Working Together to Empower Community Inclusion: Health/Housing/Independent-Living Partnerships

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ERICA McFADDEN: Hello everyone. We will get started in a minute; we are just waiting for people to fill into the room.

Good afternoon, everyone. I think we will go ahead and get started as people are coming in. Welcome to the Housing and Services Resource Center's webinar, titled "Working Together to Empower Community Inclusion: Health/ Housing/ Independent-Living Partnerships." You'll be learning a lot from the presenters in a short amount of time. We've also built in a variety of opportunities for you to be active participants too. We really appreciate you joining us today. Next slide.

My name is Erica McFadden, and I am the Director of the Office of Independent Living Programs, at the Administration on Disabilities, which is part of the Administration for Community Living. I will be serving as a facilitator for today's webinar. It really is a privilege of having so many of you here with us today. When we saw the registration list, we were really excited. Your active involvement in the webinar will be essential, for us to have an engaging, enriching discussion.

There are a few housekeeping items we would like to address. The first is the meeting is being recorded. By staying to participate, you are consenting to the recording. All of the attendees have been muted for audio quality. One hallmark of our webinars is active participation from attendees. So please frequently use the chat to make comments, and submit your questions at any time in the Q&A feature in the Zoom dashboard. You can also email question or comment to HRSC@ACL.HHS.GOV.

We did reserve time to address your questions at the end as well. You can use the chat or email if you have a technical issue or comment for other attendees.

Before we start with the presentations, I would like to tell you about the Housing and Services Resource Center, which we call HSRC. It stands for a new partnership between the Administration for Community Living, the Department of Health and Human Service agencies along with the Department of HUD. Every state and community has a number of entities and programs helping people access housing and supportive services. But the housing and services system, as we know, is often siloed.

Stronger collaboration between these systems will help more people with disabilities, older adults and people experiencing homelessness to achieve housing stability, live with dignity and independence within the community, and avoid homelessness and costly institutional care.

People with disabilities or older adults can stay stably housed, healthy and active in their communities. The HSRC provides technical assistance across the federal agencies to cultivate cross-sector partnerships that bring together housing, homeless services, aging and disability services, and health, including physical, behavioral and mental and public health, an effort to address tackling these silos. After the webinar, I hope you will look at website. It will be on the slide. At the end, we will share email addresses so that you can also be in touch with us to get periodic updates of what we are up to.

The HSRC serves many sectors, each with its own unique terms, policies and practices. Within the webinar, we will be approaching community inclusion from the ADA or the Americans with Disabilities Act. This far-reaching piece of civil rights legislation makes clear that people with all of kinds of disabilities have the same right as people who do not have disabilities to live, work and participate in their communities. Yet far too many people who can and want to live in a community remain in institutions because there aren't many options. That is why a critical focus at ACL helping people with disabilities of all ages move out of nursing homes and other institutions and avoid entering in the first place.

So today I ask that we all focus on a single goal, which is community integration. We are going to feature partnerships and strategies that have been developed particularly for people with mental illness but which are broadly applicable to all other types of disabilities.

It is my distinct pleasure to introduce our first presenter. Both are national presenters that coming up next, and we will be sending out their bios tomorrow after the webinar so you have an idea of their expertise. The first one is Kimberly Reynolds, she is a Public Health Advisor and Government Project Officer for the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The next is Marti Knisley, with the Technical Assistance Collaborative, TAC. Why don't you just kick us off.

KIMBERLY REYNOLDS: My name is Kim Reynolds, and I work for the Substance Abuse and Mental Health Services Administration, or SAMHSA, in the Center for Mental Health Services in the division of State and Community Systems Development. So SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance abuse disorders in their families. It is a privilege to be invited to speak with you today about the topic of community inclusion for people with disabilities including those with behavioral health conditions. The concept of community living is a central tenet of SAMHSA's vision and mission and is inherent in how we define recovery from behavioral health conditions. We believe all people can recover from

mental illness and substance abuse disorders and their recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

The four major dimensions of recovery that guide us include health, overcoming and managing symptoms, and making informed and healthy choices. Second, home, having a safe and stable place to live, and I will add that, in the most inclusive setting of a person's choice. Third, purpose, conducting meaningful daily activities such as employment, school, other opportunities to participate in society, and fourth, community. Having relationships and social networks that provide support, friendship, love and hope.

