CLOSING THE GAPS:

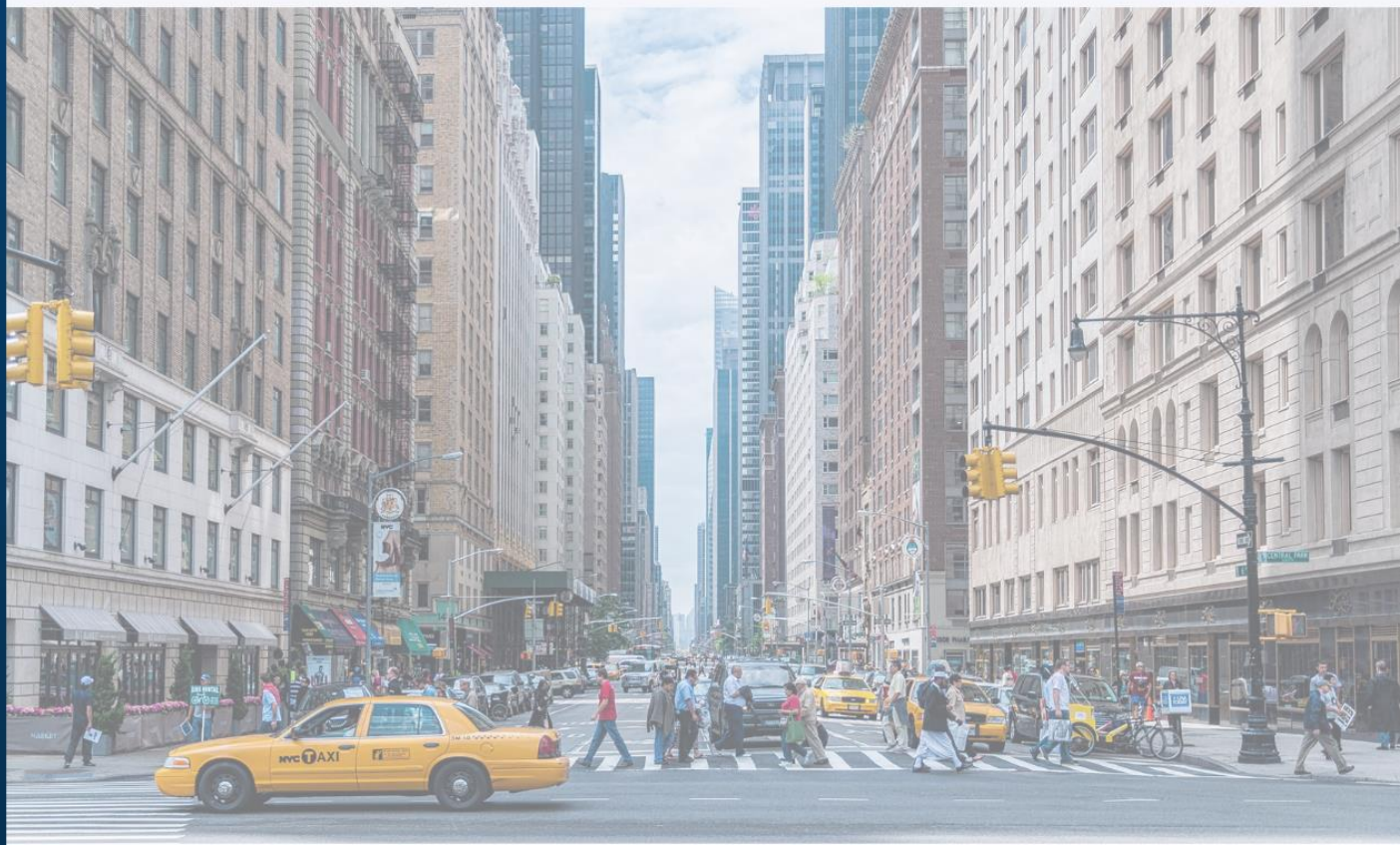
Strengthening Supportive Housing for New Yorkers with Complex Needs

2025

CSH

THE HEALTH & HOUSING CONSORTIUM

the Network
SUPPORTIVE HOUSING NETWORK of NY



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Executive Summary

Introduction

New York City (NYC) is facing a homelessness crisis, with more than 140,000 people experiencing homelessness, including many in migrant shelters.[1] Those experiencing homelessness often end up with poor health and have significant obstacles to accessing healthcare. Supportive housing is an evidence-based best practice that has been proven to reduce homelessness and interactions with crisis systems while helping individuals and communities to thrive.

NYC has made substantial investments in homeless services, including more than 40,000 units of supportive housing, and yet many still fall through the cracks.[2] While NYC has dedicated resources to fund supportive housing units and services, organizations struggle to match people with appropriate units and sufficiently fund the services needed for supportive housing tenants to stabilize.

Methodology

CSH, Supportive Housing Network of New York (The Network), and the Health and Housing Consortium (The Consortium) conducted a NYC landscape analysis. This landscape analysis sought to better understand the higher acuity needs that drive this struggle, identify the barriers to addressing them, and promote solutions that could have an impact on the supportive housing field.

To gather information for this landscape analysis, CSH partnered with The Network and The Consortium to conduct 25 interviews and focus groups with various stakeholders, including shelter staff, supportive housing staff, healthcare providers, and government agency leaders. Surveys and roundtables with people with lived experience in supportive housing were also conducted.

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[1] "2024 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S." 2024. *huduser.gov*. The U.S. Department of Housing and Urban Development: Office of Community Planning and Development. https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf.

[2] Aidala, Angela A., William McAllister, Maiko Yomogida, and Virginia Shubert. 2013. "Report on Effects of Frequent Users Service Enhancement (FUSE) on Homelessness." *Columbia University: Mailman School of Public Health*. https://doi.org/10.7916/d8xh038d.

Understanding High Acuity Needs

High acuity refers to complex, co-occurring behavioral, medical, social, and long-term care needs. Characteristics include substance use disorder, chronic health issues, serious mental illness, aging-related needs, and histories of violence or institutionalization. Increased acuity has been observed since COVID-19, with more supportive housing tenants displaying threatening behavior and substance use.

Challenges and Gaps

- **Pre-Housing:** Eligibility criteria and application barriers make it difficult for those with high acuity needs to access supportive housing.
- **Engaging Mobile Teams**: Mobile teams like Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) are crucial but face long waitlists and geographic challenges.
- **Lack of Cross-System Coordination:** NYC lacks a coordinated care system, leading to fragmented services and multiple care managers for clients.
- **In Supportive Housing:**
    - The case management model lacks on-site clinical services, and there is variability in the level of support across programs, particularly in scattered site programs.
    - Behavioral health services are insufficient, and staffing patterns do not meet the needs of high acuity tenants.
    - Staffing Shortages: High caseloads and inadequate compensation lead to high staff turnover, affecting care consistency.
    - Transitioning to Supportive Housing: Adjusting to independent living and increased risk of overdose are significant challenges.

Promising Models

- **NYC Models:** Programs like the NYC Department of Homeless Services (DHS) Complex Care Coordination Program and NYC Health + Hospitals initiatives provide coordinated care and support for high acuity individuals. Models such as Coordinated Behavioral Care (CBC)'s Pathway Home and Urban Pathways Total Wellness Program offer intensive, mobile, and on-site services to support high acuity needs.

- **National Examples:** Nationally, we saw programs incorporating approaches like Intensive Case Management teams to support the most service intensive residents, and comprehensive service models that brought programs like behavioral health and SUD treatment, and/or primary care in-house for residents.

