. And Medicare. You can learn more about the 2024 accelerator cohort on the HSRC webpage. And my colleagues will drop a link to that in the chat. Where you'll find access to records of the learning track sessions, resources developed through the accelerator, and recordings of previous national webinars. Next slide, please.

Here you can see a timeline of the activities and technical assistance that states participated in the 12-month accelerator. In January we held a kick off webinar with all participates states to they could meet your peer states and TA providers and federal agency partners and discuss their goals and technical assistance needs. And individualize needs assessment was conducted with each state in order to tailor the individualized technical assistance and peer learning opportunities. One-on-one state coaching was delivered to each of the states. So each state was assigned a two-person coaching team with a housing and a Medicare services subject matter expert, coaches met regularly with cross agency state teams to offer subject matter expertise and one-on-one implementation support. States participated in monthly interactive group learning webinars that were held on topics of common need identified through the state's needs assessment. And you'll see a list of the topics listed here on the timeline. States also have the opportunity to attend a two-day in-person meeting that was sponsored by our wonderful colleagues at SAMHSA in the DC area where they participated in topical learning sessions and round table discussions along with plenary sessions that provided opportunities for federal dialogue and support. And finally the states participated in a close-out session to celebrate their accomplishments and progress achieved over this 12-month period. Next slide, please.

We wanted to provide some examples of the types of priority goals states focused on and some select accomplishments that states achieve during the accelerator. We are not going to walk through each of these state examples but these slides will be available after today's webinar for you to be able to see all of today's examples provided and the incredible accomplishments that states achieved in reflection of our close-out session in December it was incredible to see all progress that the states have made over the past 12 months.

So the first focus area for all states was strengthening and expanding state and local partnerships between Medicare, house housing, aging, and disability. So one example of a state that was able to really achieve this goal was Arizona, who was able to establish partnerships with their PHA Public Housing Agency and local area agencies on agency, or AA in key cities where they had high concentration Medicare eligible individuals for these particular services. They were also able to establish data sharing agreements with all three of their homeless Continuum of Care. Next slide, please. The next focus was braiding and aligning housing and services resources in order to maximize the federal, state, and local investments. Washington State worked with its partners to identify a pathway for short term and long term partnerships in order to leverage their health related rental assistance

with more permanent housing stability or housing subsidies which was a really exciting development throughout the accelerator. Next slide, please.

The next focus area was preparing to launch and integrate new 1115 health and social needs housing supports so the District of Columbia was able to submit its application to CMS for their 1115 demonstration coverage of health and related social needs and leverage the housing services accelerator to learn from and connect to other states who went through this experience or was actively working on their application as well.

Next slide, please.

States also focused on building provider capacity to deliver and receive reimbursement for housing related supports and service under Medicare. So Minnesota, for example, incorporated their lessons learned from the accelerator into community engagement work, level proposals and the request for rate setting to inform the future direction of their benefit. States also focused on working with managed care entities to align requirements, simplify processes and lessen the administrative burden on providers. California developed a plan to create awareness of housing related supports and services available across med-cal, managed care plans, aging and disability agencies and HUD public housing authorities. Next slide, please.

States also focus focused on developing payment and reimbursement models and state infrastructure that supports quality service delivery. Maryland's program which you'll hear about a little bit later on the program expansion resulted in standing up a Medicare billing methodology that was effect in my view this January. Next slide, please. Lastly, states focused on accessing and integrating data to support alignment of housing and services eligibility and improve care coordination. Arizona as mentioned previously was able to establish data sharing agreements with all three CoC in Arizona and Arizona Medicare match is occurring with members in their homeless management system which is a really exciting development. Next slide, please.

While the states had a lot of progress and common areas and goals they also had some common challenges they encountered during the accelerator, which we wanted to uplift today for state who is are thinking about going down this journey to think through as they plan for the implementation of their house housing related supports and services.

First the number of public housing authorities in a state is a opportunity for states to really connect with those public housing authorities to incorporate them into their benefit, design, and service delivery. But there's also a need for states to have individual discussions with each of the public housing authorities given the structures of PHA operating independently of one another. The process for aligning referral and application processes and requirements for each public housing authority requires a considerable

amount of time and resource capacity at the state level. Incorporating health resources into the existing housing system requires a really deep focus on stakeholder engagement and identifying best practices.

A lack of understanding of each partner's limitation and program implementation timelines can result in disrupting goals and plans for service delivery so there's a real need to develop a solid understanding of partner agency plans and timelines before setting long term agendas for programs.

Some supportive services, streams remain underutilized due to a lack of understanding of the eligibility and enrollment processes. And capacity -- this is a capacity that does not always exist specially among many providers. And then lastly, identifying and ensuring integrity of various cross agencies priorities can be a challenge and require continued engagement to meet and overcome barriers with solutions that meets the needs of all the partners involved.

Then next slide, please. We also wanted to provide you with some key lessons learned from the accelerator as well. So the first one is really understanding the programs and resources available through federal funding such as HUD's public housing authorities, homeless Continuum of Care, entities funded through the Administration for Community Living such as local area agencies on aging or centers for independent living and other partners to connect housing and health and social care services allows for more mapping and braiding of roars if the most effective use of federal and state local resources. Increased standardization across health related social needs services allows for more consistent delivery and local areas. Collaboration is critical among key stakeholders who can influence resource allocation. Flexibility and agility in program design and implementation as well it's involvement of key stake holds 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 do not otherwise bill Medicare for their services. Simplifying the eligibility determination process associated administration work is critical to establishing a timely and responsive benefit. Partners take -- it takes time to build partnerships and continued engagement. So formal partnerships with MOUs and other agreements create a sustainable partnership that can develop and adapt over time. And lastly, the existing infrastructure has the capacity and desire to connect systems if the work is done to map and plan the appropriate coordination solutions. And so with that, next slide, please. We want to hear from two of our incredible states who participated in the accelerator. So it's my honor to introduce our speakers from the participating accelerator teams who will share about their progress to date in the accelerator. Lessons learned. And best practices so first we are going to hear

from Danielle and Gregory from Maryland and then the North Carolina team will cover their findings and with that I'll hand it over to the Maryland team.

