7 STRATEGIES TO ENGAGE THE HEALTH SECTOR TO ADVANCE SUPPORTIVE HOUSING AND END HOMELESSNESS

February 2022

The 2022 CSH Health Strategy presents seven strategies for the supportive housing field's engagement with the health sector. Based on the CSH work around racial equity and our Racial Disparities and Disproportionality Index (RDDI), these strategies are timely and address opportunities that communities can take now to maximize impact. We understand that every community has different needs, and a different policy and political context and while not every strategy may apply to all communities, every community can benefit from focusing on at least one of the strategies below.

1. SUPPORTING STATES TO SCALE SUPPORTIVE HOUSING
2. DEVELOPING PARTNERSHIPS THAT CENTER HEALTH AND HOUSING COLLABORATION
3. GUIDING HEALTH CARE INVESTMENT TO EQUITY and IMPACT
4. ADDRESSING CAPACITY BUILDING NEEDS BETWEEN SECTORS AND FOR PROVIDERS
5. THE OPPORTUNITIES OF HCBS EXPANSION AND #CARECAN'T WAIT
6. THE AGING POPULATION
7. INVESTMENTS FROM VENTURE CAPITAL IN AREAS SUCH AS COMMUNITY RESOURCE REFERRAL PLATFORMS AND VALUE BASED SOCIAL CARE

"The well-being of our communities depends on protecting the **health** of people facing intersectional barriers of extreme poverty, disparities in health and ability, and systemic racism." – the founding documents of the COMPACT for Thriving Communities.

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HISTORY

For 30 years, CSH has believed and operated on the statement highlighted above. From CSH's roots developing supportive housing in New York, to leading health and housing efforts nationwide, CSH has championed the supportive housing movement on the path forward to building equitable and thriving communities. These efforts have led to communities working to:

- End homelessness
- Address the needs of justice-involved individuals who are returning from incarceration
- Address the needs of low-income older adults who wish to age and thrive in their community
- Address the needs of persons who wish to leave institutional care
- Address the needs of youth and of families who have complex needs and history of trauma

While the supportive housing movement began as a means to end homelessness, communities, systems, and advocates are increasingly embracing supportive housing as not only a solution for people experiencing homelessness but for those living with one or more disability, adults over age 55, and families with complex needs. In addition, the COVID-19 pandemic has spotlighted how many of our fellow community members are forced to live in institutional or congregate settings due to the lack of affordable, supportive housing options and how those options can lead to poor health outcomes. Finally, as our country grapples with and is poised to take on the hard work of dismantling systemic racism, CSH believes that scaling supportive housing will be critical to addressing homelessness, mass incarceration, and health inequities in our communities.

Centering racial equity is a foundational value for CSH as we strive to become an anti-racist organization. Too often, Black, Indigenous, People of Color (BIPOC) communities are over-represented in public sector systems such as homelessness, incarceration and institutionalization. CSH's RDDI offers the tools to identify and measure racial and ethnic disparities witnessed across states and 16 unique public sector systems.[1] Armed with these data, CSH encourages communities to identify ways to build multi-sector partnerships, share data, and add quality supportive housing capacity. Our teams work to align data systems, create cross-sector data matches and help target resources for maximum impact. Finally, CSH

[1] https://www.csh.org/2020/04/advancing-equity-through-data/

believes that to create thriving communities, all persons must have access to the support they need to make their own individual life choices and have opportunities to participate in the community at levels of that choice. No matter the state or local priorities, CSH will bring these fundamental values and strategies to our work in any community.

Over the years, we have learned that to create quality supportive housing communities must deploy various tools. Our roots as a Community Development Financial Institution (CDFI) ensure that we can finance supportive housing development from its initial inception. Supportive Housing is one of the earliest examples of braiding funding for projects with often unique sources of funding used for capital (building the building), operating (keeping the rent affordable for extremely low-income renters) and services (the Housing Support Services [HSS] needed to help persons with challenges in obtaining and maintaining housing in the community). These three budgets (capital, operating and services) are commonly called the three-legged stool of supportive housing development. Our policy reform efforts help inform and identify federal and state resources needed to increase supportive housing capacity and quality. In addition, our consulting and technical assistance services are provided at the federal, state and local levels give policymakers, leaders, providers, and projects the support they need to execute their vision and reach their goals.