Summary of Effective Interventions and Approaches:

- **Focus on High Acuity and Complex Needs:** Many programs specifically target individuals with severe mental illness, substance use disorders, complex medical conditions, histories of homelessness, and frequent engagement with crisis services (hospitals, jails).
- **Care Coordination Across Systems:** A significant emphasis is placed on coordinating care across traditionally siloed systems, including housing, healthcare (physical and behavioral), social services, and the carceral (criminal) justice system. This aims to reduce fragmentation and improve continuity of care.
- **Integration of Healthcare and Housing:** Recognizing the strong link between housing stability and health outcomes, several models embed healthcare services directly within or closely linked to housing settings. This includes on-site nursing, primary care, psychiatry, and medication management.
- **Proactive Identification and Outreach:** Programs utilize various methods to proactively identify individuals in need, including data-driven approaches (EMR flags, incident reports), provider referrals, and targeted outreach to high-risk populations.
- **Mobile and Flexible Service Delivery:** Many programs employ mobile teams and offer flexible interventions tailored to individual needs and delivered in various settings (shelters, housing, community). This increases accessibility and engagement.
- **Emphasis on Transitions of Care:** Several models focus on improving transitions between different care settings (e.g., hospital to housing, institutional settings to community) to ensure individuals have the necessary support during vulnerable periods.

- **Person-Centered and Recovery-Oriented Approaches:** Programs prioritize individual needs and goals, promoting self-determination and supporting individuals on their recovery journeys.
- **Importance of Specialized and Dedicated Staff:** The value of having dedicated and trained staff, including nurses, social workers, peer specialists, occupational therapists, and community health workers, who understand the complexities of working with high-needs populations is highlighted.
- **Peer Support as a Crucial Element:** Peer specialists and peer-led programs are recognized as vital for building trust, providing relatable support, and promoting recovery among tenants.
- **Leveraging Technology for Improved Care:** Adopting health information exchanges (HIEs), telehealth services, and overdose detection technology demonstrates a growing trend toward using technology to enhance care coordination, access, and safety.
- **Addressing Social Determinants of Health:** Beyond medical and behavioral health, programs often address social determinants like housing, social isolation, and access to resources to improve overall well-being.
- **Focus on Harm Reduction and Overdose Prevention:** Initiatives like Narcan training and overdose detection technology underscore the importance of harm reduction strategies within supportive housing settings.
- **Data Collection and Outcome Measurement:** While not always explicitly detailed, the focus on reducing ED visits, hospitalizations, and improving housing stability suggests an underlying emphasis on data collection and outcome measurement to demonstrate program effectiveness.
- **Building Partnerships and Collaboration:** Many programs involve collaborations between different agencies, healthcare providers, and community-based organizations to provide comprehensive and integrated services.
- **Addressing Specific Populations:** Some models tailor their approach to specific populations, such as veterans or older adults, recognizing their unique needs and challenges.
- **Focus on Skill-Building and Empowerment:** Programs like occupational therapy and peer support aim to build skills, increase independence, and empower individuals to thrive in their communities.
- **Addressing Trauma and Promoting Well-being:** The inclusion of trauma-informed care and wellness programs highlights the recognition of the impact of trauma and the importance of promoting holistic well-being for both tenants and staff.

Recommendations

- **Services:** Improve intake and care coordination processes, increase on-site services, and create interdisciplinary teams for high acuity tenants.
- **Staffing:** Reimagine the supportive housing staffing model with more on-site medical and clinical care, and increase resources, training, and support for direct service staff.
- **Systems:** Establish dedicated housing teams at hospitals and incorporate health information exchanges within supportive housing to share information between healthcare providers and supportive housing providers.
- **Policy:** Simplify eligibility and transfers in supportive housing, increase funding and flexible services for tenants with behavioral health needs, and develop more transitional residential programs.

Authors and Acknowledgements

The Helmsley Charitable Trust's New York City Program is strategically focused on improving housing for health for New Yorkers with complex health needs, and recognized that CSH is uniquely positioned, with both a national and local New York focus, to find solutions to the rising health acuity challenges facing New York City's supportive housing system. CSH proposed and was awarded a three-year grant from Helmsley to focus research, pilot, and evaluative efforts on this problem.

CSH is proud to be the lead agency on this project. CSH is a national nonprofit that promotes affordable housing with supportive services to ensure everyone has a safe home. We are on a mission to help communities nationwide solve homelessness with innovative, effective, and evidence-based supportive housing solutions. We know that supportive housing works because it addresses the root causes of homelessness. Communities that integrate supportive housing noticeably reduce street homelessness, make the most of taxpayer dollars, and build thriving neighborhoods.

The Health and Housing Consortium ("The Consortium") was engaged as a key partner for several key specific aspects of this project. The Consortium is a collaborative network of health care, housing, homeless and social service organizations, and government partners with the shared goal of improving health equity and housing stability in New York City. They do this by fostering cross-sector relationships, informing policy, and building the capacity of frontline workers to support people with unmet health and housing needs.

The Supportive Housing Network of New York ("The Network") was engaged as a key partner for several specific aspects of this project. The Network represents its nonprofit

members in our collective effort to end homelessness among the most vulnerable New Yorkers through the creation of sufficient supportive housing. They work with all sectors – public, private and nonprofit – to ensure supportive housing's quality and proliferation through advocacy, policy analysis, training, technical assistance and public education.

Additionally, a robust advisory committee of key experts on supportive housing and health in New York City was engaged in this project. We are grateful to our Advisory Committee, who has been invaluable in assisting us with navigating this project. For a full list of Advisory Committee members, please see Appendix A.

Authors and Contributors

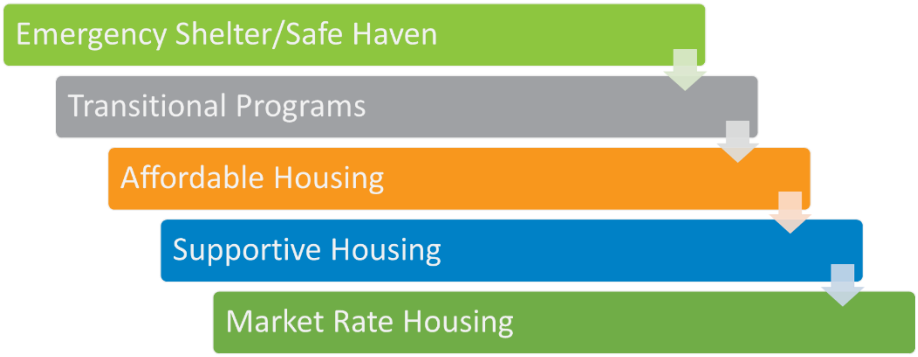
- Joelle Ballam-Schwan, The Supportive Housing Network of New York
- Emma Cathell, Formerly CSH
- Jesse Dean, CSH
- Pascale Leone, The Supportive Housing Network of New York
- Eva Lerner, Formerly CSH
- Brian McShane, CSH
- Bonnie Mohan, The Health & Housing Consortium
- Charlie Rudoy, CSH
- Nicole Ross, CSH
- Tess Sommer, The Health & Housing Consortium
- Jessica Tien, CSH
- Lauren Velez, CSH
- Rebecca Zangen, The Supportive Housing Network of New York

Introduction

New York City (NYC) is facing a homelessness crisis that disproportionately affects people without financial means or stable housing. On a single night in January 2024, more than 140,000 individuals were experiencing homelessness, including 51,000 in migrant shelters.[3][4] Homelessness on this scale puts strain on systems of care and institutions that interact with individuals who fall through the social safety net. Experiencing homelessness contributes to poor health outcomes. In addition to being more prone to chronic medical conditions, people who have experienced homelessness age roughly 20 years faster than their housed counterparts.[5] This population also faces significant barriers to accessing preventive and proactive health care, leading to unmet physical and behavioral health needs.

NYC has a wide array of resources, including more than 40,000 units of supportive housing, and billions of dollars of investment in homeless services, hospitals, and behavioral health systems. NYC operates one of the largest Continuums of Care (CoCs) in the country, leveraging over $180,000,000 in federal resources to coordinate housing access for homeless New Yorkers. Nevertheless, these labyrinthine systems of care leave many falling through the cracks.

FIGURE 1: HOUSING AND SHELTER CONTINUUM IN NYC



[3] "2024 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S."
[4] "Mayor Adams Announces New Round of Migrant Shelter Closures, Including One of City's Largest Facilities, After 27 Straight Weeks of Shelter Census Declines." 2025. The City of New York. January 10, 2025. https://www.nyc.gov/office-of-the-mayor/news/019-25/mayor-adams-new-round-migrant-shelter-closures-including-one-city-s largest#:~:text=There%20are%20currently%20under%2051%2C000%20migrants%20receiving,city%20services%20since%20the%20spring%20of%202022.&text=Additionally%2C%20Mayor%20Adams%20successfully%20reduced%20the%20city's,Fiscal%20Year%202026%20by%20nearly%20$2.8%20billion.
[5] Seegert, Liz. 2016. "Homeless get 'older' at younger ages than their peers, research says." Association of Health Care Journalists. April 1, 2016. https://healthjournalism.org/blog/2016/04/homeless-get-older-at-younger-ages-than-their-peers-research-says/.