Claire Gregory (Maryland): Hey, everyone, good afternoon, apologies I'm trying to get my start video option is not popping up but I'll get started I'm Claire Gregory a senior program manager -- here we go, thank you, I'm alive I'm here, hi. My name is Claire Gregory. I'm a senior program manager with the program of health and in the program of health care financing and we function as the state Medicare agency. And I'll give a brief overview of our pilot in Maryland and then hand it over to the Maryland assistant secretary for the division of homeless services Danielle. So we talked about it a little bit in our time together but this pilot has been active in Maryland since 20 Known it's community integration services a fancy term that Maryland came up with CMS and we provide tenancy and housing services for eligible Medicare apartments and it's active in four sections in Maryland it's three urban and rural and it's in [listing counties] and Cecil county in the eastern shore of that I recalled with you this administration is at the local level but the health care department and the Continuum of Care leads they contact the provide tore serve the eligible population. We are super excited because this week our 1115 amendment was approved by CMS. Originally we were able to serve up to 900 apartments and now we can serve up to 2,140 which is amazing. And we received funding from our governor for $5.4 million and which brings up general budget up to 10.8. We are eager to get started. I want to say in the last year or HSPA TA experience was critical to driving all of this work forward at the Department of Health level and aging and disability and housing. We were developing codes, rates, policy documents. I got a lot of help from Janice and Laura they were amazing. It helped strengthen strength between our departments and it was department of housing and aging and disabilities and health. And we applied together and participated together. Everybody was instrumental in developing the benefit and expanding it out. Just from things from reporting compliance to sharing best practices and lessons learned from states and agencies and this opportunity has taken us really far. So, starting this quarter our aces providers enroll as Medicare providers and bill claims and our team is busy here at the state Medicare agency to provide technical assistance to the current providers and work on expanding this pilot statewide. So I would now like to introduce the assistant secretary for the division of homeless services, Danielle.

Danielle Meister (Maryland): Good afternoon this is a great afternoon to start with the aces pilot because it's a critical component of our new supportive housing we developed with all the resources and technical assistance we received over the last year. The

connections with the states participate and the TA providers were really beneficial to helping us learn the best practices around how other states are leveraging their housing financing to create more housing for people who are experiencing homelessness. So this is our first strategy. I like to say. Base we have a lot more planned. But for those that are not as familiar, permanent supportive housing typically relies on three different funding components. The physical unit someone lives in. you have to have supportive services for folks. And you have to have operating or a rental subsidy. So next slide. And the operating piece is really important because the typical person experiencing homelessness has really extremely low income that even in an affordable housing world isn't enough to be a renter. So it's a really key piece of the puzzle. So, for those that might not interact with the low income housing tax credit program much it's the number 1 source of development financing for affordable rental housing in the U.S. and the largest driver of housing production overall. There's two types of the tax credit. That's 9% credit that's more limited that is specific allocation that goes to states and it's allocated to projects through a competitive process each year. There's also a 4% credit, which is not as valuable but still really beneficial that's non-competitive and it's not limited.

So housing providers or housing develop earls apply for these credits and the 9% credit provides a bigger boost to their project and makes its more financially viable. So it's really lucrative for housing developers to go after the 9% credits and how it works is the IRS allocates these credits to state governments and generally it's a state housing agency. It might be a housing finance agency, which sometimes can be in a state government or it can be a quasi. And the housing agency awards the credits to the developers through that competition. And then they sell those credits to private investors to obtain funding or equity in a projector. And once that housing project is built and occupied investors are able to use those credits to offset the tax liability. Theres a funding model maybe outside how the realm how we fund services. Often times we make a grant and the services are delivered. This is a funding stream that involves in the private investors and the private market. Next slide.

Affordable housing projects to be eligible for tax credits have to be meet one of the following criteria. They either have to have at least 20% of the projects units occupied by tenants with a tenants of less than 50% and of an area of income covering no more than 60%. And no units can be covered by tenants with a income greater than 80%. And you only have to meet one of these three criteria.

Next slide. The 9% credits are very competitive. A lot times states integrate additional priorities to achieve their housing goals so you are going to see a lot of states integrate like a priority for people with disabilities. Maybe seniors. Whatever is the most important

populations or most challenging pressing issues in their state they are going to try and leverage the 9% credit process to achieve those goals. So some states do permanent supportive housing. Some focus on transit oriented development. It can vary a lot between states and what they prioritize for these credits.

Each year, the allocating agency issues what is called a qualified allocation plan or a it's basically a request for proposals and that comes out every year. And you might hear me use the kinship QAP quite a bit for the rest of the presentations. It lays out the projects and how the tax credits are awarded and scored. In Maryland we have a competitive 9% allocation of 16.5 million. That's our budget to get these big housing goals done. We also do 4% credit projects those are funded by tax exempt bonds and they are accepted on a rolling basis throughout the year. When the project is ready to apply they apply. In Maryland we have some scoring preferences that we had to accommodate as we were thinking how to add homelessness as a priority. We already had transient oriented development. We have some preferences around family housing we have a shortage of affordable family units and we have targeted populations for people with people with disabilities and not homeless with disabilities and we also do targeting as well. Next slide.