Our work in the health space began in the early 2000s, as we realized that the health care needs of supportive housing residents and potential supportive housing residents were not being met. CSH began to research and better understand the policy goals, priorities, and networks within the health care sector to create the partnerships required to address unmet needs. The CSH Frequent Users System Engagement (FUSE) projects utilized the power of data to bring together sectors for drive local leaders to braid funding and to address community needs. CSH in 2012, highlighted that to bring supportive housing to scale, Medicaid is necessary as the primary services funding source. [2]. In 2015, the federal Center for Medicaid and Medicare Services (CMS) agreed.[3] Since then, CSH has worked in states such as Massachusetts, Washington, Minnesota to develop and implement Medicaid funding for the services component of supportive housing, focusing on capacity building for developers, nonprofit agencies, and the people who deliver and receive the services.

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[2] https://www.chcs.org/resource/medicaid-financed-services-in-supportive-housing-for-high-need-homeless-beneficiaries-the-business-case/

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf

STATUS

States and localities have a variety of priorities that increasing supportive housing capacity and quality can help address. States with expensive housing markets and low housing vacancy rates may have large populations of people experiencing homelessness and a strong priority in that arena. Other states may see an aging population who wish to remain in community housing options as long as possible. States will want to support those wishes but need quality, affordable and accessible housing and aligned services and supports. Other states will have seen high rates of COVID-19 deaths in congregate care settings and wish to increase supportive housing capacity to have different choices to give these households. States may have a high rate of persons returning from long-term incarceration who have complex medical needs and know that supportive housing is the right solution for these folks. Finally, states may see rising numbers of child welfare involved families who need aligned housing and services to address the trauma and challenges of intergenerational poverty. Again, supportive housing is the solution.

Sectors and funding are seldom aligned at the funding source level and dedicated, supportive housing providers must navigate a complex web of various funding streams. CSHs advocates for a cross-disability and cross-sector referral system that places the effort of navigating complex systems primarily on government and private sector partners, secondly on providers and lastly on those persons needing services. The current system places the primary responsibility on individuals and families, following providers, and the government. The government often works in siloes complicating the matter further.

EQUITY

Health equity describes the ability of all people to access care and achieve good health without regard to race, ethnicity, income, neighborhood or community, housing status, or other characteristics.[4] The data are clear on racialized health

[4] http://www.who.int/topics/health_equity/en/; https://www.apha.org/topics-and-issues/health-equity

inequities - Black, Indigenous and People of Color (BIPOC) populations have a lower life expectancy, higher prevalence of chronic health conditions and poorer health outcomes.[5] Various reasons for this exist, including institutional and structural racism, implicit bias and lack of access to health care coverage and quality care. The data reveal that BIPOC populations are over represented among those experiencing homelessness and housing instability[6] and mass incarceration driven by a racial wealth gap.[7] Only equity-centered investments in historically marginalized and medically-underserved communities of color, including supportive housing and quality and culturally-responsive services will advance health equity. In addition to investments in community housing and services, CSH and its partners must address the systemic factors that result in disparate outcomes and actively work to undo them.

CSH's RDDI tool tracks how BIPOC are overrepresented in various public sector systems, including homelessness, justice, and institutionalized settings such as nursing homes. Also, communities must examine inequities in resource access and quality of services that lead to disparate outcomes. These strategies must center the needs and experiences of BIPOC, with lived experience. Communities must learn from challenges in current systems to lead the process and to develop strategies to remedy inequities. Only by combining multiple approaches with strict local accountability can systems and communities begin to redress harmful structural and institutional practices, policies and norms and move forward to advance health equity.

While a small portion of vulnerable populations need supportive housing, a more significant percentage of the population will need access to quality affordable housing and community services. Health care services are included under a broader array of services, though they are not exclusive. Health services investments need to be responsive to evolving community needs and since the system is skewed to underserve people of color, we need to develop targeted strategies to ensure equitable distribution and resources.

