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# POLICY PRIORITIES TO ADDRESS LIVED REALITIES OF HEALTHCARE AND HOUSING INSTABILITY IN CONNECTICUT

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## Introduction

Before HR 1 (the Big Beautiful Bill) was passed by Congress on July 4th, many Connecticut residents already facing the effects of under-investment in affordable housing braced for impact. During the state's 2025 legislative session, housing services and healthcare providers engaged actively in policy discussions and advocacy efforts alongside the communities they served. Housing advocates stood alongside nursing unions on advocacy days in Hartford, fighting for state funding to compensate for encroaching federal losses in Medicaid and HUD (Housing and Urban Development) funding. On rally days for H.B. 5002, the omnibus housing bill that aimed to expand high-quality, affordable housing options for low-income residents, providers from Community Health Centers made their presence felt. Their collective participation underscored the deep connection between housing and health in the state, sending a clear signal to policymakers that the two are intrinsically linked.

The early impacts of HR 1 are already being felt by many, but come 2026, severe threats to both Medicaid and housing program funding are expected to shift greater responsibility onto state policymakers if they want to keep vital safety net programs like Medicaid alive.

In some cases, integrating Medicaid funding with housing-related services improves housing stability and healthcare access. Historically, strategic advocacy efforts can help protect and expand these programs, even in a landscape of dwindling resources (Paradise & Cohen Ross, 2017). For instance, Connecticut's Housing Engagement and Support Services (CHESS) initiative is designed to improve housing stability and health for individuals with complex needs, particularly those experiencing homelessness and behavioral health concerns (CT Department of Social Services, 2021).

I sought to understand the effectiveness and impact of existing policy making at the nexus of health and housing from the perspective of the communities receiving services, the providers delivering them, and domain-expert researchers.

Exploring how state and town-level policies at the intersection of housing and healthcare shape the well-being of low-income and housing-insecure residents, I conducted interviews and focus groups with individuals with lived experience of homelessness, case managers, program supervisors, and policy experts. These interviews aimed to capture perspectives on current programs and options for

future state and local-level policies. Finally, the interviews examined the utility and drawbacks of policymaking at the intersection of housing and healthcare. This policy brief highlights direct quotes from interviewees, organized by theme, to demonstrate this intersection.

## The Interlinked Experience of Housing & Health Crises in Connecticut

The interviews consistently highlight that housing instability and health are linked, and addressing one requires considering the other. The interviews demonstrate the growing recognition that housing and healthcare are inseparably linked, with secure housing understood as a crucial social determinant of health. Respondents articulate how the environments where people live directly affect both physical and mental well-being, challenging policy silos that treat housing and health as unrelated sectors.

> "I truly believe that it is the responsibility of a government to take care of its people...Housing is a health crisis, you know, and I feel like a lot of policymakers treat them as two completely separate entities. And there's a housing issue and there's a healthcare issue, but they're really very intrinsically linked." —*Senior Program Manager at local Supportive Housing Organization*

> "As soon as I was able to get on Husky, it saved my life... that is the key to staying stably housed is being able to stay stabilized. And Husky, the Medicaid keeps you stabilized because you have access to things that you wouldn't be able to afford if you had marketplace insurance." – *CT resident with lived experience of housing insecurity*

> "I think you know, I've heard people say that housing is healthcare, and I've seen new models where developers and agencies are really making an effort to consider social determinants of health, and housing being one of them." — *Senior Program Manager at local Supportive Housing Organization*

## Barriers to Housing due to Healthcare-related Challenges

The interviewees detailed numerous systemic barriers, including insurance gaps, inflexible Medicaid eligibility, fragmented care, lack of coordination, and high turnover among case managers that compound and complicate health and housing security for CT residents.

"One of the biggest problems with the eligibility limit for Husky is that the eligibility limit is not high enough for most people to live in Connecticut... people are giving up wages that they actually need to live so that they can get health coverage." – *2nd CT resident with lived experience of housing insecurity*

"I feel like it still leaves people underinsured and under-resourced. So, for example, in the past I've had to call mobile crisis to try to help a tenant. And the process was not as streamlined as supposed. Because I called, and they weren't available... So our system...has a great framework, but when it's in practice, it's not always effective or timely." —*Senior Program Manager at local Supportive Housing Organization*

"My Medicaid story is very similar. I'm a very bad asthmatic...I have to pay attention...I will do my job for little to nothing because a certain type of job that I have, I do it 'cause I love it. So I'll do it for free, but bills to pay." —*CT resident with lived experience*

"I can get one check up a year...if something happens, I just go to the walk in 'cause it's gonna be that amount anyhow...it's crazy...when you have conditions that require maintenance, like diabetes...It's very hard to live that way and keep a roof over your head." —*CT resident with lived experience*

"Elders who have chronic untreated mental health conditions are particularly susceptible to losing housing...not to say that communities have everything that we need, because the reality is that it just isn't meeting the current needs of the population." —*Senior Program Manager at local Supportive Housing Organization*

## Existing Programs: Service Delivery & Case Management

The interviews also demonstrated that effective housing programs rely on enrollment achievability, as well as collaborative relationships between tenants, case managers, and healthcare providers once enrolled. Additionally, housing programs that collaborate with care providers to support the unique mental and physical health needs of their clients are necessary for many clients' ability to stay housed. However, high turnover and inadequate resources undermine continuity of care and outcomes.