So how we got here in the TA has been incredibly helpful. But executive leadership is also really important. And we are really fortunate our governor Westmore came into office in 2023 and installed a cabinet that frankly works really well together and is really interested in integrating our strategies across agencies and so we've gotten the pleasure of working together across all these different agencies and figuring out how to integrate housing and health care resources and the TA could not have been more perfectly timed because it gave us the technical expertise and the access to peers who are already doing this work to help us guide our way. For us the governor introduced the first state plan in over a decade last year and that laid out a set of priorities for us inside a state and what we need to invest in and the greatest need and two of the major metrics we have is reducing homelessness and ending chronic homelessness by 2035 and that connects to governor's state plan around ending child poverty in your state and affordable housing production. On top of that we earlier this past year created a new division of homeless solutions we always had one in terms of we've done the work. We had funds for services and we had a interagency counsel on the homelessness. But we needed more executive leadership and folks who could work across state agencies to build coalitions and programs. Last year we created this new division, we created my role which is brand new to the agency. And I work with my peers as you'll hear across all of our different agencies to coordinate strategy.

We also elevated the issue of homelessness so this gave us more public visibility and more support and also helped us clearly demonstrate a preference and priority of homelessness

as a issue with the different stakeholders whether those be housing developers or investors or our local partners we work and service from.

To achieve an end to chronic homelessness by 2035 which is our North Star the state needs to increase supportive housing specifically by 500 to 600 units a year for next 10 years and are that's to address the folks who are chronically homeless today and it may be a little bit more. So I think that number is probably higher. If we were to look 10 years out from now but this is a ambitious goal for us to start working with. So we are really excited to talk about the specific way we are going to get there.

Next slide. This is what our landscape look nix in Maryland in terms of the needs. As of fiscal year 23 we had 4300 people across the state considered chronically homeless under HUD's definition. Obviously we all know a lot of other people have housing instability that don't neatly fall into the chronic definition that HUD has. So that number is a floor not a ceiling.

We also have ability 4800 people who are what we call rising seniors to 55-65. And are experiencing homelessness. And then we also have seniors who are 65 and up. And experiencing homelessness and that is by far our fast fastest growing population. The data has shown 77% in increase of older adults experiencing homelessness over the last 6 years and it's our fastest growing. While the other populations are going down the older adults are going up. Those groups of people we have some challenges. 68% of folks who are chronically homeless have 0 cash income which means as we plan for housing we have to have the deeply affordable units. Things that are subsidized because these folks don't have enough income from disability assistance or from a job to afford market rate rent or subsidized rent in some cases. Of those chronically homeless, 66% are experience a disability and many are over 65. They need to have when he will access and allow mobility throughout the unit and not have stairs. Is there stair entry into the building? Those are things we are thinking about as we work on our plan and we need to have a housing first approach. We are unequivocally committed to housing versus state. And 48% of our homeless households have at least one criminal case. And 68% have a mental health diagnosis and. 48% have a substance use disorder. As we think about housing we have to make sure it's low barrier and can serve a folks with a wide range of needs and it's accessible. We are not excluding people because they have a higher level of need. And geographic diversity, every single Continuum of Care in our state needs more permanent supportive housing. We are building out a strategy that builds out PHA everywhere. And with low income housing projects those are centered in urban communities where there's a high density of housing. So one thing we are looking at is how can we make sure we are funding projects in rural areas at a greater rate to be able to solve this gap as well. Next.

So what it looked like before? We didn't have a PHA strategy. So low income housing tax credit plans there was one year where we had a PSH set aside, it resulted in having one project awarded and created about 35 units and that's the history of what we have done around the issue of homelessness with our low income housing tax credits in our state, PSA is mostly developed through multiply CoC funding and vouch IRS that have a local homeless preference. There's not one local state program that funds and supports permanent supportive housing. We have a couple little ones here and there and maybe targeted to a certain kind of disability or a certain kind of health condition. And they are not well coordinated and we don't have one system that everybody can access. And we also have a hard time getting philanthropic contributions because it's a permanent funding need and boards change funding priorities and we always had a hard time getting a significant enough of philanthropic commitments into the PSA project because of the long-term need and changing funding priorities. So really what has helped get us here in a big way is this aces pilot. Our communities that joined it back in 2017, they started using aces and pairing it on their own with housing choice vouchers with HUD CoC funding to create PSH at the local level A lot of our model we are building off of is based on the local experiences of integrating Medicare coverage and health services with these housing units.
Next slide. So this is our timeline. Basically this has been a yearlong process we did a lot of research we leveraged our TA a lot to talk about other states and learn from experts how to best structure a tax credit for homelessness and we went through a long community independent and public hearing process and multiple iteration of our draft and I'm really excited to share a as of Friday it's final. So we are officially launching we are going to be incorporating homelessness into our housing production for the first time. And we could not be more thrilled. And these projects are ones that are -- they are all new construction for the most part there are going to be some projects that are rehabs or redevelopments. But the vast majority of our housing is going to be new construction and these units are going to come online in most likely 2028 or 2029. Next slide.
So this is the final result. So we went through a lot of public input and we did change our plan. We started out with a goal of having 15% of all units both 9% and 4% credits be permanent supportive housing and the states commitment is we would commit the services as well as the rental subsidy to make that financially viable for developers. We got a lot of feedback folks felt that was the lot for the first year. So we did make some changes to our approach. We are going a little lighter the first year although we'll still get a lot of bang for our buck with the goal to keep growing it as the years go on. Where we landed is for our 9% competitive round projects. These are the projects that are going to come in for the highest credits we are going to do two different strategies. There's going about the set