Supportive housing is part of a range of housing solutions for those experiencing homelessness or housing instability (see Figure 1). New York City, with its legal right to shelter, has a robust but overwhelmed shelter system. In shelters, case managers help individuals meet housing goals and connect with services.

Transitional housing provides short-term housing (up to two years) and case management to find long-term solutions. **Rapid Rehousing** offers temporary rental assistance and light case management to help people secure housing and eventually take over rent payments. **Affordable housing vouchers and subsidies** reduce rent costs for tenants based on income. **Supportive housing** is permanently affordable and provides the highest level of service intervention in an independent living environment.

Supportive housing is a proven, cost-effective intervention in the fight to end homelessness, helping people live with stability, autonomy, and dignity. In NYC, services in supportive housing are funded by State and City contracts with nonprofit providers. Programs are based on a case management model, with staff providing support and connections to services in the community but in most cases, not directly providing clinical services.

While NYC has dedicated resources to fund supportive housing units and services, organizations struggle to match people with appropriate units and adequately fund the services needed for them to stabilize. Additionally, stagnant funding and crisis-level staffing shortages have strained NYC's housing and homelessness systems, leading to further bottlenecks and insufficient support.

Supportive housing is a solution to homelessness and has the support of city and state leadership. However, we need to improve our ability to help people with the most complex needs to thrive in supportive housing. There is an urgent demand to increase the supply of supportive housing, especially with more flexible and comprehensive service models that can meet the complex behavioral, social, physical, and long-term care needs of prospective tenants.

This landscape analysis was conducted to understand the challenges that make it difficult to address the needs of individuals with the highest acuity in supportive housing programs across New York City. To accomplish this, CSH worked with partners throughout the city to identify existing systems, providers, and resources available to people with high-acuity health needs experiencing homelessness or living in supportive housing.

In collaboration with these partners, this landscape analysis serves to promote potential solutions that can equip the systems of care across NYC to address the challenges of working with individuals with the highest acuity needs.

Methodology

To gather the information needed for this landscape analysis, CSH engaged two key partners, the Supportive Housing Network of New York and The Health & Housing Consortium, to conduct key informant interviews and small focus groups. We developed a standard set of interview questions that we followed in each of our sessions, while also allowing room for the conversation to expand beyond this question set.

In total, we conducted 25 interviews and focus groups that represent various critical perspectives in the NYC supportive housing, homelessness, and healthcare systems.

- Shelter staff
- Direct service staff and program leadership in supportive housing
- Healthcare staff, including clinicians working with homeless and unstably housed patients
- Leadership from various City and State government agencies, including the NYC Department of Homeless Services (DHS), NYC Department of Health and Mental Hygiene (DOHMH), NYC Health + Hospitals, NYS Office of Substance Abuse Services (OASAS), and NYS Office of Mental Health (OMH)
- Community-based service providers
- Health Home leadership and care management staff

People who have previously lived or currently live in supportive housing were also engaged as key informants. The Health & Housing Consortium sent a survey to its Consumer Advisory Committee (CAC), a steering committee composed of people with lived experience (PWLE) of homelessness, housing instability, substance use, and/or incarceration. The CAC was instructed to only complete the survey if they have lived in supportive housing. The Supportive Housing Network of New York hosted a series of five tenant roundtables across New York State, including two in NYC. The Network gathered valuable insight on tenants' first-hand lived experience in supportive housing from 60 tenants in NYC associated with 25 different provider agencies.

Understanding High Acuity Health Needs

The term "high acuity" is often used in homeless services, supportive housing, and healthcare systems to describe people with more intensive service needs. One of the primary questions in conducting this landscape analysis was: *How is high health acuity defined across systems and programs?* Through our dozens of conversations with stakeholders, we found no single definition of "high acuity." Rather, we heard a collection of intersecting identities, characteristics, and circumstances that our current systems of care have been unable to adequately serve.

Generally, high acuity is defined as extremely complex, co-occurring behavioral, medical, social, and long-term care needs that are not wholly addressed by the existing system of care. Below we outline characteristics of people with highly acute needs, as described by our stakeholders.

1. Experience one or more of the following challenges:
    i. Substance use disorder
    ii. Chronic physical health issues and/or physical disability
    iii. Serious mental illness and/or developmental disability

2. Along with a combination of these factors (this list is not exhaustive):
    i. Being a young adult/teen or over the age of 55
    ii. Conduct and behavioral concerns
    iii. Intimate partner violence and other histories of violence
    iv. Recent return from an institution, such as prison/jail, hospital, or long-term care
    v. History of hospitalization for psychiatric condition(s)
    vi. History of hospitalization for physical health problem(s)
    vii. Have experienced or currently experiencing chronic homelessness (more than one year and/or repeated periods of shorter-term sheltered or unsheltered homelessness)
    viii. Impaired activities of daily living (ADL) and/or instrumental activities of daily living (IADL)
    ix. Cognitive decline
    x. Physical health decline

Increases in Health Acuity

When asked about changes in acuity, particularly since COVID-19, many responded that they have seen people's needs increase. Increased isolation and loneliness corresponded with decreased social and program engagement, which exacerbated pre-existing issues, such as substance (mis)use. Some remarked that the level of assertive and in person engagement has not rebounded even after the worst of the pandemic ended.

Tenants living in supportive housing described more neighbors experiencing increased acuity, making note specifically of an upsurge in tenants displaying threatening behavior, fires occurring in neighboring apartments, active drug-use and overdoses in buildings, and the domino effect of causing others to relapse. This was all reported as contributing to a decreased sense of safety and well-being in their residences. Many felt that supportive housing providers often accept individuals without the necessary services available to best support them. They identified a need for higher levels of care, specifically for those actively using substances.

Providers have also reported a marked increase in the health acuity of supportive housing referrals and tenants, and they are concerned that they lack the capacity to provide the level of support and intervention that is needed to help this population stabilize. Additionally, providers remarked on the challenges that occur when an existing tenant's needs change, particularly if that tenant is not aware of or does not accept their increased need.

Challenges and Gaps

Several challenges and service gaps exist for people with highly acute needs who are seeking, transitioning to, and living in supportive housing. Some of these challenges and gaps cut across all phases of the process (summarized below), and some exist in specific phases of the process (summarized in the following section).

Staffing Shortages

There is a significant staffing shortage across the board in health, housing, and human services. High caseloads and inadequate compensation contribute to high staff turnover, making it difficult for clients to establish trust and to create and implement a consistent care plan. In the homeless services or shelter setting, progress on completing a supportive housing application, or following up with tenants and other stakeholders to move them through the process of obtaining supportive housing, can be slowed by staff turnover, lack

of training, and lack of time. This is a particular problem for people with highly acute needs, who may need more support and attention throughout the process.

Within the supportive housing setting, based on industry surveys, staff vacancies for existing programs hover above 20%. Supportive housing tenants noted the shortage of staff working in their residences and unmanageably high caseloads for a single case manager. Tenants empathized with the staff, understanding that they are overworked and underpaid. Staffing shortages across the spectrum of healthcare and human services makes it challenging for supportive housing case managers to connect tenants to the support they need in the community in a timely manner.

Lack of Cross-System Coordination

NYC has many services but no true coordinated care system, relying instead on individual staff and their ability to develop relationships. People are not always connected to the program that best matches their needs, but rather one based on their case manager's network. Additionally, because every program or service requires a case/care manager and a person-centered care plan, clients can end up with multiple care managers who aren't talking to each other.