SAMHSA resources support recovery in many ways. I will talk about a couple of examples today. First through the Protection and Advocacy for Individuals with Mental Illness or PAIMI program, we provide formula grants to protection and advocacy programs in all states as well as DC, five territories and the American Indian Consortium for Native Americans. PAIMI programs protect and advocate for the rights of those with serious mental illness or serious emotional disturbances, residing in public and private facilities and community settings at risk for abuse, neglect, and rights violations by using administrative, legal, systemic or other appropriate remedies on their behalf.

They also investigate reports of abuse, including the inappropriate use of seclusion and restraint. They ensure the enforcement of U.S. Constitution, federal laws and regulations as well as state statutes. As you may know, the state of Georgia's PAIMI program was instrumental in bringing the *Olmstead vs. L.C.* case to the Supreme Court.

So we also provide formula grants to states, territories and tribes that enable them the flexibility to meet their unique community-based mental health and substance abuse prevention, treatment and recovery needs. We provide funding to behavioral health providers for Certified Community Behavioral Health Clinics, or CCBHCs. This model is designed to ensure access to comprehensive behavioral health care and is assisting individuals not only in navigating and coordinating their behavioral health services but also their physical health care, social services and other systems that they are involved in. CCBHCs are required to serve anyone who requests care for mental health or substance use regardless of their ability to pay.

Through a variety of mechanisms, we provide funding and other resources to support states, territories, tribes, and behavioral health providers to develop comprehensive crisis systems designed to support individuals in their homes and communities during times they may otherwise end up in more restrictive settings. We provide funding, technical assistance and other resources related to housing and homelessness including five grant programs. The PATH, Projects for Assistance and Transitions Homeless programs; treatment for individuals experiencing homelessness; cooperative agreements to benefit homeless individuals; grants for the benefit of homeless individuals; and our SSI / SSDI Outreach, Access, and

Recovery or SOAR program. We also provide technical assistance and training through our national Homeless and Housing Resource Center.

In addition, within SAMHSA we have an internal housing stability workgroup, which focuses on infusing housing stability as a key component and consideration over all SAMHSA programs given how foundational housing is to recovery and overall health. Finally, we partner with a number of federal agencies and national nonprofits on related initiatives, including our recent work with the Administration for Community Living on two new resources to address competitive and integrated employment for individuals with disabilities, including those with behavioral health conditions. Now I will turn it over to our next speaker, Marti.

MARTI KNISLEY: Thank you, Kim. I am going to briefly reiterate what Kim just mentioned about what is community inclusion, and why are we here today. It is really the opportunity for a person to live in the community of their choice, as a contributing member, being valued for their abilities and uniqueness and at the same level as a nondisabled person. We each play a role in helping individuals become more included in their community by building partnerships to support a person to create their life and be a part of the community and to create housing opportunities that make a house a home.

So why does this matter? As Justice Ginsburg wrote in the *Olmstead* decision, "Segregating people with disabilities really severely diminishes [their] everyday life activities, including family relations, social contacts," all of which you see here on the screen. Educational advancements, cultural enrichment.

Clearly, institutions segregate people. Without support for those everyday life activities, segregation can also continue in the community. We are here today to talk about how to prevent that from happening. I believe I am turning it back to Erica.

ERICA McFADDEN: Thank you for the great information. Now we have time to turn it over to our powerhouse panel. They will be sharing information about some best practices, potential partnerships, things that they are doing to promote community integration. First, we will start out by introducing Vicki Smith; she is the Executive Director of the Alliance of Disability Advocates, which is a Center for Independent Living in North Carolina. We are also going to have Ann Oshel, she's a Senior Vice President of Community Health and Well-being for the Alliance Health Plan. While both have alliance in their name, just know that they are two totally separate distinct organizations, okay? So we all work together in that space.