aside for two permanent supportive housing projects. Typically these are going to be places that have a higher density of PSH in one location. They have a mission oriented housing program or housing developer. And then the rest of the projects that apply for and receive 9% credits they have to establish a 15% homeless preference. So for 15% of all the units that are created, those are going to be targeted to people experiencing homelessness. And then for both the 9% round and the 4% round, if the state has a rental subsidy in supportive services fund available for PSH, so say two years ago from now we have a budget pass that includes funding for PSH. We can then go back to the projects we funded in this found if they are still under construction and haven't opened yet and we can require them to accept our funding and create more PSH so we have a back up clause in there because the timeline for housing development and budget cycles for the state are different. So we have to have some options that give us flexibility so we don't have to wait a whole year before we allocate those funds. And this also putting the burden on the state. So rather than expecting developers or service developers to come to table and find resources on their own and cobble together a lot of different funding sources we are trying to flip that on its head and say here's a package from the state. We are going to give you the subsidy. We are going to pair you with the services to make this possible. So that this is something that can be done system wide. So we are hoping that this lowers the barrier for PSH projects to get created and maintained. And do the hard work for developers and for those service providers so they are not having to do that themselves.

Next slide. So these are the different roles we anticipate. Obviously the state will play a huge role. We are going to administer the rental assistance, create vouchers for PSH where we can. And although our PSH don't have a lot of resources and have a long wait list. We are not looking at that being a major funding source, this is a new funding source for us. And we match the supportive service providers from our aces pilot as much as we possibly can to provide the services for any units that we create under the live tech program. And we are going to be tracking housing outcomes through our homeless service data warehouse. We are going to be engaging property managers to ensure they understand how to work with folks who might be coming out of unstable housing situations. And homelessness. And really train them on things like $$TRANSMIT informed care. How to trauma informed care and how to avoid evictions and how to partner with a service provider to avoid eviction. If a tenant falls behind on rent instead of going through the eviction process call the service provider and see if we can create a payment plan and create new source of income. And try to be a problem solver and partner before we put folks through a eviction process. We are looking for them to be collaborative. And on the CoC side every unit we create whether a PSH or a homeless preference all of those

referrals from the unit come from the Continuum of Care. It's a dedicated referral process. This is probably the most important part we are not adding another wait list that people have to get onto get housing. We just want to integrate and streamline into the CoC process so when someone gets on the binding list for the coordinated entry system they are automatically considered if for all of those other housing opportunities we are creating so we don't want to create a multi waitlist system. And we don't want folks to have to apply to every single process property in our community to get access.

And then service providers are the most essential part of this because they are the ones doing the hard work at the end of the day but we will be working with them to support them financially with the right amount of funding to pull this off.

Next slide. And that might be the last one. One more. So just some things we are thinking about policy wise. We are looking to make our eligible pool broader than the HUD definition of chronic homelessness. We specifically want to include folks that are in transitional housing. Or currently in an constitution setting. So they still have to have a homeless history for sure. But we find that a lot of folks who maybe are in treatment or skilled nursing facilities even though it's temporary they might be there longer than 90 days and our program is intended to be inclusive of those folks. If I have if they have a homeless history we consider them eligible for this program. And we streamline the definition of disability. A lot of our programs have a different definition of disability, they have different requirements around health conditions. So we are going to try to work across our Medicare team and across our local CoCs to figure out how to streamline some paperwork requirements and make it as low barrier as we can. And then for referrals coordination we know one challenge is we are getting feedback that a lot of folks with disabilities are homeless. They are engaged with maybe a disability services providers. But they are not in the CoC's coordinated entry system. So that's some if we feedback we got on the public input process and we'll dig into how can we unpack that challenge and make sure that folks getting services from the disability agencies or aging services and experiencing housing instability and are homeless how do we get them into the CoC entry system so we don't miss them with these different opportunities?

Then quality supportive housing will provide a lot of training and support to property managers and owners all throughout the process. And I think that might be the last slide.

And next slide. So the last thing I just want to highlight is in addition to all of the PSH and the Medicare work we also leverage our older adults to apply for the modified home care program and we received a 2.1 million-dollar award and that's a partnership between our agency and the department of aging and we'll implement that together along with our partners at disabilities and that program will provide home modifications to low income

seniors who may have a housing risk or housing instability because there are difficulties navigating the home or staying safely there the goal is to help them age in place and the program comes in and provides OT assessment and services and registered nursing services as well as home modifications to help folks stay in their home longer and hopefully avoid going to an institutional setting on a homeless shelter. And we are building out our partnerships with AA in general is a lot of time our Continuum of Care and AAAs haven't coordinated or don't coordinate on a regular basis so that's the relationship we are hoping to help facilitate and open up and bridge some gaps. Izzy from our department of aging do you want to add anything about those partnerships?