THE DATA LANDSCAPE

While understanding the role housing plays in health care is intuitive, data regarding this topic is also available and should be harnessed to drive

[5] https://tcf.org/content/report/racism-inequality-health-care-african-americans/?agreed=1&session=1
[6] https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/inequality/
[7] https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap/

community efforts. The over-utilization of emergency crisis care, such as ambulances, emergency departments, and inpatient hospitalizations, is well documented. Communities repeatedly conclude that people experiencing homelessness who have complex medical histories are often among the costliest patients with the poorest health outcomes. The effectiveness of housing and services on this population has been documented extensively. Nearly all studies conclude that providing housing and services promotes long-term housing stability for high utilizers of healthcare.[8] The research on the impact of both health costs and health outcomes is less conclusive. The most comprehensive summary of the study on the effects of supportive housing on health outcomes comes from a National Academy of Sciences, Engineering, and Medicine (NASEM) study panel that highlights supportive housing's success at ending homelessness.[9] The report also notes the few high quality, randomized control trials (RCT) studies around the impact of supportive housing on health care outcomes and costs. The report notes that the field has few standardized metrics, and samples are seldom chosen randomly, so RCT studies have not been implemented. The most recent rigorous study comes from research in Santa Clara County, California, conducted in partnership with Abode Services.[10] The study concluded that the supportive housing intervention resulted in people experiencing more housing stability and decreased service utilization in psychiatric emergency services.[11] Costs shifted from emergency care to outpatient services. The Santa Clara study and CSH's work on the Social Innovation Fund has shown that while a Return on Investment (ROI) is possible, so is appropriate cost shifts from emergency, crisis care to outpatient and pharmacy costs because persons can consistently access the health care they need. We aim to continue our work to achieve the outcomes discussed above.

The health care sector is broadly adopting screening methods for Social Drivers of Health (SDOH) needs, particularly for Medicaid recipients with low incomes. These activities will lead to better data in the field around unmet social needs such as food and housing. But better data do not immediately address the needs. The field is also adopting technology solutions such as Community Referral Platforms or closed-loop referral networks to address the need for better information at various points of services entry.[12] While communities do need

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[8] https://www.csh.org/supportive-housing-101/data/

[9] https://www.nationalacademies.org/news/2018/07/permanent-supportive-housing-holds-potential-for-improving-health-of-people-experiencing-homelessness-but-further-research-on-effectiveness-is-needed-including-studies-on-housing-sensitive-health-conditions

[10] https://www.ucsf.edu/news/2020/09/418546/study-finds-permanent-supportive-housing-effective-highest-risk-chronically

[11] https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13553

[12] https://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf

better data and information, this strategy will **not** address capacity needs. At its best, this strategy will give communities better data about those needs and hopefully quantify budget and capacity needed to fill those gaps.

THRIVING COMMUNITIES

Thriving communities are built by ensuring that everyone has the healthcare, food, economic opportunity, education and community connections needed to be healthy and have the lives of their choosing. Safe and affordable housing aligned with supports that help people connect to community health, human, and economic services is at the foundation of optimal health and thriving as members of communities. Having optimal health means that people have the information and care needed to manage and improve their health. It means working together as communities and systems to enhance the quality of care and reduce disparities in health care access and outcomes. Most of all, it means that people can live long and healthy lives, free from trauma, with ongoing access to responsive care.

The health care sector has a variety of values and priorities that support this goal of thriving people and communities particularly for people with disabilities. Coming from leadership within the disability community, the value of choice of the person is paramount. Choice of services, service providers, and community is crucial and built into the structure of Home and Community Based Services.[13] A second value, Community Integration, as outlined in the Americans with Disabilities Act and the Supreme Court's Olmsted decision, guarantee the right of persons with disabilities be integrated into the community. The health care sector has a growing recognition of health disparities and SDOH. This understanding should motivate the health care sector to fully collaborate with Community-Based Organizations (CBOs) to achieve their population health goals.

Finally, within the advocacy community – specifically the disability rights community- the mantra of "Nothing about us, without us" is a starting point for change. Similar to CSH's Speak Up! Initiative, the health care sector has been building platforms for People with Lived Experience (PLE) to have a voice in the

[13] https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/index.html

services they receive and in the evolution of their communities. At times, that voice is solely advocacy. At other times, that voice includes job roles, such as Community Health Workers (CHWs) for those with physical health challenges or Certified Peer or Recovery Specialists for those with behavioral health needs. Aligning these voices and working towards community-defined goals will be a key strategy in building thriving communities.