Marti is also going to be on our panel; she's been working with both Vicki and Anna. We're going to be speaking to all of them about their approach they are using, their funding, partnerships and more. After they are done sharing their wisdom, they will turn it over to you all, hearing what your questions are for the panelists. Kim is also going to be staying on, you can be sure to post your questions too in the Q&A feature. That would be within the Q&A feature. With that being said, we will turn it onto the panel discussion, that we will turn it over to Marti first. What is the model

of community integration and inclusion that you have been using to guide the process of transitioning individuals?

MARTI KNISLEY: Thank you, Erica. Let me set the context for the model in North Carolina first. I'm the independent reviewer advising the state on meeting the terms of their *Olmstead* agreement between the U.S. Department of Justice and North Carolina. This requires the state to offer and provide services and housing to individuals with disabilities in the most integrated settings possible. The agreement followed the DOJ investigation that found that individuals with serious mental illness, and other disabilities and health conditions, were given few if any choices to live in the community.

Instead, individuals were directed to move to and remain in congregate settings, primarily adult care homes. Over time, this became the de facto placement option for thousands of individuals with serious mental illness. The state began implementing this agreement with the required transition process providing more supportive housing and supported employment and services including tenant support. The state knew that the support to help people move and remain in the community would not by itself be all the help an individual needed to live a full life in the community. We sought opportunities to assist individuals to make connections recognizing and pursuing their interest in life. Luckily the NCADA was also interested in assisting in the same place and reached out with the idea for a community living inclusion project. They knew they would need a partner organization, one that could help them make introductions to individuals and adopt the model.

The Alliance for Behavioral Health was responsible locally for transition services, supported housing and supports. They also recognized the need for a partnership with the NCADA. So the state took the chance by providing seed money for the project. But make no mistake. Both the alliances have quite a bit of sweat equity in the project. They both knew they would need a partner and it could not come through, the supports could not come through, the formal system alone. The […] of their success has […]. These two partner organizations shaped the model themselves, again, testing it out one person at a time. It works and now the state is wanting to take this approach statewide.

ERICA McFADDEN: That is a fantastic model, and we appreciate you sharing that today. Will turn it over to Ann to share.

ANN OSHEL: Is nice to be here today. Thank you so much for your visionary work and imagining this kind of conversation. I think that this is exactly this kind of conversation we need to be having nationally. Even as people were putting their names and where they are from in the chat, I saw Oregon, Seattle, LA, Philly. Those are all places we have been carefully watching ourselves over the last few years, for the innovative work that they have done along the 1115 waivers, especially states that have been under a similar settlement as North Carolina. So we all learn from each other. I think it is going to be a little weird to hear from two alliances that really are separate and apart. For Alliance, as a health plan, we

believed before we figured out the operational managed-care logistics that housing is health care.

When you think about the coupling of housing and healthcare, we naively at the time, this was more than 10 years ago, thought, we are obligated under managed-care function, so what does it look like to have a benefit package that covers community living and community inclusion, supportive services? What does it look like to have medical necessities for these services when often their needs of tenancy are longer than sometimes their symptoms of whether or not they are in the hospital or such.

So we have spent years to figure from an operational managed care, how do you pay for it? What does it look like? So finally, the question that we should all get to is, is it making a positive difference for people? We could speak the rest of the time about the iterations of learning that it took. We are very comfortable in our zone of the typical Medicaid services, the services for people who have no insurance. North Carolina is not a Medicaid expansion state, where a lot of the work that Vicki, and Alliance and others have done together do not want to create a dichotomy of a system of those who have Medicaid and those who do not.

For us it was really the realization several years ago, that said health care doesn't just happen within the four walls. Health care happens within the community, and health care is not, the outcomes of health are not, necessarily related to what service they receive. It is about their satisfaction of life, their inclusion in life. Erica, some of the things you described as community inclusion was exactly the impetus, of why we have persevered and stayed determined in looking at whole person care from a managed care perspective. It really is about honoring the life that people want for themselves and incumbent upon us to have the money follow that person and follow what it looks like in community living to have full and equitable participation in their communities. From a health plan perspective, and managed care perspective really, we are perfectly positioned to make all of that work come together in terms of how people perceive services and how people experience services. Go ahead; I'm sorry.

ERICA McFADDEN: That is great. I was going to ask for all the Centers for Independent Living participating today, what made your health plan decide to partner with the CIL Alliance as an advocate, making that vision a reality?