Health Homes is a service designed to support people with chronic health conditions, coordinate medical care, and assist with connections to community resources, including housing applications. Health Home providers report weak relationships with housing providers and insufficient technology to support coordination. Even when people are successfully referred to supportive housing, many have not been connected to benefits and entitlements, including public assistance, social security, and Medicaid. Without active Medicaid, tenants' enrollment in programs such as home health services, is delayed. Supportive housing providers often spend considerable time on benefit and entitlement enrollment, while tenants may be in crisis or struggling with the transition to housing. Some supportive housing tenants shared that they ended up owing multiple months of rent because they were moved in before their public assistance was set up.

Healthcare professionals who work with unhoused patients described that when a patient was placed into supportive housing in a different borough, it often meant they completely lost touch with them. It was unclear where the patients would get their medical care in their new housing and community. Coordination between the existing care team and the supportive housing provider is extremely limited.

Hospitals do not always coordinate with housing providers when discharging supportive housing residents. Supportive housing providers often struggle to get information when their tenants go to the hospital and are rarely able to speak with the care team to

coordinate a safe discharge. Unfortunately, emergency rooms are often at capacity and do not have the ability to provide this level of coordination. Providers also noted that there used to be warm handoff groups for people leaving psychiatric hospitalizations to support the move back to the community and that this kind of intermediary transition support is needed again. In 2024, NYS OMH/DOH released regulations and guidance to hospitals to improve coordination with community providers. It is too early to determine the level of impact.

Challenges with Mobile Teams

Mobile Teams, such as Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT), are very important resources for individuals with highly acute needs. These are clinical, interdisciplinary teams that can provide around-the-clock services and meet clients where they are in the community. At one agency, ACT and IMT teams have been shown to reduce hospitalizations by more than 30%. However, providers noted that connecting to teams can be very difficult and the waitlists are extremely long. Because the teams are mobile, there is an opportunity to provide continuity of care as someone moves through the process of homelessness to supportive housing or when a tenant's needs escalate. However, there are a number of barriers and challenges with ACT and IMT teams, noted below:

- The application for ACT and IMT is extremely cumbersome and requires details that the patient may not know.
- IMT resources are concentrated toward unhoused people, and they are generally not available for tenants for enrollment after they move into supportive housing.
- Geographic proximity can be a challenge if someone is housed far away from their team. When crises happen, it can take too long to get a response.
- There is variability in the quality of care provided by different teams.
- Services are not available until someone's condition has escalated to a certain point.
- ACT does not provide psychiatric evaluations for supportive housing applications.
- ACT teams may discharge people for non-participation.
- Clarifying roles and coordinating across teams is a challenge: ACT teams can have a misconception that the supportive housing providers will provide most of the support.
- Hand-off to ACT can be difficult and clients are often stepped down too soon.

Challenges and Gaps: Pre-Housing

Homeless History Requirements

Supportive housing often requires or prioritizes a specific homeless history. The U.S. Department of Housing and Urban Development (HUD) defines chronic homelessness as a person with a disability who is homeless for a cumulative total of 12 months or more within a period of 3 years. Supportive housing funded by HUD via the Continuum of Care prioritizes people who are chronically homeless. In 2015, NYC committed to funding operational and services dollars to create 15,000 new units of supportive housing by 2030 through the NYC 15/15 program. While these programs are not HUD-funded and not mandated to mirror HUD guidelines, the city still currently requires chronicity to be eligible for 15/15 units. It should also be noted that while we are roughly two-thirds of the way through the committed timeline for these units, only about half of the promised units have come online to date.

For the transient unhoused population, providing date-specific details for applications can be challenging, especially for those not engaged with the DHS system. DHS, operator of the City's largest shelter system, is not equipped to support people with acute needs, often excluding them from accessing supportive housing. Consequently, those most disconnected from services struggle to prove their homelessness duration (homeless "chronicity") for eligibility. Additionally, patients leaving institutions like skilled nursing facilities or jails are not considered homeless during their stays, limiting their eligibility for programs using HUD's chronicity guidelines.

Complicated Eligibility Criteria

New York State has 46 different categories of supportive housing, each with its own set of eligibility criteria. This system requires individuals in need of supportive housing to "fit" into one of these categories, rather than the housing fitting their needs. Additionally, there is a mismatch between the housing needed and what is available. Some categories have long waitlists, while others have vacancies that cannot be filled.

Housing Application Barriers

The supportive housing application process is time-consuming and involves multiple steps and stakeholders. One requirement is a psycho-social assessment but finding a qualified and available clinician to complete this assessment can be challenging. City budget cuts to mental health services have exacerbated this issue. Furthermore, untreated serious

mental illness or active substance use can hinder individuals from navigating the lengthy and intensive application process.

Another component of the supportive housing application is the NYC Standardized Vulnerability Assessment (SVA), which prioritizes referrals based on applicants' vulnerability. Focus group participants noted that the SVA does not encompass all needs, such as accessibility, leading to inappropriate referrals. For instance, people who require wheelchairs have been referred to walk-up buildings with no elevators. Participants also mentioned that the SVA, which scores applicants as High, Medium or Low, is not always accurate and may underestimate individuals' vulnerability.

Finally, some supportive housing tenants felt excluded from the application process. The application must be submitted by a referring case manager, preventing individuals from applying directly. This has led to gaps in communication, with some supportive housing tenants unaware of what supportive housing was or that they were applying to it. Case managers facilitated the application process without involving the clients, who were then sent to housing interviews and apartment tours without having any input in the process.

Challenges and Gaps: Transitioning to Supportive Housing

Adjusting to Independent Living

For many people, transitioning into housing occurs after experiencing years of homelessness and housing instability, often accompanied by trauma. Many clients have never lived independently or haven't done so for a long time. As a result, many clients lack the skills necessary to set up and maintain a home, shop for groceries, manage medications, prepare meals, and pay rent. Due to the limited supply of supportive housing in New York's tight housing market, people often end up in unfamiliar boroughs without the support systems they previously had.

The transition from homelessness to housing also changes how people socialize and engage with their community. Supportive housing providers recognize that residents often struggle with loneliness and isolation. This isolation is concerning for mental health and can be dangerous for individuals who use substances.

Increased Risk of Overdose

Healthcare providers are concerned about individuals actively using substances once they move into supportive housing. Substance use poses peaks and valleys; when actively using, it can be aggressive and unpredictable. Overdose is always a concern and there is not always a good treatment option for some types of substances, such as K2.

Intermittent users can be at greater risk of overdose because they may not have a tolerance or experience with drugs. New stressors that arise with moving into supportive housing, adjusting to a new environment and experiencing loneliness, can result in drug use as a coping mechanism.

Challenges and Gaps: In Supportive Housing

Needs in the Case Management Model

Supportive housing in New York, as currently funded and structured, operates on a case management model. In this model, staff members connect tenants with community-based, wrap-around services, such as mental health and addiction treatment, public benefits, education and job training. However, the model is not designed or funded to provide clinical interventions like on-site nursing, medical care, psychiatric services, or medication management. Tenants also report that supportive housing staff are not trained to address medical issues, exacerbating gaps in care.

Although referrals are an important component of care delivery, the absence of on-site services creates significant challenges. Many high acuity tenants require care that supportive housing does not provide, including chronic disease management (e.g., diabetes, heart disease), behavioral healthcare, and dental care. Unfortunately, mobility issues, lack of transportation, immunocompromised conditions, cognitive decline, and behavioral challenges limit access to off-site treatment.

Furthermore, the case management model relies on the assumption that adequate physical and behavioral health services are available in the community. In reality, there is a concerning trend regarding physicians who do not accept Medicaid, including primary care providers, dentists, cardiologists, and podiatrists. The American Medical Association predicts that 2034, there will be a shortage of between 17,800 and 48,000 primary care

physicians who accept Medicaid.[6] Even when providers do accept Medicaid, many lack the training needed to address the unique needs of high-acuity populations, especially those with a history of chronic homelessness. These patients often require care providers who understand the complexities of their current or past circumstances and recognize the importance of trauma-informed care, building trust and rapport, and integrated physical and behavioral health treatments.