Isabella Shycoff (Maryland): Sure. Give me a video. Maryland department of aging. And I want to add my voice noting that the HSPA technical assistance created an intentional structure for us to work together. And although the department of aging is enough smaller than these other agencies it was deliberative. It got us together. It set our sights on some goals that we could work together on. I think what the department of aging brought to the table is we were able to help on the grant writing phase. With DHCD on the capable grant. And we were playing a liaison role. With our local area agency network, which I think is really vital because what we are finding and kind of known all along is our network is pretty insulated. And our relationship is a state agency to the local AAAs is pretty transactional. And what we are trying to change is the culture around that. We are promoting these programs to our network. I did a presentation yesterday to our monthly AAA director's meeting about aces and capable. We also have a unique DME program that we think we can add to the mix on the capable program for the areas that are regions that are being standing up that program. And then lastly, we have a single point of entry process for folks who are looking for resources and services for older people called the Maryland access point. We are going to train those counselors so they are available -- they are aware of the program expansions and understand what eligibility is and get the people to the right resources. So they can participate in a program and one of the things we've noted is that because our network doesn't know about the programs there's a lot of underutilization and we want to change that because there's no doubt there's demand out there. We just need to get the people to the programs and. That's all I have. And that's a pleasure working across the agencies. I think we are getting a lot more done that way.

RYAN ELZA: Thank you, Maryland, team that was a insightful presentation. And we are good questions in the chat and now I'll pass it to the North Carolina team to hear what they've been up to the past 12 months.

Maria Perez (North Carolina): Thanks, Ryan, hello everyone. Excited to share with you what we've been up to the last 12 months. I think you will hear some echoes here. The neck team and across all teams that we worked with that we were able to interact with as part of HSPA I think one of the things I found that was inspirational the hope we can draw from knowing there's other states working to achieve the same goals recognizing at the end of the day and I'll say I'm coming at this from a Medicaid perspective because I work with the Medicaid agency I think we are all the end of the day trying to ensure the wellbeing of the people that we serve whether that be through the focus of Medicaid agency or through the focus of different housing agencies that's at the end of the day what binds us together. And I think what that learning experience allowed us to really focus on in a dedicated way. So I'll go into my first slide, please.

So really our overarching goals in North Carolina. We talked a lot about silos in North Carolina and what they meant and if they were good or bad. At the end of the day there's a purpose and intent why teams need to be able to operate and specialize within silos that they work. And we wanted to connect the silos more intentionally and be able to create more transparency between them. So we really focused over the last 12 months on areas where we can connect different areas of work across the state. Again, to better serve the populations that were a greatest needs and we focused on better understanding, up front eligibility and requirements and identifying service gaps by matching current services provided by the different services and in particular we focused on three. So there's back at home. Balance of state. The healthy opportunities pilots. And transition to community living. And then we also focused on looking at cross program provider training and technical assistance and quality assurance and thinking of the expansion of affordable housing resources within those three programs. And I think I heard reference to that braiding of funding that Maryland was speaking to. And I think really acknowledging that braiding of funding happens somewhere. And I think Denise on our team will talk how balance of state addresses that one model of North Carolina where funding gets braided and where it makes most sense. And at the end of the day data braid braided somewhere and usually it's the beneficiaries and people on the ground who have the greatest need to navigate these complex systems to braid those needs together and be able to navigate the challenges in a their lives and that in addition to challenges they face.

And of course I would say the greatest challenge we tried to tackle over the last 12 months is looking at cross agency governance structures and how to better modify those for future work in order to improve the way in which housing supports are coordinated in North Carolina.

So to dive into an overview of the three programs that we focused on, next plied supplied, please, I'll talk about the healthy opportunities pilots so the healthy opportunities pilots are North Carolina's 1115HSRN waiver of approach. And this system in North Carolina was approved in 2018. We implemented in 2022. And it includes housing supporting but also includes supports that address nutrition needs. Transportation needs. Internal violence supports. And really looking at through the Medicaid lens how we can better support a member's holistic needs a person's holistic needs with the intent to develop that evidence base which is a crucial part of a 1115 model.

As well as utilizing defined fee schedule which to preview we borrow from another housing program and then we built on it and another could bill on it from there so we could cross learn and really be able to provide as much information to the field as possible to provide clarity about how these services were to be provided, how they were to be invoiced to entities could receive payment for the provision of these supports on a per-member basis or a per-service delivery basis. And now we also did provide capacity or infrastructure support through a care hub entity, which we refer to as a network lead. And that allowed us to really leverage the local or community based organizations that were really a part of the communities in North Carolina and were already doing a lot of housing work through other programs and another way we tried to bring together the ways of which different resources could be leveraged and coordinated.

Now this approach I think the main thing I would say is because this is operating in a Medicaid model I think our three main tenants is how can you improve the health outcome of people throw the provision of housing supports? Again going back to that core or foundational goal of how do we just overall address the needs of people who need to ensure they have access to safe housing that is affordable and sustainable to them? And that a consequence of that, which we are hoping through this pilot to evaluate is that allows a person to live a healthier life, which we are able to measure and show through pilot findings.

I will hand things over to Deb who will speak to the TCL program.

Deborah Goda (North Carolina): Thanks so much, Maria. My name is Deb I'm the Olmstead director for North Carolina. One program that we have that takes advantage of housing is health care. Is our TCL program, which comes outs a Department of Justice settlement for Olmstead. And our population of adults are severe and persistent mental illness either living in adult care home diverted from health care homes or discharged from state psychiatric hospitals who are unstable housing are or homeless and the work we do including funding housing for these individuals through funding from our general assembly. And housing supportive services which are often funded through our Medicaid partner.