ANN OSHEL: I can answer that in a single word: Vicki. So for us it really was the longest realization, this path, of what does it take? And hearing from the people that we have served, especially hearing from the advocates, about what matters the most to them. Social connectedness. Having all of the opportunities, doing the rights and responsibilities of tenancy in communities of their choosing. Those are not just lofty aspirations and theory for us, that is with Vicki's support and always sitting in my ear saying we have to do more. We have to get this done. That is exactly the kind of advocate that you want to push the system as a payer, push the system across all populations to really live our practice of having people not only transition out of institutions but living their best lives out of institutions.

So it really, Vicki will be way too modest to say, it wasn't me. But it was really Vicki and her advocacy and what the Centers for Independent Living represent to health plans. So that is really where it came, and it is all for us about empowerment and using our best practices, using what we know to create the service system that encompasses all of that. Not just having community life be a part of our philosophy but a part of our practice, part of our payment structure.

ERICA McFADDEN: That is great. Sounds like you were saying perseverance pays off. Relationships are key. Which is a recurring theme across the panel. So with that great introduction, Vicki, is a good segue to you to share some of the highlights that your center, what you have done with the center to empower people with disabilities and transitioning from institutions, helping them remain in their communities.

VICKI SMITH: I shifted my camera so I couldn't see my mute button. I think Centers for Independent Living are essential to promoting community living. I saw as people signed up, lots and lots of folks signed up as a Center for Independent Living. So centers really are about moving from an institutional setting into the community, so it is a natural fit. This is what we are created to do. I think that this settlement agreement does create the opportunity for centers to move into an area where we do not usually think about as transitioning from a facility given our history. What we do mostly, is that we listen to the people who are making the moves.

Literally moving from one place to the other. In North Carolina we call these individuals consumers. We do not call them clients, we do not call them patients, we call them consumers. They consume our services. So one of the first things we do, when we get a referral from Alliance Health and other programs like them, we sit down and ask them, the individuals, "What you want to do in the community?" The goal is help them to maintain their housing but first we have to turn the house into a home.

We been working with a list of things that people do in the community developed by Temple University, the individual named Mark Salzer, some may have heard of him before. These are about 30-some activities that people do. That you do, I do. We sit down, we talk with the individual, then we just work down the list.

We come to a first item and then we ask them, "Is that important to you? Is going to the library important to you?" If they say, no, then we move onto the next one. If they say yes, then we ask them, "Are you doing it? And are you doing it enough?" If it is something they want to do and not doing enough, that becomes our goal. What it does is it creates a connection for those individuals to the community. Out of that, they develop a whole list of resources and natural supports that make them successful. So when you have that approach, as someone who is doing some work on this, Mark Salzer, can say that using this approach, three out of four people retain their housing as a result, of finding them, connecting them to

the community. If we do not do that, 50% of the people returned to a facility at some point in time.

So this is really, demonstrates that, finding that community, that connection, those natural supports, are key to successful community living.

ERICA McFADDEN: Thank you, Vicki. It sounds like you have the perfect ingredients for attention by using the Temple model. I know that people on this call today are going to be asking about the funding. It is always the big elephant in the room, funding. I'm going to turn this question to Ann and Vicki. Ann, I wonder if you could just start us out with what are the different sources of funding out there that can be used to support this work, especially from your health plan as an example?

ANN OSHEL: This is where the rubber hits the road and how do you pay for it. For us, for the people we serve, it is a variety of funding streams and funding sources. Looking within Medicaid, service definitions for those opportunities, not everybody wants to be in a Medicaid network. It changes your business model. How could we have flexible funding, for Vicki's group, who says, "Medicaid is great but I do not want to hire 10 account specialists each month to reconcile my billing then have you all live by what we authorize."

I think there is opportunity state-by-state to look at block grant funding and SAMHSA funding. I think community inclusion, while it has always been a thing, it is becoming a thing. So we are always looking for partnerships and funding opportunities and those things within Medicaid and where North Carolina has made progress on incorporating some of this language in Medicaid service definitions. And we still need to take it further because the first thing that you will see in how we authorize services is what is their level of functioning, and their symptoms. Not all of the really important questions that Vicki just talked about.