Health care is beginning to look at community-wide needs, through a public health lens, using the tools of population health. For example, suppose the goal is to ending smoking among a population. In that case, a nicotine patch is individual clinical intervention, while an advertising campaign to educate the public on the adverse effects of tobacco is a population health strategy. Moreover, many health care organizations recognize that they cannot reach their sector's population-level goals without partnerships, particularly those with the housing sector.

The challenge will be to bring together sectors with differences in languages and priorities. The health care sector has historically been the more powerful player in these discussions, with limited willingness or ability to adapt. For example, the health care sector is investing in technology, such as Community Referral Platforms, while seldom addressing the capacity needs of the community-based organizations to whom they are referring patients.[14] A common strategy used has been matching data to determine persons or households who are a priority, for both sectors. A second strategy has been to align priorities between sectors with increasing coordination between sectors.

THE SOCIAL, POLITICAL AND OTHER DRIVERS OF HEALTH

For more than a decade, CSH has been engaging the health care sector to underscore how housing is a foundational Social Determinant of Health. Without stable, safe, decent, affordable housing and community-based services, members of our community can only address immediate survival needs and not proactively engage in managing their more complex health-related conditions. The health care field has been more willing to call out SDOH as critical in building

[14] https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations

health equity. The medical field has become so complicated to navigate driving more health disparities.

What remains to be seen is whether the health care sector will make actual, equitable investments in SDOH, particularly housing. The health and housing sectors are learning to communicate, collect and use better data, build networks, and develop limited pilot projects. Still, the alignment, coordination and integration needed between these sectors are far from the scale required to build thriving communities. Too often, applause is given to investments from health care that is required by funders or other authorities. Part of the future will be tracking these investments, determining the drivers and impact, and recognizing entities that have made real change in communities.

MEDICAID AUTHORITIES- THE POTENTIAL FOR SCALE

Beginning with the 2015 Center for Medicaid and Medicare Services (CMS) informational bulletin, CMS has been clear that Medicaid can cover Housing Support Services (HSS).[15] From the start, CMS has seen HSS as part of the Home and Community Based Services (HCBS) program. This distinction is essential to conversations with Medicaid partners who know that housing-related costs generally speaking cannot be covered by Medicaid. What the housing sector calls "Capital" and "Operating" funding, CMS calls "Room and Board," and it has been clear that these are non-Medicaid covered services with minimal exceptions. A notable example has been the late 2021 approval of California's 1115 Cal AIM waiver that covers 6 months of housing related and services costs.[16] If this change is adopted beyond California, then the next challenge will be connecting health and housing sectors so that 6 months of housing assistance does not lead to a new episode of homelessness.

[15] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf

[16] https://www.cms.gov/newsroom/press-releases/cms-announces-extensions-calaim-support-greater-health-equity-across-communities

The work of ensuring that HSS is available in your state is a state-level decision. Advocates, city and county officials, providers, and state legislators may all influence the decision to offer these services. However, the lead agency is the State Medicaid office. If new funding is needed for these services, state legislators have a crucial appropriation role. State Medicaid offices may choose from several Medicaid authorities to offer these services, including 1115 Research and Demonstration Waivers, 1915 (c) Medicaid waiver, and 1915(i) Medicaid state plan amendments. The 1115 waivers generally last five years, test a hypothesis (e.g., Supportive Housing decreases health care costs for people experiencing homelessness), and, if successful, transition the services offered into another permanent Medicaid authority. New funding is seldom needed here; instead, the state office projects savings from the further intervention, which it uses to pay for the new services. HCBS authorities generally do require new funding from a state legislature as part of the state budget. HCBS waivers and State Plan Amendments (SPAs) often begin with advocates, move to the governor's office, Medicaid office, or gather state legislative champions. 1915 (c) waivers can be capped, meaning only a certain budgeted number of persons can receive services. Therefore, unlike most in Medicaid, these services can have a waiting list. 1915(i) SPAs require that anyone who meets the criteria receive benefits. Therefore, the state is concerned with crafting Needs-Based Criteria that help the state office predict how many people will qualify and the costs for that number of people in the program. States generally do this research internally to determine program costs. Then state offices work with the state legislature for funding, craft the waiver or SPA based upon these activities, and negotiate with CMS for a waiver or SPA approval. Participants accessing these services may have to wait as long as 3-4 years from initial conceptualization to service.