And so as this work continues it's very clear that we are not only impacting individuals with disabilities but we are impacting individuals who are homeless so we have been able to work with our partners at Medicaid to really maximize the amount of funding that there is for our population. So that we can serve additional people. So our pillars of core in-services center around housing, mental health services that are recovery-oriented, discharge and transition from adult care homes and state psychiatric facilities and supported employment and diversion from adult care homes. And keeping those individuals from being institutionalized further. Recently we had a modification to our settlement agreement it will be continuing if an additional two years but we have met a number of our requirements, including going from 10,000 people per year, who are in being admitted to adult care homes from 1,000 to 64 to 65 in the past two years.
And I will turn it over to Denise.

Denise Neunaber (North Carolina): Thanks, Deb. We'll go to the next slide on this one. I'm Denise and I'm with redesign collaborative. And we support the state on their rehousing programs. So back at home program is essentially a rehousing program. There's a lot of different acronyms that all of our programs use. We found in working together that we are really working on the same things. So maybe using slightly different language or a coming at it from slightly different angles. The back at home program started directly after hurricane Florence which was after 2018. This program enabled us to lean on the homeless systems learnings over years of what it takes to get somebody back into housing.

At its heart, we it really is a rehousing program that focuses on rental. But we do that in a variety of ways. So the key essentials here is that the program provides financial assistance, which looks like a lot of different things. Of course a big piece of it is [skipping] stabilize a lot of folks experiencing homelessness they need rental assistance and utility assistance so that's a corner stone of the program and over time with the program we found there's many other financial needs that folks need in order to be able to access and get into housing. So we pay things likes application fees. Security deposits. Pet deposits. Landlord incentives. A lot of move-in costs. Furniture. All those things that it takes to really set up a new unit. If for most part what we are doing is working with folk who is have been somehow displaced whether it was through a disaster, or, you know, through individual situations we are help helping them find new units and we do this with a combination of financial assistance and stable housing services so we know this is all very familiar because it's work that many of you do is and it's been in previous slides what it takes to support someone to find a new home.

So we are talking about housing navigation services. Help applying for units. Help negotiating leases. And then help with general case management really. Looking at what does it take to support someone in housing? We do a lot of system navigation as well of connecting folks to other resources make sure they apply and receive other benefits they are eligible for.

As housing program we had several iterations. It standard as a disaster rehousing program with state funds in 2018. We then used the program again to house folks during COVID with some COVID funds. Its latest iteration was launched just one year ago. With this combination of funding where we are braiding together fund from actually it's 8 distinct grants that are getting braided together. There's five grants from the Continuum of Care special funding all of that come HUD. There's emergency related assistance funds, COVID money from treasury. And state fiscal recovery funds. And we are just now adding in rapid unsheltered survivor housing. This is funds from HUD that follow the emergency solution grant program that are awarded to communities that have experienced a disaster. So in North Carolina, we are hit very hard in our the Western part of our state by Helene. So we are taken a program that we used in to house folks in 79 counties and we now expanded that to 90 counties. When Maria was talking about funds get braided together at some point. Fund get braided together, services get pieced together. Anything that a household needs in order to move into and stabilize in housing at some point someone is putting those things together and what back at home does is try to focus on what is that full package the holistic need of the household? How can the program help gather the funding in one place, put that together so it's much easier for our service providers and agencies to deliver services. Instead of us all getting to be experts and all of these different funding regulations and pieces how do we put that at the state level instead of what is otherwise at the nonprofit level or other local organization level or with the household where they are putting those pieces together. It has been a lot of work to understand all of those different funding streams and how to put all of those things together. But it does enable the state to really make sure that all of these different pieces are coming together and making the greatest impact. We have a funding matrix that we go by that spells out this funding source will pay for this eligible expense. That funding source will pay for that eligible expense as well. But it pays for 10 others at that limited funding source can't pay for so it's a will the lot of putting those pieces together. As we are doing this, I just want to say this is work that we all know, any of us who are in charge of moving into a new living situation, who any time any of us have a transition in housing we are having to figure out what is it, where do I want to live? How am I going to afford it? And what kind of supports do I need support to make sure that that is a stable housing for me? Sometimes that looks like case management.

That might look like mental health care. That might look like substance use treatment. That might look like my kids childcare or education. All of us are putting together our lives and it's the same for everyone. We all have some kind of housing stability planned. And for the folks [audio dropped] we work with we are really [audio dropped] folks that have disabilities. So [skipping]

Take that same lens of what does it take [audio dropped] I hope you can still hear me okay? While back at home really does concentration on rehousing folks with rental assistance we also are coordinating with other programs. Sometimes we are finding other situations that people are choosing. We also as in some assisted living facilities for folks that have high needs we are reuniting folks with family and friends. We are partnering with housing authorities to get access to vouchers that way as well.

So as we are -- as we design this program there's three innovations I want to talk to you about. The first is centralized financial assistance and property provider recruitment. So before this latest iteration, we were the state was dispersing funding across multiple providers and everyone was having to figure out how to do that financial assistance and also recruit the [audio dropped] we centralized that with all one agency now and it's allowed us to streamline roles and really allowed one agency to get really good and expert with that particular case piece of the puzzle and also enables the state instead of having to honor all providers for that what can be complicated financial assistance the state is now monitoring one [audio dropped] make sure we got all the documentation for. The second innovation is that the payment system is different than we normally have used in HUD funding before. We are using a payment system that's a flat rate fee. Right now it's about $433 a month. That providers are getting paid per household. This mirrors the healthy opportunities payment. So we have really just let them do -- let the Medicaid actuaries do the hard work of setting the rate and let Maria and the team set the way that's defined and we use their per member per month [audio dropped] model and how we [skipping]

This sets us up for eventually that Medicaid program. As we design we also try to build in a way that makes it scalable that's one of our struggles during COVID when we got a large influx of money to be able to scale up quickly. So we've been working on design to do it that way. That's informed a lot of how we have done contracts and looked at case loads and things like that. So that came in handy as we really responded to Helene in this latest disaster. I'll turn it back to Maria. Hopefully the sound was okay. For most of that I'll turn it back to Maria to talk how our programs have worked together and learned from each other.