Variability in Supportive Housing Services

Across the various supportive housing programs, funding and level of services provided varies wildly. The lowest-funded programs receive just $2,964 annually for services for single adult tenants, while the highest-funded programs receive $38,632 annually combined for services and operating costs.[7]

Supportive housing tenants reported experiencing differing ranges of support and services across different programs. While one tenant received off-site support for substance use disorder treatment and assistance from a counselor with money management, others were offered very little support beyond being placed into housing. One resident believed their building was supposed to have on-site services but had not observed them. Another mentioned that accessing additional services required going through their case manager, creating unnecessary barriers to care. Overall, tenants expressed a desire for more guidance and structure in navigating and accessing social services and benefits.

Lack of Behavioral Health Services in Supportive Housing

Staff and tenants in supportive housing reported an increase in mental health concerns and an uptick in active substance use. With an extremely dangerous and deadly drug supply, supportive housing is not immune from the larger opioid crisis – in 2023, 10.4% of overdose deaths in NYC took place in supportive housing.[8] Many providers feel ill-equipped to support the level of active substance use they are seeing, and current models are not funded to provide the intensive counseling and treatment many tenants need.

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[6] Robeznieks, Andis. 2022. "Doctor shortages are here—and they'll get worse if we don't act fast." American Medical Association. April 13, 2022. https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act.

[7] Barth, Rachel. 2024. "The State of Supportive Housing." *shnny.org*. The Supportive Housing Network of New York. https://storymaps.arcgis.com/stories/d51aa52864324e99a673e09e7fb1a0ab.

[8] "Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2023." 2024. No. 142. *Data Briefs and Data Tables*. NYC Office of Chief Medical Examiner and NYC Department of Health and Mental Hygiene Bureau of Vital Statistics. https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief142.pdf.

Furthermore, there are insufficient day-treatment and outpatient mental health programs to meet the growing demand. Patients can wait up to six months for an intake appointment for therapy. Additionally, without an effective mental health crisis response system, supportive housing communities often rely on police intervention, which tends to escalate situations and reinforce trauma without addressing underlying causes that lead to substance use.

Staffing Patterns

Staffing models in supportive housing programs typically include daytime, on-site clinical and case management staff. During the evening hours, when incidents are most likely to occur, maintenance and security staff are usually the only staff on site, and most are not trained to work with the individuals served in supportive housing. Providers have noted the need for more staff on-site throughout the day, with a particular emphasis on increasing evening staff.

Additionally, there isn't funding available for specialized staff beyond the typical staffing patterns. These usually include a team of case managers, peer support staff, and program supervisors. Caseload ratios in NYC can range from 1:15 to 1:50 depending on the contract. This is a challenge for people with high acuity needs when staff have more clients than they can adequately support. Programs would benefit from on-site therapists and psychiatrists, nurses and nurse practitioners, as well as occupational therapists. Providers also strongly expressed the need for a psychiatric nurse specifically.

Supportive housing tenants noted a lack of cultural sensitivity and compassion from some staff, stating that some case managers are "book smart," but are unable to understand their experience and "can't speak the language." They felt strongly that supportive housing would benefit from more peer staff.

Inaccessible and Insufficient Home Health Services

Accessing home health services frequently presents challenges. The application process is marked by long wait times for assessments due to a shortage of nurses completing the assessment. Since assessments can only be conducted in the individual's home, services cannot be set up until someone moves into housing. Additionally, the interview process has a tight timeline. If someone is in the hospital and they are not discharged on time, they may have to restart the process.

A shortage of home health aides (HHAs), high turnover in the field, and limited scope of services are key issues. People are often approved for fewer hours than they need and these hours are typically provided in one session, whereas clients need periodic help

throughout the day. Clients may have to work with multiple HHAs before finding the right fit. Once the right fit is found, consistency is crucial to maintain trust. Many clients face behavioral health challenges, but HHAs are primarily intended to support physical and functional limitations. Not enough HHAs specialize in or are willing to work with formerly homeless individuals with serious behavioral health needs, especially those actively using substances.

Limitations of Scattered Site Housing

In contrast to congregate supportive housing, where services are provided within the building where tenants live, scattered site supportive housing requires providers to identify units on the private market in a rental market with a historically low vacancy rate.[9] Providers deliver services to scattered site tenants in their individual locations. In NYC as of 2024, approximately 17,000 units of supportive housing were scattered site.[10] In addition to the severe shortage of accessible, affordable units in the private market, the lack of on-site staff and less frequent contact with clients make scattered-site supportive housing an impractical option for the people with high acuity needs, especially those who are at risk of overdose. Scattered-site units also tend to be located in older buildings without elevators, which can be particularly difficult for tenants with limited mobility. The NYC mayor Eric Adams administration acknowledged some of these shortcomings when announcing the City's preliminary fiscal year 2026 budget, which seeks to reallocate a portion of the NYC 15/15 supportive housing program's scattered site unit targets to congregate unit production and preservation.[11]

Shared Housing

Within the supportive housing context, there are two main types of shared housing: scattered site apartments and Single-Room Occupancy (SRO) buildings. The lack of quality affordable units on the private market combined with low funding rates has led many scattered site providers to rent two- or three-bedroom units for multiple single adults to share. In SRO buildings, apartments do not have kitchens and/or bathrooms and tenants share those facilities.

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[9] "2023 New York City Housing and Vacancy Survey: Selected Initial Findings." 2024. *New York City Housing and Vacancy Survey (NYCHVS)*. New York City Department of Housing Preservation & Development. https://www.nyc.gov/assets/hpd/downloads/pdfs/about/2023-nychvs-selected-initial-findings.pdf.

[10] "The State of Supportive Housing."

[11] Donaldson, Sahalie. "Eric Adams to prioritize supportive housing in upcoming NYC budget." City & State New York. April 28, 2025. https://www.cityandstateny.com/policy/2025/04/eric-adams-prioritize-supportive-housing-upcoming-nyc-budget/404878/.

Challenges are often exacerbated in shared housing. Tenants report a decreased sense of satisfaction and safety. Tenants in recovery from substance use shared challenges of living with tenants who were actively using substances. Others felt that their safety was threatened by their roommate, including one interviewee who was attacked. When faced with safety issues, it is extremely difficult for tenants to obtain a transfer to another supportive housing apartment.

Additionally, many tenants noted that their roommates did not have independent living skills, causing them to take over maintaining most of the shared living areas and/or take on the role of case manager for their roommate without receiving any compensation for those efforts.

Inflexibility of the Supportive Housing System

The complicated nature of New York's supportive housing funding leaves little flexibility for individuals to move around within supportive housing, or across the continuum of housing, as their needs change. These housing transfers are processed by a small team at the NYC Human Resource Administration (HRA) and are only allowed under very limited circumstances. The process usually requires completing an entirely new application, which supportive housing staff are not typically trained to do. This results in some congregate units being occupied by individuals who would succeed in and prefer a scattered site apartment in the community. Similarly, scattered site apartments are occupied by tenants who need the increased attention and on-site services made possible in the congregate setting. The system does not work around the changing needs of the clients.

Promising Models

This section will highlight successful programs that support people with highly acute needs, despite the challenges described in the previous section. These programs can serve as promising practices to replicate and scale.

The people we spoke with who have lived experience of homelessness and supportive housing shared positive sentiments about gaining access to affordable units with support

coordination and services. They appreciate living in a community with people who share common experiences and that have caring staff. Tenants value interactions with other residents and feel secure knowing staff will check on them if they are unwell. Those in private apartments especially appreciate having their own space after years in shelters. Additionally, tenants find supportive housing units affordable.

New York City Models

NYC Department of Homeless Services (DHS) Complex Care Coordination program:

The Complex Care Coordination Program coordinates care across silos for people with complex health issues. The program provides the NYC Department of Homeless Services' (DHS) homeless clients with dedicated support, coordination across agencies and systems (including transitions of care), connections to specialized medical and behavioral health care, and ongoing monitoring and advocacy support. The target population is DHS clients with severe service and complex health needs, including clients who are associated with multiple negative incidents in shelters and the community and/or who have cycled through multiple city systems, such as jails, shelters, and hospitals.

Adult clients are identified through DHS' incident reporting systems, provider referrals, and other data sources. In the short-term, the program aims to improve clients' stability and reduce aggressive or violent incidents, self-harm, emergency department (ED) visits and unnecessary hospitalizations, service duplication and gaps, substance use-related incidents such as altercations, accidents, and overdoses.