Medicaid 1115 Research and Demonstration Waivers

Home and Community Based Services (HCBS)

1915 (c) Waivers

1915 (i) State Plan

Over a dozen states have now begun to fund supportive services through the state's Medicaid plan.[17] Early adopter states such as Massachusetts, California, Washington State, and Maryland have all used the 1115 Research and Demonstration Medicaid authority. Each state has lessons learned that align with the state's original objectives. For example, Massachusetts's Community Support Program for People Experiencing Chronic Homelessness (CSPECH) began in 2006. The 1115 waiver was the partnership between the state Medicaid office, the State's Behavioral Health Partnership, and the MA Housing and Shelter Alliance

[17] https://www.csh.org/resources/summary-of-state-action-medicaid-housing-services-2/

(MHSA).[18] The program offered housing support services to 50 persons accessing housing options. A partnership was also brokered between the small, community-based agencies that made up the MHSA and Eliot Community Human Services for the administrative support these agencies needed to bill Medicaid for services.[19] The Massachusetts model has evolved into Flexible Services, including housing support services via Massachusetts' Accountable Care Organizations.[20] Next up was California, which used its county-based health system to launch the Whole Person Care Program.[21] Maryland also took a county-based approach with their Assistance in Community Integration Services or ACIS program.[22] These programs were all approved by CMS in the Obama administration.

The State of Washington was also approved at the very start of 2017. The state's Foundational Community Supports (FCS) program combined Supportive Housing with Supported Employment services to help persons experiencing homelessness or housing instability regain their life in the community.[23] CSH was an early advocate for this benefit and has helped the state implement it. The program shows early promising results in ending homelessness, improving health, and decreasing healthcare-related costs.[24] CSH believes a variety of factors are contributing to this success, including:

- Using a Third-Party Administrator (TPA) so that housing agencies only bill one Medicaid entity. Washington chose Amerigroup as the TPA for its FCS program. Amerigroup has done an exceptional job understanding the capacity building and technical assistance supports needed by housing agencies.
- Offering per diem rates so that providers can focus on quality care rather than billable units.
- Aligning housing resources with the new benefit and ensuring that the population's services and timing of funding match up so that CBOs have an easier time braiding funding.
- Aligning employment and housing supports so that persons have the support needed to achieve their employment goals.
- Statewideness, meaning they offered services in all counties across the state. While this is a requirement for the 1915(i) program, it is **not** a requirement for the 1115 or 1915 (c) authorities.

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[18] https://www.csh.org/wp-content/uploads/2017/01/CSPECH-Provider-Profile-FINAL-2016.pdf
[19] https://www.eliotchs.org/adult-services/
[20] https://www.mass.gov/doc/flexible-services-program-summary/download
[21] https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx
[22] https://health.maryland.gov/mmcp/Pages/Assistance-in-Community-Integration-Services-Pilot.aspx
[23] https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/initiative-3-foundational-community-supports-fcs
[24] https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-251.pdf

States whose 1115 waivers were approved during the Trump administration were required to administer the HSS similar to the state's HCBS program. States use various administrative structures to operate their HCBS programs. As of November 2020, 25 states used Managed Care to administer their HCBS programs.[25] Other states may use their Department of Human Services or administer the program based on populations, so that waiver and SPA services for aging populations are administered by the aging system, while the intellectual disability/developmental disability (ID/DD) system administers services for persons with intellectual and developmental disabilities. No matter the method, states that received this approval need to align these systems with these new services and potential new populations. Another example is Oregon's 1115 waiver that offered services for persons with substance use disorders, including housing support services, and had a similar requirement. That requirement means that Oregon also must administer these new housing support services benefit in alignment with their state's HCBS system. The Biden Administration approved that waiver in April 2021.

Other states, such as Minnesota and North Dakota, are approaching these services as part of the HCBS program from the start of the program. Those two states have CMS-approved 1915(i) State Plan Amendment housing services. In Minnesota, the program is called Housing Stabilization Services, and in North Dakota, the program is called Housing Support Services. Minnesota's program started delivering services in July of 2020, and North Dakota began in February of 2021.