Maria Perez: Thank you, Denise, next slide, please, and do was a little bit in and out and we got most of your message and there are comments having for the resources you referenced. So I want to spend just a minute. We talked about these three programs and

wanted to show you all how these programs connected in part because in North Carolina, and I'm sure in other states as well there's been this huge focus over the years on innovation. And how we can continue to innovate on existing innovating ideas. And this shows at least for one portion of that for the part that has to do with these three programs what that has looked like, how we have tried to be intentional over the life of these programs to build lessons learned from one to the other, and also how HSPA allowed us to continue to refine that. So transition to community living has been in existence for a very long time in North Carolina, we are talking 2012. And that creates the foundation upon which so much of our knowledge about how we can best serve communities with housing supports began where a lot of this innovation and innovative thinking really started to evolve. Denise obviously spoke already to back to Florence and where disaster in an emergency crisis created an opportunity for us to think about how can we better serve communities and this huge gap where emergency housing resources are needed and it allowed for the development of an infrastructure for housing navigation supports and building that out in a way that the healthy opportunity pilots which was focused on a wide range of supports, food, housing, transportation, and IPV, could look at an existing program, the lessons from that, use it to build it into our definitions for housing navigation. And then also think about how that housing navigation could be a part of the other housing supports that exist for the program. Things like payment for security deposit and first month rent and utility support and making sure we can help people as they need it to develop stability plans for those things or as well to that effect making sure that weren't just getting people newly housed but that we are able to provide sports that help people stay housed and can remediate some of their housing needs like home modifications that may be needed in order for an individual to avoid having to move but to be able to remain in the housing that may be already affordable to them but they need to see some of these modifications to remain there in a way that's safe and healthy for them in that household. And then when we look at back at home COVID that was a space where we it isn't listed here but there was a mini pilot that existed during COVID that really worked together with the housing supports at that time where we continue to learn the lessons around the types of supports that we are needed by community based organizations to be able to provide supports. So when we launched pilot services in 2022, we were able to proactively provide capacity building resources to organizations that allow them to stand up more quickly and allowed us to recruit organizations that again may have been doing this work for a very long time but haven't have as much capital up front to start doing this work but could do it really effectively and for a wider subset of their local community having these resources up front to start the work.

As the reimbursement structure became stabilized. Denise spoke to back at home balance of state, which evolved into back at home Helene and the back at home balance still exists and I think this is where HSPA was a huge influence in the state because of all of the connections that were formed and because of the coordination already in progress for us to be able to improve on the eligibility and the referral processes for these different programs that were operational in the state at the time, also allowed us to leverage infrastructure that existed in western North Carolina, a region that had not seen flooding like that in living memory and beyond that. And really allowed us to get supports into communities quickly. Anecdotally we had community based organizations from the healthy opportunities pilots back up and running within a month which was incredible and knowing they were the network lead the care hub was coordinating with balance of state organizations and other housing supports again because of these connections that were built and because of the infrastructure developed to make sure that the supports were supporting each other and that we were reaching the widest range of folks that were really in severe need at that time and continue to be as this is ongoing recovery so that's why you see the arrow. We are expecting to continue this work for some side. And on the hop side this is part of the pilot TC.L piece in North Carolina healthy opportunities pilot in our waiver is built into our managed care model. So the entities that administer the service delivery funding and enrollment are our managed care organizations. And in recalling that we launched in 2022, that was with our standard population. In July of this last year in 2024, we launched for our tailored plan managed care product which is for individuals with Intellectual and Developmental Disabilities, substance use disorder, traumatic brain injury and some that have the most significant needs in the state and we were able to coordinate across different divisions in North Carolina to ensure that, again, we could continue to provide housing supports and also layer on the other supports that the populations may need to help stabilize their overall health needs through nutrition, transportation or IP. Next slide, please.

Now each of these programs that we have focused on in North Carolina, there are a lot of impacts I'll say in a housing space across the board but within these three programs other the course of the last year, some of the most significant impacts that we have seen is for healthy opportunities pilots. We saw evaluation findings showing there is an $85 per member per month deduction in health cares cost as it relates to service provision when comparing individuals in counties that are served by hop to those not served by the pilot. And there's also a reduction in the emergency department utilization and inpatient hospitalization for some populations. These findings relate to overall pilot services. So this is for any service that a person may have received whether food, housing or

transportation. These are findings associated with that enrollment. We are looking forward to over the course of this year doing a more in depth evaluation that allows us to hopefully tease out by service type and by population a little bit -- get granular in our findings about the impacts and cost impact for those populations. When we look at services. Now for transition for community living, we saw that 84% of participants were able to retain their housing. We saw that we went from 1,000 annual admissions to adult care homes to 65 or less annual admissions for people with severe and persistent mental illness. Back at home, we see that 464 households for housed as of January 9, 2025. So nearly a year from when the program was launched nearly 500 households were housed and again cannot understate the value of the coordination and infrastructure in being able to scale up these supports in response to a disaster after hurricane Helene to be able to support households to be rehoused. Next slide, please. With this, I will hand it over to Deb to talk about what we are looking forward to in the state of North Carolina.