We also worked with Mark. He developed a toolkit especially for us and our work on transitions of care. Because we haven't figured out how to pay for everything we want to pay for, we have hired our own team of community inclusion specialists. So that we can test out what are some of the interventions, what are the payments, then you just move into the world of Medicaid and everything has a rate. Before we do that, we really just wanted to see, how does this model need to evolve to doing it according to best practices? How do we back into a payment structure? So we're still working on that.

VICKI SMITH: From perspective of any nonprofit organization, we are looking for funding sources all the time. So we fund a very similar program for helping people with disabilities move out of state prisons. Using an individualized re-entry plan based on the activities people want to do in the community. That is funded with DD Council money. We also look for a lot of grants; we are constantly looking for private foundation funding. As well as the board does fund raising. We are out there trying to raise more money to expand our work.

ERICA McFADDEN: That is great. I have to tell you, that the people on the chat are asking for the list of 30 activities from Temple. So we will be sending you all that at some point. Hopefully, with the resources after this call. You will have access to that, is that available? Vicki? Ann and Marti?

MARTI KNISLEY: I saw someone put a link in the chat.

ERICA McFADDEN: Turning it over from funding, I wanted to ask if you have been partnering with the Public Housing Authorities in this work?

ANN OSHEL: Yes. We can spend hours talking about access to housing inventory. I think that was another quick learning for us as a health plan. That as much as we stood behind community living, housing choice, community choice, you can't create that for people if you do not have access to housing. Even with federal protections, the people we serve are often discriminated or marginalized in housing and we are not developers, we are not property managers, we're not landlords, we do not buy property. That would never be a business we are in, so we went looking for partners where that is what they do. We've done several million dollars in capital investments. I think our most impactful work is what we have done with the local housing authorities both in terms of creating access to the inventory that we want as well as educating our housing authorities around the importance of housing for people with disabilities.

For our three major housing authorities in the region that we serve, we all have *Olmstead* agreements with them that outline our partnership agreement in terms of federal vouchers that they have exclusive to the people we serve. To date through the three housing authorities, we have over 170 vouchers exclusive to the people that we serve. We can negotiate tenant selection plans, reducing the barriers to accessing housing. Since it is a federal voucher, it honors the importance that we place on scattered site housing.

So people choose where they want to live. Yes, the landlord has to accept the voucher. We have a whole team that does nothing but landlord outreach and engagement, customer service. We didn't start with that; we started with just knocking on the doors of Housing Authority saying, "I know it is kind of an unusual relationship, but we would really like to talk to you about how we can be good partners."

So out of this has grown the relationships with housing authorities, and as a result of that, the number of specialized vouchers for people with disabilities that have come into our communities has over quadrupled. We have housing authorities who have never applied for vouchers for people with disabilities because they couldn't do the supportive services, and now that is a part of our partnership agreement on every round of HUD vouchers that they can for people with disabilities, they are partnering with us and applying for that. We went from hardly any, on the same waiting list as everyone else, to having these exclusive vouchers in just a few years. With the importance of the housing authorities, adopting an *Olmstead* preference as a part of their housing voucher plan.

So it was that symbolic victory, and it literally created the Willy Wonka Golden ticket that we really could give to people who are leaving wherever they are coming to and actually get to choose the housing that they want. That is scattered site, which is really important to us.

ERICA McFADDEN: Thank you, for detailing how you did that. It was one meeting at a time with one Housing Authority at a time to build the relationships and advocate and educate about the need. So I appreciate you doing that and increasing at least the access point to affordable accessible housing for our community. So that is wonderful. I will turn to the hardest question of the day for this panel. Okay? That is, you have to only give one tip to others about how they could replicate the work. And if you are going to give them one tip, what would it be? Then I will just turn to whoever wants to answer first.

MARTI KNISLEY: I will start first. Partners have been talking, and really it is about trying to find the connections for these partnerships. It is true here in North Carolina, the impetus was how do we be successful not just in meeting the terms of the settlement agreement, but sustaining long-term. The housing that Ann is talking about will be available long after the settlement agreement is over and the same for Vicki and her work as the state takes this work statewide. For me, I think it was finding the two partners, one in the formal system, one who was investing in housing, one who was investing in the choice of housing and, by the way, with great support for tenancy rights, home health, personal care services, all of that package people needed in putting all of that together and finding that missing piece.