THE FUTURE AND CSH'S ROLE IN BUILDING THAT FUTURE

CSH brings a unique mix of local networks, relationships, knowledge of challenges with the national and federal expertise needed to build equitable thriving communities. Even though the work is different in every state and community, it commonly builds upon:

- CSH's growing network of supportive housing advocates, health and housing system leaders
- State policy priorities, including:

[25] https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/#:~:text=As%20of%20November%202020%2C%2025,2018%3B%20Advancing%20States%202020).

    - Ensuring that all states offer quality tenancy support services statewide to all who need these supports to have a thriving life in the community. Also ensuring that these benefits are structurally aligned with affordable housing resources to create new quality supportive housing capacity.
    - Building equity in our communities.
    - Addressing SDOH needs for complex care populations.
    - Relying less on institutional and congregate care and creating more supportive housing, trends that are being driven by Olmstead settlements or other factors.
    - Building a strategy to 'age in place' for low-income seniors.
- Identifying populations to assess need and success based on data
- Identifying the state's or community's weakest leg of the Supportive Housing three-legged financing stool. Most communities have some federal or state funds for capital but may have trouble aligning operating subsidies. Many communities also do not have the services funding needed to move forward with increasing supportive housing development.

The work for advocates is to know your state and local priorities and develop your networks and strategies to address specific needs. Below is a list of seven opportunities to develop health and housing work that strategically fits within the current political and fiscal environment.

1. SUPPORTING STATES TO SCALE SUPPORTIVE HOUSING

CSH can work with the state Governor's, Medicaid, and program offices to create tenancy support Medicaid benefits. CSH can advocate for specific state policy choices that ensure that the benefits:

- Address racial disparities in homelessness, incarceration, and healthcare in the state
- Ensure that the benefit reaches those experiencing homelessness and housing instability.
- Limit administrative burden for both individuals and households needing the service and for housing and homeless services providers, who may have little if any experience in billing Medicaid.
- Are aligned with deeply affordable housing opportunities in a state to create new, quality supportive housing.

Depending upon the current state context, CSH will support states in building cross-sector system and provider capacity through Supportive Housing Institutes, Medicaid Crosswalk and Business Cases, and Medicaid Academies. With new

guidance and emphasis from the federal Administration for Community Living (ACL), CSH will expand your network to advocate for a practical tenancy support benefit and ensure access to supportive housing for all who would choose that option.

As states and communities look to invest in supportive housing, several CSH messages and tools may be most persuasive and helpful to have at your fingertips. For instance, you can adapt CSH's Thrive Framework to lead the visioning work needed in your communities. CSH's 3-pronged stool model guides us to develop efforts to enhance all stool legs.

Our Supportive Housing Needs Assessment quantifies how many housing units communities need and for what populations. CSH's RDDI tool can develop baselines for communities to measure progress towards equity in your community.

States often look to other states for examples, and CSH tracks state activities on tenancy support services benefits closely.[26] States also need to build their internal capacity, cross-sector capacity, and partnership capacity. The work ahead is to enhance and develop similar networks at the state level. This strategy would put states on a path towards scaling supportive housing by leveraging our solid federal and local relationships.

2. DEVELOPING PARTNERSHIPS THAT CENTER HEALTH AND HOUSING COLLABORATION

Health and Housing partnerships are needed to scale supportive housing. From the Flexible Housing Subsidy pools in Los Angeles and Chicago to leading benefits design work in Washington State, networks are growing between the health and housing sectors to operationalize needed partnerships. Scaling supportive housing will require new levels of cross-sector collaboration at the federal, state, and local levels. CSH's pioneering work on FUSE was an early model to share data and develop cross-sector projects. CSH's Cross-Sector Partnership 8-step model offers a framework for state and local leaders to bring together sectors to scale supportive housing and address complex needs in their communities. The Impact Investment arena brings together the best of community's progress in investment, program, data, and quality fields to harness the needed capital and capacity to scale supportive housing. As the housing sector sees new investments such as the Emergency Housing Vouchers from the American Rescue Plan, the sectors are uniquely positioned to work together to align, coordinate an even

[26] https://www.csh.org/resources/policy-brief-summary-of-state-actions-on-medicaid-housing-services/

perhaps integrate health care systems with the housing sector. This alignment would ensure equity and impact for communities.