"Major challenges facing permanent supportive housing is people aging in place. As they age, their needs become more complex. Case managers may not be able to identify what these medical needs are. The resources MIGHT not also exist in the first place." *—Senior Program Manager at local Supportive Housing Organization*

"If I had an emergency, I wouldn't know which hospital is the NGO and which one is not. I would just go to the closest one and hope for the best." *—CT resident with lived experience*

"Case managers who are experienced are effective...who build relationships with community mental health providers...Newer case managers have high-turnover, and continuity of care isn't always there...one tenant said he had been in the housing program for 10 years, and he's had 9 different case managers." *—Senior Program Manager at local Supportive Housing Organization*

"Home care, even if it's a visiting nurse coming to check in... that is a resource that I hear case managers say they want to access but don't know how to access." *—Senior Program Manager at local Supportive Housing Organization*

"Programs that are most successful are the programs that have very collaborative relationships with tenants, on the same page on intended outcome. Programs where case managers don't have to do it all, where the case manager is a link to a resource--a resource that exists, not a resource where you call and get a voicemail." *—Senior Program Manager at local Supportive Housing Organization*

## Addressing the Knowledge Gap at the Intersection of Housing & Health

Many interviewees highlighted the critical role of legal advocacy and medical-legal partnerships in addressing housing and health inequities and educating both patients and providers to better meet their housing-related needs. Additionally, interviewees noted that these experts can alleviate the burden on case managers to understand complex policies existing at this issue-intersection.

"In a medical partnership, lawyers are educating the residents in a teaching hospital to think about social determinants of health, and sometimes they're

doing policy advocacy work to...to kind of change these upstream drivers." – *Connecticut Housing Equity & Public Health Professor*

"Case managers may not have the expertise to be able to identify what these medical needs are or may not have the knowledge of what resources are available in the community... and not to say that communities have everything we need, because the reality is that it just doesn't—it just isn't meeting the current needs of the population." *—Senior Program Manager at local Supportive Housing Organization*

"Lawyers in medical settings...can have a unique ability...to address social determinants of health, including housing." – *Connecticut Housing Equity & Public Health Professor*

## Successful Strategies in Connecticut

Clarified through interviews was that innovations that integrate flexible funding, cross-sector partnerships, and intentional program design have produced striking differences in outcomes for residents facing housing instability and complex health needs. Additionally, successes often depend on the local context, leadership, and targeted state or community investment according to interviewees.

"NOAH Community Health Center, they have a mobile medical unit and its behavioral health, and it was detailed to the shelter—made a big difference." *—CT resident with lived experience*

"Some of that funding comes from Medicaid dollars... they have services right on site to people who may not go if they had to go someplace off site." *— CT resident with lived experience and Board Member of a local Community Health Center*

"Some agencies...are trying to get a mobile healthcare van to come to their site, which I think is a very cool idea. It's innovative. They're trying something new." *— Senior Program Manager at local Supportive Housing Organization*

"The Medicaid dollars that go through the federally qualified Health Center are more flexible and address sort of a different need... those dollars were very helpful and very timely." *—Resident with lived experience*

"If you want your message to get to people who are currently homeless or unhoused...Short Instagram posts with an impactful quote that links back to something longer-form. People like short-form media...TikTok is great. And sometimes people just need digestible chunks." — *Senior Program Manager at local Supportive Housing Organization*

## The Need for Systems Change

Interviewees across disciplines agree that deeper policy changes at the intersection of housing and health are essential for structural improvement to address the daily health needs of CT residents who are housing insecure.

"People are giving up wages that they actually need to live so that they can get health coverage...That's why we keep pushing for the limit to be raised. And that's also why we push for universal health coverage." —*CT resident with lived experience*

"I think we need more government owned and operated project-based housing that may look different than [old models] ...well-funded, well maintained, vibrant places, maybe that have some income mix in them." — *Housing Equity & Public Health Professor*

“We need something like Universal Health care that’s not tied to employment, so people aren't getting bankrupt and losing their homes when they have health issues, which is something that happens.” – *Connecticut Housing Equity & Public Health Professor*

"One thing legislators should consider when designing programs like CHESS is that health insurance status *does* guide clinical decision-making...Who can we add to the team to deal with case management?" —*Senior Program Manager at local Supportive Housing Organization*

## Strategic Policy Priorities

Across multiple perspectives, interviewees prioritized improvements to Medicaid funding, stronger integration of health and housing services, and protection for affordable housing models, especially those structured as state- or publicly sponsored initiatives.