As Ann said, I cannot say enough about the CIL and how seriously they have taken the step to find that one thing, or more than one thing in some situations. If we have time to hear Vicki's stories it would amaze you about what is really happening in the community. It is unbelievable. As a reviewer I get a chance to see their work, and I can tell you, that it is real.

VICKI SMITH: I would love to take my time to tell one story.

ERICA McFADDEN: We would love it. Go for it.

VICKI SMITH: This is first person that I heard about. I retired from Disability Rights North Carolina, which is the P&A in North Carolina, and two months later I came here to be temporary while they were looking for a new executive director. I am still here. The first story I heard from using this connection to community inclusion involves a woman named Patty. Patty was at the time in her late 40s, early 50s. She had never lived alone before. She had always been in a situation where it was an abusive situation, there was a lot of substance abuse. She was in and out of facilities. When we first met with Patty, we asked her what she wanted to do. She wanted to do is to live in her house alone. But she didn't want to be alone. She didn't want to live with any people, but she was terrified to be alone. So we started talking with her, and we found out that she also had never had a pet. So

she decided she wanted a dog. We helped her go through the process of finding work, and she wanted to rescue a dog—that was really important to her. So we looked at animal shelters and talked to her about what she would need in order to care for a dog, where she would have to walk it, feed it, they would have to get permission from her housing provider.

Long story short, she got a dog. She learned how to take that dog, she got a collar and a leash, and she started walking the dog. The dog happened to be cute. Which was a good thing, and friendly. So she kept running into people who had dogs. They were walking their dogs and they would meet up to walk the dogs together. They would then go to a park where the dogs can play. Then they started going out for coffee afterwards.

Patty, who had never had a driver's license before, eventually went on to get her driver's license. We helped her practice for the test. We told her how to sign up. She is now going to church on a regular basis, connected to the community, and she is going out there in the community doing good work. That is Patty's story. She wanted to live alone, she had a house, but she didn't know how to make it a home. And that is key.

ERICA McFADDEN: That is a great story, Vicki. It shows the importance of actually listening to what the individual or consumer wants as part of that transition. Thank you; now we understand, truly inclusion is not just sticking them in a house, it is beyond that. Ann, do you want to share your tips before we segue?

ANN OSHEL: That is a hard one to follow, so I had two quick things to say about it. That really is about being innovative. Pushing the envelope, pushing the service system, pushing the way it always has been done. Really thinking again beyond the typical healthcare delivery of what people want for themselves, what they deserve, what *Olmstead* had mandated in setting up your service system, payment system for that.

Just a quick story from a health plan perspective. About eight years ago, when we really embarked on this for real, for real. All of that culminated into us deciding as a health plan that we will no longer pay for mental health group homes. That we created the community living options and the supportive services with the community inclusion toolkit, that we wanted to begin giving everyone the opportunity to live their lives in the community without saying, you go here and you go there.

We had four gentlemen who had spent their entire adult lives living in the same group home. They all said yes, this sounds like a way better life that one we all have in the group home. Nothing against group homes, but just to Vicki's point about asking people, we never asked people is this where you still want to be, would you like another life for yourself? We found them four one bedrooms in the same apartment complex during COVID. One gentleman, by the time he transitioned—for all of them, it was the first time that they signed their own lease in their whole lives—and for one gentleman, he was in stage IV kidney failure. His

community inclusion process helped him plan his end-of-life. It was powerful to watch this group of people, in the community that he had created outside of a group home, with the people he chose to accompany him through some difficult health decisions that he wanted for himself, which included no longer having dialysis, which was not an option for him as long as he was in the group home. He eventually passed away.

His community inclusion team accompanied him through the whole journey. There are definitely all of the stories of how people have the opportunity to live their best lives. There is a power in community inclusion to give people the opportunity to make their own decisions without formal systems, bureaucratic systems forcing a different decision upon them. We will never do housing without community inclusion. It comes in the same breath. There is a lot more work to be done but for us, it really is about finding the great partners of Vicki, the wisdom of Marti, and all of our state partners to create a service system that is paid for to do this great work.