3. GUIDING HEALTH CARE INVESTMENT TO EQUITY AND IMPACT

The next wave of investment in health and housing work must center equity in a manner that is accountable to communities. Measuring that impact will be central to determining if and how efforts need to be adopted, revised and/or retained. Health care investments in SDOH require greater scrutiny to ensure equitable impact. From insurance companies investing in Low Income Housing Tax Credits (LIHTC) to hospitals using their community benefits funds for housing to venture capital investors considering technology solutions and value-based social care, the fields of public sector health care and housing have seldom seen this level of investment consideration. Racial Equity need to be developed to design impact analysis and ensure that these investments lead to more significant health equity in communities. The work must be led by those with the values, the expertise, and the networks to guide investments in local communities.

4. ADDRESSING CAPACITY BUILDING NEEDS BETWEEN SECTORS AND FOR PROVIDERS

The challenge of all this exciting investment is the capacity-building needs. State and local governments have lacked sufficient staff and resources for a long time, and now the tidal wave of funding, starting in 2020, can almost seem overwhelming at times. Whether for direct services staff, supervisors, or administrators, provider agencies need support and time to grow. CBOs have considerable opportunities to draw down funding from Medicaid and Managed Care if they have the administrative capacity to take advantage of these opportunities. Partnerships between sectors are the future wave, but these partnerships take time, resources, and support to grow. The work ahead includes housing pipelines development and management, development of Medicaid authorities, or creating data sharing frameworks and agreements. CSH's Supportive Services Transformation Fund (SSTF) proposal includes resources to build the needed capacity for CBOs. The proposal builds upon our work in states with Medicaid housing support services and the challenges CBOs faced in taking advantage of the opportunity of the Medicaid benefit.

5. THE OPPORTUNITIES OF HCBS EXPANSION AND #CARECANTWAIT

The HCBS field is poised for historic investment over the coming years. With the aging of the American population and the high rate of workforce participation comes care needs that Americans cannot address for their children, their aging parents, and themselves. The HCBS program was called out early in the Biden Administration as needing attention, policy reform, and investment. The Better Care, Better Jobs plan offers a pathway for states who wish to expand their HCBS programs in an integrated and strategic manner.[27] Since the services in supportive housing have been called out by CMS as a state optional part of the HCBS program, this attention is welcomed by CSH. This attention allows us to grow supportive housing services in a manner that aligns with new and future investment in affordable housing in our communities.

6. THE AGING POPULATION

The aging of the American population over the coming decades is well documented.[28] These facts impact current supportive housing residents, homeless systems throughout the country, and the state's long-term care rebalancing efforts to ensure older Americans remain in their homes for as long as possible. Americans' preference to remain in their homes is also well known. Still, we need to develop the affordable and supportive housing and services needed to ensure that people can stay in their homes and live with dignity.

7. INVESTMENTS FROM VENTURE CAPITAL IN AREAS SUCH AS COMMUNITY RESOURCE REFERRAL PLATFORMS AND VALUE-BASED SOCIAL CARE

States are investing in technology solutions to address unmet basic needs such as food, clothing, and housing. The dilemma, however, is that while information around these resources can be improved, the fundamental problem is capacity. A technology platform can offer information about where food pantries are in a community but can do nothing when the pantry has no staff or food. These platforms can provide data to drive investment if the social services field remains vigilant in understanding the uses and misuses of these systems.

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[27] https://www.aging.senate.gov/imo/media/doc/Better%20Care%20Better%20Jobs%20Act%20One%20Pager%20SBS%2006223.pdf

[28] https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging#:~:text=The%20number%20of%20Americans%20ages,quadruple%20between%202000%20and%202040.

Ideal systems will lead to gaps analysis and developing the budgeting necessary to close gaps. CBOs expected to enter data into these systems will need funding and training to be the partner states believe they can be. CSH would like to remind states and tech partners that these systems are a means to an end, not the outcome of meeting community needs equitably.

SUMMARY AND NEXT STEPS

These seven opportunities over the coming decade have the potential for the supportive housing movement to grow exponentially and hopefully reach the needed scale. As the supportive housing movement leaders, our role is to guide and support the field and increase engagement with partners from the health care sector. This health care strategy, aligned with CSH's values and drivers, outlines some aspects and factors in the growing health and housing ecosystem and can help us develop specific work and tools internally to move our agenda forward. CSH has led the supportive housing movement from its humble beginning and the 2020s.