Longer-term goals include promoting positive experiences in the shelter system, supporting care transitions and transition to permanent housing, obtaining long-term and appropriate services and benefits, and improving overall health and quality of life. Individual long-term goals are identified by clients themselves, with care team members offering support and advocacy.

NYC Health + Hospitals (H+H) Programs

H+H has several programs that provide more streamlined access to housing and services.

1. Medical Respite: a fully enhanced discharged planning program, connecting patients who will be discharged to the services they need to maintain their recovery.

2. Complex Care Program: seeks to improve the health and well-being of individuals who repeatedly cycle through multiple healthcare, social service, and other systems. H+H also has four Safety Net Clinics which provide primary care specifically to unhoused patients.

3. Housing for Health (H4H) initiative: moves patients experiencing homelessness into permanent housing to improve their health and well-being. The team offers patients experiencing homelessness housing location and placement services, including assistance applying for supportive housing. H4H also has a partnership with CBOs where the H4H team pays for enhanced services for CBO partners working with medically complex H+H patients.

Montefiore Medical Center's Housing At Risk Program (H@RP)

Over a decade ago, Montefiore Medical Center in the Bronx established the Housing At Risk Program (H@RP) to address the housing needs of their patients.

Montefiore developed a flag system in their Electronic Medical Record (EMR), that triggers an alert to ED social workers and H@RP if someone registers in the ER with a shelter address. H@RP can also add specific patients to the alert system ensuring that H@RP staff are notified whenever that patient comes to a Montefiore hospital. Once the person is considered stable, they can be removed from the alert system.

H@RP conducts thorough assessments of patients and identifies appropriate services and referrals. Services are provided in-person, either in the H@RP office or in the patient's home. Once patients transition into housing, the H@RP team provides a warm handoff to the services in the community, making sure that patients feel secure and supported in their new community.

H@RP is a promising model that could be replicated in other hospitals. It is financed by the hospital itself, so implementing similar programs would require high-level buy-in from hospital leadership unless external funding could be identified.

Medical Respite

New Yorkers experiencing homelessness or housing insecurity often also have complex medical and behavioral health needs. For those who end up hospitalized, their lack of stable housing can be a barrier to safe discharge. While these patients no longer require inpatient-level care, they do need a safe place to recuperate. Medical respite provides a temporary place for individuals to recuperate and get connected with permanent housing, including supportive housing when appropriate. Through coordinated systems of care, medical respite provides patients with short-term clinical care, case management, food, transportation to medical appointments, and most importantly, a safe place to recover from injury or illness.

Coordinated Behavioral Care (CBC)'s Pathway Home

Pathway Home™ is a community-based care transition/management intervention offering intensive, mobile, time-limited services to individuals transitioning from an institutional setting back to the community. CBC acts as a single point of referral to multidisciplinary teams at ten care management agencies (CMAs) in CBC's broader Independent Practice Association (IPA) network. These teams maintain small caseloads and offer flexible interventions where frequency, duration and intensity are tailored to match the individual's community needs and have the capacity to respond rapidly to crisis.

Dedicated + Trained Staff

Supportive housing providers benefit from employing specialized and dedicated staff when working with people with high acuity needs. A number of supportive housing providers, such as The Bridge and Community Access, have internal risk committees/teams with staff members who problem-solve, assist, and support tenants who are high acuity and/or having an acute episode. Providers may refer to these as "clinical risk teams," which provide safety planning, short-term counseling, psych appointment accompaniment, and assist with complex psych discharge planning. In addition to clinical risk teams, specialized staff have been proven to support high need clients, including wellness coordinators and patient navigators who help clients, particularly older adults, manage their health care, including appointment scheduling, reminders, and understanding their medical conditions. Lastly, health care providers, including home health aides, nurses, occupational therapists, and psychiatrists, offer necessary and low-barrier care when contracted to provide services on-site. Providers working with high acuity clients can improve their services, along with client and staff experience, by employing dedicated staff who are trained to work with individuals with complex medical and behavioral needs.

Medication Management

St. Francis Friends of the Poor has a successful model that embeds medication management, on-site nursing, primary care and psychiatry. Each of their supportive housing residences has a full-time on-site nurse. Every residence has a program room on the bottom floor that acts as a one-stop shop staffed with a nurse, support with managing finances, entitlement specialist and activities coordinator. Tenants can come down in the morning and get their medication from the nurse as well as connect to other services they need for the day. Additionally, they have a part time weekend nurse on staff that packages these distributed medications for the week. This medication management service is entirely voluntary, but the majority of tenants opt in after seeing the ease of medication management. The on-site nurse also acts as a case manager, building relationships with tenants and assessing their well-being when they receive their medication. If a tenant misses an appointment, the nurse can follow up with them. The nurse also reminds tenants of upcoming doctor's appointments and provides support as needed. Evening medications can be kept at the front desk for easy access.

St. Francis also offers on-site primary care with a nurse practitioner available once a week at each residence, and on-site psychiatrists three days a week at each residence. These on-site medical services have always been part of their agency's model and are cited as key to their program's success.

Concern Housing Partnership with Janian Medical Care

During the COVID-19 pandemic, Concern Housing had a grant-funded program in which a psychiatric team from Janian Medical Care visited two housing sites and saw a cohort of tenants in need of treatment. The doctor(s) provided treatment in-house, including medication assisted treatment for those struggling with substance use. The intervention saw a reduction in emergency department visits and a decrease in substance use relapses among participants.

Urban Pathways Total Wellness Program

Urban Pathways Total Wellness Program is an on-site medical and wellness program that partners with a subset of Urban Pathways' CR-SROs and supportive housing sites. Since its inception in 2015, it has been credited with cutting ER visits down by 50% at participating residences. The Toal Wellness Program is staffed with a Medical Director, Project Coordinator, Wellness Social Worker, Peer Specialist, Case Managers, Licensed Practical Nurses and Medical Assistants. It connects residents to physical and mental health care – including substance use services. It also takes a holistic preventative

approach by addressing spiritual health, nutrition, communication skills, disease management, and other physical and interpersonal activities.

Program Nurses and Project Coordinators facilitate group and one-on-one health education sessions to increase residents' knowledge of the risk and protective factors associated with their lifestyle and health behaviors, and their impact on chronic and infectious diseases. Additionally, on-site staff, including maintenance and security, and tenants are trained to help evaluate medical situations and what constitutes a "medical emergency," and when someone should go to the ER versus accessing urgent care, or remaining at home. Since its inception in 2015, the Total Wellness Program has been credited with reducing ER visits down by 50% at participating residences.

RiseBoro Community Partnership's Community Health Worker Program

RiseBoro Community Partnership piloted a program in which a community health worker accompanied tenants to health appointments, sat with them throughout the appointment, and discussed discharge papers with the tenant to confirm they understood post-care instructions. This role helped build trust between the tenant and medical providers and provided an advocate for the tenant, while also teaching tenants self-advocacy skills. RiseBoro noted more medication compliance as tenants learned why their doctor prescribed certain medications and how these medications would help them.

Peer Programs

Providers and tenants agree that peer specialists and peer workforce programs are crucial to serving all tenants living in supportive housing, especially higher acuity individuals. Two peer programs of note are Community Access' Howie the Harp Advocacy Center and Project Renewal's 2nd Chance Program.

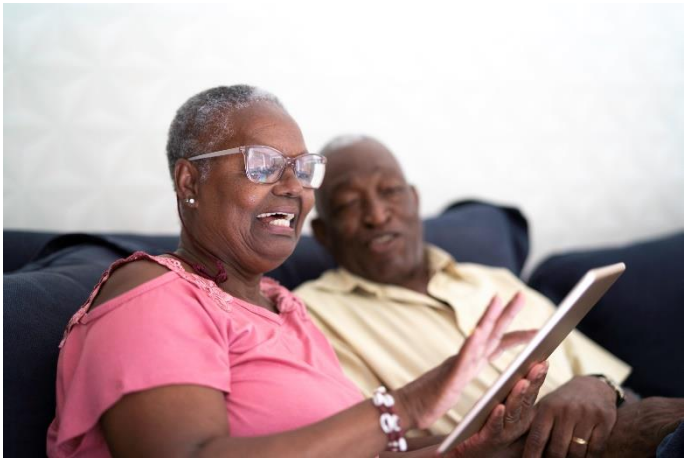
Community Access' award-winning Howie the Harp Advocacy Center provides training in mental health recovery preparing individuals to work as Peer Providers in Human Services. The program includes a 20-week classroom-based training course on personal wellness, professional development, and work readiness. Then, a 12-week internship with partner agencies, including in-patient and out-patient hospital settings, respite centers, PROS programs, supportive housing, mental health/wellness recovery programs, Alternatives to incarceration Programs and co-occurring services program. After completing their courses and internships, participants are given support in obtaining competitive employment. All trainees accepted into the program are required to complete and obtain the New York State Peer Specialist Certification offered by the Academy of Peer Services.