ERICA McFADDEN: Thank you. That was definitely a powerhouse panel. Would you all agree? We really appreciate your stories and your insight today. Now it is your opportunity, as the audience to ask questions of the panelists. I think Kim is still here as well. So I'm going to actually tap to my colleague Molly French, who is serving as the HSRC director, to field these questions and answers because I cannot multitask on technology. Molly, what is our first question?

MOLLY FRENCH: Thank you Erica. There's been so many great questions. Thank you all for putting them in. One of the questions was for Vicki. Ann or Marti, if they have also responses they can chime in, or maybe even Kim, you may have an additional response. It's going into the funding question. Vicki, there are a number of questions where people are asking if you are still using any Medicaid funding to support your community inclusion work?

VICKI SMITH: We have not to date. We are getting our funding mostly through partnerships and grant opportunities. We're trying to avoid a fee-for-service reimbursement, because that would actually change the dynamic of how we approach the work.

MARTI KNISLEY: I wanted to add, particularly with Kim on the phone here today, I believe that some of the initial funding for the project did come through the mental health block grant. The state has…it is very interesting when you look at the success and the outcomes (Audio Issues) the state got the benefit.

ERICA McFADDEN: Did anyone have any responses for that question? Okay, we will turn into the next question. Molly, are there any others in the queue?

MOLLY FRENCH: There are quite a few. One of the participants asked what can be done so states better leverage their existing networks of Centers for Independent Living?

VICKI SMITH: I will take this one. I'm not sure I know the answer to that. I think part of the answer, at least in North Carolina, is early on, Centers for Independent Living really operated as an entity unto ourselves. Again, this is history. We didn't look to partners like the DD Council. Like the managed care organizations in the state.

I think it has to be a blended service. It would be great if we could find one big funder or get lots and lots of money to be able to do the work. But in North Carolina, we have 100 counties, and our Centers for Independent Living only cover half of them. Centers for Independent Living, at least in some states, ours included, are not covering all of the counties. Until we can get the appropriation from Congress, that is always going to create gaps. We have to get out there and talk about who we are and our successes.

MARTI KNISLEY: Is it true that the state is asking you to help other centers get their projects off the ground?

VICKI SMITH: Right at the moment, there are I think six or seven LME/MCOs in the state. Alliance Health is one. We're working with another one, East Point, directly, but the state is now interested in giving money to the other local management entities to expand this. But even when they do that, we still wouldn't cover the whole state. So it is a resource.

ERICA McFADDEN: Thank you, Vicki. So I'm curious; we have a lot of questions. Molly, where do you want to go next?

MOLLY FRENCH: This is a great question we had early on for Kim. Just because employment can be a really integral part of that community inclusion, the participant was wondering what supports or assistance does SAMHSA make available to help people with employment?

KIMBERLY REYNOLDS: That is a great question. I would say that one of the greatest resources that we provide are the mental health block grants to every state and territory. States then flexibly decide how they're going to distribute that funding based on the needs within their own state. So supported employment is certainly one of those services, one of those key services that are provided using block grant funds.

One of the nice things about mental health block grant funds is that while it is a relatively small amount of the total funding of a state on their behavioral health and their mental health services, it leverages, it is sort of a key lever to pull down other funding. So if you are interested in how supported employment is being funded in your state, I would encourage you to talk to your state behavioral health authority.

ERICA McFADDEN: Thank you, Kim. Next question, Molly.

MOLLY FRENCH: There were quite a bit in the chat and also some in the Q&A. Just relating to community inclusion only works if there is a place for someone to move

to that is affordable and accessible. So what have been some effective strategies that our panelists have found in terms of finding and securing that housing?

ANN OSHEL: I can start with that. At Alliance, we have over 1,400 people living in our supportive housing programs. A thousand of those are persons who are participating in the DOJ settlement. It is a struggle. It is a struggle, and there are many policy issues that create a hardship.

So for us, this is where we placed a lot of our sweat equity. We knocked on the door of the Housing Authorities with really nothing to offer except a promise that we would be good partners. That we would offer supportive services, that we would have a point of contact at Alliance, so that if there was a tenancy issue, that they would have somebody to call that would always to call them back. We did a landlord incentive program. We do have a whole team, and I want to say a whole team of people is three people. So a whole team of three. People who really focus on our landlord engagement and recruitment.