>> What we are looking forward to and what we have received from this group. We all know on a regular basis day-to-day it is so hard to commit the time to things that we would like to have versus the things that have to be done because they are on fire. And this group gave us the opportunity to carve out a space and hold ourselves accountable to that space to learn and to grow and to work together to figure out how we connected with each other, how our programs connected. It gave us an opportunity to look at other states and our peers in other states to see what they were learning. What they did well. What we could do better. And despite all of our differences in opinion, we were able to get past the jargon of all of our programs and the differing requirements. To get down to the core of what it takes to make this work. So we built relationships within our state leadership and formed a new peer group. We crossed fertilized our programs and completed a beautiful service eligibility crosswalk of all of the services that touch housing in our state. Developed a PSH framework and definition. And we have recommendations for the next steps. In the areas that we are going to continue on in the five identified areas. We've developed a cross agency governance structure for our strategic housing plan. Which applies to all disability groups. And this group that we formed for HSPA is going to continue as our services group for our strategic housing plan. So we are going to keep going with the work that we have done. We've identified and addressed our service gaps. And that is something that we are going to work towards over the course of the next two years. We've cross referenced our provider trainings and certifications and quality assurance. And look forward to the expansion of the affordable housing for all three of our programs. I don't know if we could actually put a price tag on what we learned and what we got out of this. But for anyone who was not part of the first group, I would strongly encourage you to take advantage of any

future HSPA opportunities. And thank you. and thank you to the North Carolina team. Because I've learned a lot this year.

RYAN ELZA: Thank you, North Carolina. That was a really informative presentation. And those outcomes, wow. I think, you know, you have shown us that we all know that access to housing, food, and other critical services are the right thing to do but they are also a return on investment for investing in those services so really look forward to continuing to see ongoing evaluation, data that comes out for that and how you can drill down into those services so we are going to transition into Q&A so we have a couple minutes for questions. And just want to open it up first by there's a lot of excitement in the chat from folks. And different organizations or agencies. So how would you recommend folks get engaged in their state's work if they are a community-based organization or a state agency who might not be traditional involved in that work? What recommendation or advice would you give to the field? Anyone who wants to jump in, go for it.

Maria Perez: I think it's to start engaging. I think one thing this North Carolina, which I didn't initially touch on but the healthy opportunities pilot is part of a broader department wise strategy and North Carolina is a state where we have one DSS agency that oversees everything except for housing so we do not centralize housing. But because we are this broader agency we were able to have this strategic priority across HHS and say we were going to invest in improving health and not just ways for health care that was our framing for it. And before the pilots were designed well before they were implemented we were building out through our RFIs, request for information through the Medicaid agency to develop an SDOH screening tool or a screening tool to pet better identify the support needs we thought we should be better prioritizing. We built out a referral platform to allow us to when we told providers you have to use this screening tool the providers can say great this person screened positive and I have a way to send them somewhere where I will know that somebody picked that person up and is helping them. And then -- and then after all that infrastructure was developed and we worked to build a staffing infrastructure with the community health workers that's when we started building the 1115 infrastructure involved with the HUD and the funding structure for services so beginning to get engaged. Getting to know the different entities is the step 1. The ongoing step.

Deborah Goda: Invite people into your space it's not a matter of going to people is and saying can I come? But inviting people into your space because they know other people

too and being invited to Denise being invited to your space has just opened up so many people to work with. And then it just it creates a web.

Danielle Meister: I think for Maryland like if you are a service provider who is ma maybe not in the policy space but you want to start getting involved I know for us we rely on advocacy coalitions to run options by them and they do for the most part advocating for their members and engaging us proactively. So most state haves a mental health coalition or a aging coalition, if you are a service provider I would start looking for those entities in your state because usually well networked with the state agencies and know who the key players are. And go to them and say I want to be involved in expanding this or pursuing this kind. And they should be able to navigate you to the right place.

Ryan Elza: Thank you, and we got 1 minute left so unfortunately, we don't have any more time for questions and thank you all to our printers. We are all rock stars leading the field and we are so grateful for you to share your learnings and insight with the rest of the field and if we could bring back up to slides. I know folks are eager for a recording of the presentation and the slides today. Those will be posted to the housing and services resource center website. So you can go to ACL.gov slash housing and services and there's a QR code here. Next slide, please. The housing services resource center website has a lot of resources on aligning housing, health, and social care. We have case studies guidance, tools we post funding announcements across federal agencies we have a national listserv you can sign up for. So we encourage you to visit the website and sign up for latest webinars that are happening and tools that will be produced and we are excited in addition to these webinars we'll be producing a series of technical briefs that will document the best practices and learning and also have case studies from the state participated in accelerator. So those will be published soon. So make sure you subscribe to know when those are dropped and also check the housing and resources services website. Next slide, please.

And if you miss the other three webinars in this series, we also have links to those. So you can go back and watch those recordings and also access those slides. And next slide. And we also would love for you to help us improve our webinars so please complete our short feedback form so my colleagues will drop it in the chat and you can also access it through the slides that will be posted later on. And through scanning the QR code on your screen. And next slide. And know the Housing and Services Resource Center is your resource center so reach out to us at our inbox at HSRC@ACL.hhs.gov. We want to learn about your innovation from the field that we can help lift up. Let us know if you have technical assistance need that you would love some direction or being pointed to the right

resources. And as a I already mentioned please subscribe to our listserv, with that have a great rest of your day and week. And we look forward to our next webinar and hope you join us then.