Project Renewal's 2nd Chance Program is funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and consists of two peers and one occupational therapist. The program officially enrolls clients using opioids or those who have opioid use history. Project Renewal also runs peer programs that are open to anyone in Project Renewal's shelter and housing programs. The peer team also conducts Narcan training for staff and clients, provides education and testing strips, as well as facilitates groups and one-on-one engagements with individuals post overdose or high-risk clients referred to them internally.

Implementing Medical Technology into Case Management

Healthix and the Bronx RHIO are Health Information Exchanges (HIE) that enable participating entities to access clinical data about their clients' health. HIEs ensure that individuals' health information is accessible to both healthcare and social services providers, promoting continuity of care and improving health outcomes. Additionally, participating housing providers also receive real-time alerts when their tenants are hospitalized and/or upon discharge from a hospital stay. These alerts help providers stay connected to clients, regardless of where they are receiving care.

ZiphyCare bridges the gap between telehealth and in-person health care. This service allows patients to schedule an in-home care coordination appointment. The care coordinator connects the patient to a doctor virtually and then performs diagnostics as instructed by the doctor. This model improves access to care for older adults, people with disabilities and complex care needs by removing the barrier of in-person care while improving the telehealth capability.



Emerging overdose detection technology is utilized by organizations like The Bridge and Breaking Ground. When placed in residents' rooms, bathrooms, or common spaces, this technology alerts housing staff and emergency services in the event of an overdose. LifeguardLite and Brave offer a range of overdose response technologies, many of which are designed specifically for supportive housing providers.

Institute for Community Living (ICL) STEPS & Health Connects Program

Launched in 2023, STEPS is a 3-year pilot program ran by the Institute for Community Living (ICL), funded by Helmsley Charitable Trust. STEPS is an inter-disciplinary team that serves as a step-down program for individuals enrolled in ACT or IMT teams who no longer need such intensive care. Teams include a program director, licensed psychiatric nurse, nurse practitioner and peer specialist. STEPS has a full case load of 100 and currently serves 82 individuals.

Of the 82 individuals served, fewer than 75% had recent incarceration, 98% had no recent hospitalization, and 99% have retained housing. Most participants would not have been able to transition off an ACT/MT without STEPS. As a result, those spots on ACT/IMT teams have opened for new participants and ICL has seen a significant decrease in wait times for those teams: 18 months to 6 months wait time from SPOA application to ACT/IMT team placement.

Health Connect

Health Connect is a new program designed by ICL to improve success outcomes for high-risk tenants living in scattered site supportive housing. The program provides comprehensive behavioral and health care services to scattered site tenants via mobile support teams. Health Connect aims to prevent tenant deterioration, as well as high burnout for traditional scattered site teams who have limited capacity. The team consists of a Program Director (licensed clinical social worker), Licensed Master Social Worker (LMSW), Peer Specialists, Licensed Practical Nurses, a Quality Improvement Specialist and an Occupational Therapist. Tenants moving into ICLs' scattered site supportive housing portfolio are assessed for psychiatric, medical, and social needs, and those who are identified as high-risk are assigned to Health Connect. The program launched in January 2025, and ICL estimates 200 existing scattered site tenants will benefit from this program.

The Bridge Aging Services Model

Aging Services was established in 2014 to support older Bridge residents who require additional services to remain stably housed. Nearly half of all current Bridge residents (700 out of 1,600) are aged 50+. The Aging Services team provides specialized geriatric and mental health care to older adults living in Bridge supportive housing. The goal of Aging Services is to reduce preventable hospitalizations and to promote the ability of older adults to safely age-in-place within their communities.

The team helps residents stay connected to their treatment providers, increase social connectedness, and promote the highest level of autonomy possible. Services range from assisting with advance care planning to identifying opportunities for personal growth and wellness.

The Bridge also operates Critical Care Services (CCS) to support the highest-need residents. CCS aims to improve quality of life for older adults while helping them safely age-in-place and avoid costly hospitalizations and/or nursing home placements. The program features a mobile multidisciplinary team that provides specialized geriatric and behavioral health care to older supportive housing residents. Staff members assist residents in reaching their personal goals, which include maintaining and developing social connections, following through with physical and mental health care, planning for the future, and more.

WSFSSH Cluster Care Home Health Aide Program

To address the limitations of traditional home health services, which are concentrated in consecutive blocks of time rather than throughout the day, the West Side Federation for Senior and Supportive Housing (WSFSSH) developed a cluster care model of home health services in their 18-person adult home. In this model, 3-4 home health aides are present from 7am-6pm. These aides are contracted through a Home Health Agency (HHA), so all services are billed through Medicaid.

The cluster care model is based on a volume of clients in one location and allows aides to visit clients periodically throughout the day as appropriate to their needs. For example, they could assist a client for one hour in the morning, midday, and early evening to help with specific tasks rather than for three consecutive hours. In the WSFSSH program, a lead aide in the building coordinates services with the other aides and ensures that staff are using their time effectively. Aides develop relationships and build trust with clients by engaging with them over time.

Notably, this model requires clients to enroll in a managed care organization that the designated HHA contracts with. It can also be difficult to find a home health aide partner who understands working with people with SMI and SUD. This model is best suited to a congregate setting where clients are in one place as opposed to a scattered site building.

Project Renewal Occupational Therapy Program

Project Renewal has implemented occupational therapy in almost every housing program and has seen a tremendous difference in their clients' ability to maintain housing and thrive in their environment. Occupational therapists perform assessments and provide individual treatment and group work that is focused on developing skills to help people reach optimal levels of independence and safety within their home and community environment.

Interventions vary widely depending on client needs. From recreational therapy, including music, art, or cooking, or group games, to supporting ADL and IADLs, to providing home modifications, OTs provide tangible pathways to improve social isolation, mobility, aging-in-place, and more. These interventions can be successful for higher acuity individuals who may not respond as well to more typical therapeutic or case management services. Occupational therapists create interventions that help people to rediscover a sense of self-worth and be valued within their community.

Strengthening Tenant & Staff Dynamics

Concern Housing partnered with the Jewish Community Council of Greater Coney Island's Mental Health Services, funded by the New York City Council, support tenants and staff. The support provides trauma-focused counseling to veterans in a supportive housing site and a support group to the staff, who were dealing with overdose deaths among the veteran community and other vicarious trauma. Tenants and staff reported feeling supported and heard, and on-site group sessions are consistently well attended. Staff indicate that these sessions provide essential support, allowing them to concentrate on their daily responsibilities.

Promising Models from Across the Country

As a national organization, CSH conducted interviews with providers and supportive housing experts from across the country around how different communities are experiencing and responding to an increase in the complexity and intensity of new and existing supportive housing residents. Here are some of our main takeaways as well as promising models we discovered from throughout the country.

While there is no standard definition of "high acuity" as it relates to supportive housing residents, we spoke most often about people with:

- Serious mental illness, substance use disorders, and co- or tri-morbid conditions,
- Complex medical conditions, and
- Chronic, pervasive homeless histories.

It was also noted that across the country, there is concern that coordinated entry in its current forms is not effective at referring high acuity individuals to appropriate supportive housing programs. Additionally, the programs that appeared to be most successful in serving those with complex, intensive service needs had 24/7 staffing (including on-site clinical staff).