"I think Medicaid helping with subsidy costs would be incredibly beneficial. Medicaid helping with the cost of services to ensure that case managers are paid a living wage—that could be beneficial and help reduce staff turnover. —*Senior Program Manager at local Supportive Housing Organization*

"My philosophy is sort of as a model: when you take the private market out, there's more oversight, more commitment, more stability, and more protection for tenants when it's project-based... outcome after outcome after outcome, we see the same pattern where the project-based housing provides better health protection." —*Housing Equity & Public Health Professor*

"If there was a way for state-sponsored housing that allows for like rent to own situations...the state builds a house, allows you to rent...bases it off your current income to set a certain rental price, then allows that wealth to carry on generationally..." —*CT resident with lived experience of housing insecurity*

"Housing affordability and access to subsidized housing... Public housing itself is being completely dismantled in favor of vouchers, which have their own challenges... Project-based housing provides better health protection. We want to understand why." —*Housing Equity & Public Health Professor*

## Discussion and Conclusion

Where housing and health policy are thoughtfully integrated, low-income, and housing-insecure Connecticut residents experience more stable housing and better health outcomes. Participants point to flexible Medicaid-funded service models, such as care delivered directly to shelters, mobile medical units, and supportive housing programs with deep behavioral health expertise, as especially effective. There appears to be strong value in program designs that allow experienced case managers to serve as connectors to a network of community-based providers, rather than expecting them to solve complex problems alone.

Moreover, participants seem to indicate that supportive housing models are most effective when they foster collaborative relationships between residents, case managers, healthcare partners, and community organizations. Successful programs tend not to place the entire burden on any one provider or the tenant alone. Instead, case management is envisioned as a bridge, connecting tenants to a wider web of resources. Facilitating this kind of collaboration may require not only adequate staffing and training, but also fair pay for frontline workers to reduce

burnout and turnover, as well as infrastructure that centers on tenant choice, voice, and evolving needs. The recurring mention of continuity, flexibility, and trust suggests these are key ingredients for long-term success.

Practically, residents, providers and researchers alike point to mobile care, integrated legal and medical support, and greater outreach as promising strategies for improving both health and housing stability. While universal health coverage and expanded public housing are described as aspirational, the voices here indicate that incremental steps toward these goals, like raising Medicaid eligibility, piloting site-based care, and meaningfully engaging people with lived experience, can help Connecticut build on what already works to protect those most at risk.

While many interviewees stop short of making sweeping demands, their lived experiences and observations point to a greater need for policy reforms. They suggest expanding Medicaid eligibility and piloting state-backed rent-to-own initiatives that build wealth for low-income residents over the long-term. Policy conversations highlighted by participants highlight that integrating housing and healthcare dollars and designing programs with built-in feedback loops from those with lived experience lead not only to more stable outcomes, but to a system that feels fairer and more humane.

As Connecticut confronts federal threats and the ramifications of national policy shifts, it is increasingly urgent for leaders to advocate for Medicaid funding and look to replicate and localize the cross-sector, people-centered programs that have succeeded elsewhere. There are promising models from other states that Connecticut can look to in countering these challenges. In places like Washington (Thiele and Baily, 2014) and Illinois (IL Department of Healthcare and Family Services, 2024), Medicaid 1115 waivers and cross-sector pilots have allowed Medicaid dollars to fund not just clinical care but tenancy supports, case management salaries, and mobile clinics that effectively bridge the gap between healthcare and housing. These programs demonstrate the value of flexible funding arrangements and community-based care that meet people where they are, facilitating easier access and greater continuity of support.

As Connecticut navigates the impact of federal constraints, advocating for these proven approaches and exploring new policy tools to replicate them at home will be essential to keeping populations stably housed and well.

## References


CT Department of Social Services. (2021, May 5). *Connecticut Housing Engagement and Support Services (CHESS) Initiative Frequently Asked Questions (FAQ).* Ct.gov. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Connecticut-Housing-Engagement-and-Support/Medicaid-Supportive-Housing-Benefit-FAQ.pdf

Deborah Canavan Thiele and Peggy Baily. (2014). *Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States.* Corporation for Supportive Housing and Washington Low Income Housing Alliance. https://www.wliha.org/sites/default/files/FINAL%20Creating%20a%20Medicaid%20Supportive%20Housing%20Services%20Benefit.pdf

IL Department of Healthcare and Family Services. (2024). "Illinois 1115 Waiver Demonstrations." https://hfs.illinois.gov/medicalproviders/cc/1115demonstrationwaiverhome.html

Paradise, J., & Cohen Ross, D. (2017, January 17). *Linking Medicaid and supportive housing: Opportunities and on-the-ground examples*. KFF. https://www.kff.org/mental-health/linking-medicaid-and-supportive-housing-opportunities-and-on-the-ground-examples/