It is pretty competitive out there. There are the CoCs that are also looking for affordable housing and so for us, several years ago it became apparent to us that we would have to develop our own strategies to create access to inventory. And that is how we make capital investments into acquisition rehab and tax credit development. We have done that, and it has been a big payoff for us, as well as the partnerships with the housing authorities.

So my advice is, if you're looking to start someplace, start with your housing authorities. They are often the largest landlords in your communities. And to understand the voucher system, to understand a quid pro quo. It took us a while. We knocked on a lot of doors before anyone talked to us, and I think it was because we were pesky, but it has more than paid off for us.

MARTI KNISLEY: To add what Ann was saying, the state of North Carolina has also used Home 811, they encourage the application across the state and help with applications for mainstream funding. They have been using National Housing Trust Fund and setting aside units in tax credit and bond properties for people across disabilities. So this is not just for individuals in the settlement, but understanding that all people with disabilities need affordable, safe housing, and they work very hard on improving tenant selection so people aren't turned down as often and making sure they use reasonable accommodation. They have gone a long way to not just say "for settlement we will pay out so much money," because they understand that it will end, and what you really need to do is to have a strong housing system. The rent issue today is a major (Audio Issues) across the country.

ERICA McFADDEN: Thank you, Marti. I think with that I think we are going to have to segue to conclude the webinar today, but I have to tell you, you all had tons of questions and answers. That is why HSRC is here, because after this webinar is over, they are still there to provide information and assistance. I want to thank the panel. You all have proven that you're definitely experts. You've shared some great advice, in a short amount of time, and you stuck to your time

allotments, so thank you, as a facilitator. I just... you also showed us what inclusion was. The stories are so powerful. It's not just a house. It is supporting the person with a community of people that are there for them. We also heard activities we can act on in the couple of weeks. Just wanted to remind you all, in the coming days there's going to be a recording of this webinar posted, and the slides are going to be located on the HSRC website. I know you are asking about that. Keep using the website, which staff provided in the chat.

We will go ahead and see the upcoming HSRC webinar. We have another fantastic webinar coming up. It is next week, it's going to be on August 29, from 3 to 4 Eastern Time. It's called Developing Partnerships between Homelessness Systems Continuum of Care and the Disability, Aging and Health Sectors. They will be offering that and highlighting opportunities for organizations in other service networks to collaborate with each other to address homelessness. If you registered for today's webinar, we will send you the link tomorrow. Or you can use the link that staff are putting in the chat.

We also recommend some other websites that may be useful in your efforts to support community integration, community inclusion. Staff will be putting these web links into the chat as well. We will also email them to you, so do not worry about having to remember these. One is the ACL website for Care Transitions Programs, which features innovation strategies, tools to help to transition individuals from institutional settings. For webinar participants who want to learn more about Centers for Independent Living, which we hope that you do, we have a webpage with background and more links on this slide.

We also recommend our Empowering Advocacy webpage, where you can learn about programs and help individuals advocate to make these choices and ask for support and services they may need to achieve community living and full integration and inclusion.

One last note, our Independent Living program has background information about all of the different types of independent living and wellness programs available, even ones in your area, and that is on the slide as well.

This is the part where we ask you to evaluate us. We will ask you to take some time for short feedback. The staff is putting a link in the chat. There are only five questions asking you to rate different aspects of the webinar. If you have other comments, you can provide them as well. Just know we read all the comments and find ways to act on the input, so is not going to be a checkbox.

Remember, the HSRC is your resource center; it is there for you. You can email us at hsrc@acl.hhs.gov. If you need technical assistance or have website suggestions or if you want to share stories that you have or examples of great cross-sector partnerships, we encourage you to do so.

So finally, I just want to thank Molly and Mission Analytics' whole team, USAging, Jasmine, our ASL interpreter, Herman Dell our CART transcriber, for their roles in

producing this webinar. It was a lot of work, but it had a lot of information, so we are thankful. We are especially grateful for you all for coming today, asking your really critical questions and getting involved. We hope you join us again on future webinars. Thank you, and have a great afternoon.