Promising National Models:

Denver SIPRA (Social Impact Pay for Performance Results Act):

- Eligibility: 8+ arrests in past 3 years, history of repeated homeless episodes, 2 or more ED visits in the past year
    - Referrals intentionally matched to supportive housing programs
- Service Model: Modified ACT
    - Does not require traditional ACT eligibility
    - Housing and services provided through Housing First team and FQHC
- Housing Model: Single and scattered site
    - Flexibility in housing placement was noted as being key to success of the program
- Outcomes:
    - Reduced ER use
    - Increased engagement in behavioral health services
    - Increased medication compliance.

Cook County Flexible Housing Pool:

- Eligibility and referrals:
    - Referrals made through data match among HMIS, jails/carceral system, and hospital (not part of Coordinated Entry System)
    - Three targeted cohorts: single adults, re-entry, youth
- Service Model: Intensive Case Management
    - Clients with higher behavioral health needs referred to ACT teams for additional support
- Housing Model: Scattered Site
- Outcomes:
    - 93% of participants maintained housing stability after 1 year
    - Reduction in mortality rates

Downtown Emergency Service Center (DESC), Seattle WA:

- Eligibility: referrals all come through Coordinated Entry system; the site discussed here is for residents with high mental health needs and histories of chronic homelessness. VI-SPDAT is used for assessments.
- Service Model:
    - Heavy emphasis on Housing First
    - 24/7 social services staff on-site
    - Integration of property management and supportive services
    - All units have an intercom connecting them to the front desk
    - Mental health services provided offsite through agency
    - Medication management provided on-site
- Housing Model: congregate/single site
- Outcomes:
    - 95% retention rate
    - Low turnover; roughly one unit turned over every 18 months
    - Increased participation and engagement

Native American Rehabilitation Association (NARA) of Portland, OR:

- Eligibility: clients coming through coordinated entry who have identified that they are interested in culturally specific services for Native Americans
- Service Model: multi-service agency, includes FQHCs, outpatient treatment for SUD, mental health services (therapy, psychiatry, ACT team, ICM team); totally integrated.
    - Case management team includes a housing specialist and a peer specialist working in tandem for a caseload of 20- 24 individuals
- Housing Model: Congregate and scattered site models
- Outcomes: being a multi-service agency allows for more robust and client specific engagement and service planning

Recommendations

Below is a set of recommendations focused on additional services and policy changes that would benefit people with highly acute needs transitioning to and living in supportive housing based on the above findings.

Services Recommendations

Improve intake and care coordination processes

- Strengthen care coordination across settings to ensure appropriate placements, maintain provider relationships and warm handoffs to new care providers during the transition into housing.
- Connect tenants to benefits earlier in the housing application process.
- Create specialized assessment systems to best understand incoming tenants' needs.

Increase embedded on-site, in-person services in supportive housing

- Provide intensified services and guidance in developing tenants' independent living skills during an initial 6-months transition period.
- Increase resources for activities of daily living (ADL) supports and skills needed to take care of personal needs.
- Provide more support for older tenants aging in the community, including mobility accommodations, ADA compliant units, geriatric social workers, nurses, occupational therapy, end of life planning, and more support for homebound clients.
- Create "high risk committees," to identify and track tenants with highly acute needs and provide interdisciplinary services.
- Create in-house mobile, interdisciplinary teams, that include peers, prescribers (MDs, NPs), and occupational therapists, which can be deployed flexibly depending on needs.
- Bolster substance use prevention and harm reduction resources and increase connections to rehabilitation services.
- Establish partnerships with medical providers that specialize in co- and tri-morbidities and mobile care services.

Staffing Recommendations

Reimagine the supportive housing staffing model.

- Expand staffing to provide increased access to services on-site.
- Hire on-site medical and clinical care like nurse practitioners, registered nurses, and psychiatrists.
- Hire specialized staff to enhance support for tenants' medical needs, such as dedicated staff to coordinate with hospitals, wellness coordinators, community health workers and peer health advocates. The latter can accompany tenants to medical appointments, review discharge papers, advocate for tenant healthcare needs, and help tenants understand information from their providers/appointments.
- Create more peer positions within all areas of staffing.

Increase resources, training and support for direct services staff.

- Decrease caseloads for staff working with tenants with highly acute needs to 1:12
- Increase staff trainings and resources specific to intensive and clinical services
- Offer stronger staff supports such as increased supervision, peer support, and therapy.
- Provide new case work staff with a simple guidance document with community resources and services for tenants

Systems Recommendations

- Implement housing screening for patients at hospital intake and establish dedicated housing teams within hospitals or partnerships with CBOs to address patients' housing needs.
- Incorporate the use of health information exchanges, such as Healthix or the Bronx RHIO, within supportive housing to enable access to tenants' electronic health records and real-time alerts when supportive housing tenants are hospitalized and discharged.
- Develop stronger partnership between supportive housing providers and managed care system.
- Increase capacity for provider agencies to track and investigate critical incidents to better understand how incidents occur and how they can be avoided in the future.

Policy Recommendations

Simplify eligibility and transfers and modernize supportive housing.

- Simplify supportive housing eligibility in NYC by collapsing the 46 different categories and moving toward placements matching tenants with level of care offered.
- Enable easier transfers between programs to provide appropriate placements as needs change and to ensure tenant satisfaction.
- Move model away from utilizing shared housing.
- Create pay parity between disparate supportive housing programs and increase funding to the New York State Supportive Housing Program (NYSSHP).
- Implement policy and budgetary initiatives that achieve equitable wages for human services workers in the long-term.
- Increase and provide flexible funding streams to offer more intensive services for tenants with behavioral health needs, with a frequency that meets each person's individual needs.

Bolster resources

- Develop a nursing home "lite" model with units dedicated to people aging or with highly acute needs who require more support than supportive housing can offer, such as 24-hour services, personal care overnight, shared kitchen space where an aide can help cook meals, and space for social activities.
- Create more transitional residential programs, such as medical respite, crisis respite, and supportive crisis stabilization centers.
- Increase funding and number of mobile teams like ACT, IMT and CTI and dedicate teams specific to working in supportive housing.
- Design specialized supportive housing training for home health aides to understand and support the unique needs of the population.
- Implement a citywide, 24-7, peer-led, non-police mental health crisis system, as proposed by Correct Crisis Interventions Today (CCIT-NYC), for providers and tenants to access when crises arise for providers and tenants to access when crises arise.

Appendix A - Advisory Committee Members

1. Wydalis Rosario, The Bridge
2. Leora Jontef, NYC Health + Hospitals: Housing for Health Team
3. Jonathan Meldrum, NYC Health + Hospitals: Housing for Health Team
4. Van Yu, M.D., Center for Urban Community Services (CUCS)
5. Fabienne Laraque, NYC Department of Homeless Services (DHS)
6. Tamara Gayle, BronxWorks
7. Cal Hedigan, Community Access
8. Luke Sikinyi, The Alliance for Rights and Recovery
9. Fred Shack, Urban Pathways
10. Faye Malado, Subject Matter Expert
11. Kenny Alvarez, Subject Matter Expert

Appendix B - Organizations Involved in Providing Feedback for Developing this Landscape Analysis:

NYC Health + Housing: Housing for Health Team
NYC Health + Housing: Safety Net Clinic Teams
Bronx Accountable Healthcare Network (BAHN) Health Home
Coordinated Behavioral Care (CBC) Health Home
BRC
Community Access
Comunilife's medical respite program
ICL's medical respite program
Concern Housing
The Bridge
WSFSSH
Urban Pathways
Montefiore Medical Center's Housing At Risk Program (H@RP)
Project Renewal
NYC Department of Homeless Services (DHS) Medical Director's Office
NYC Department of Health and Mental Hygiene (DOHMH)
NYS Office of Mental Health (OMH)
NYC Office of Alcohol and Substance User Services (OASAS)
AIDS Center of Queens County
NYC Health + Hospitals (H + H)
Sun River Health
HeartShare St. Vincent's Services
HealthCare Choices NY
Acacia Network
Care for the Homeless
Midway Living
Brooklyn Community Services
Breaking Ground
163rd Street Improvement Council
We also conducted focus groups where some did not have an organization affiliation, or the focus group was not recorded:
The Health & Housing Consortium's Consumer Advisory Committee
The Supportive Housing Network's NYC Membership Meeting
Health Home Care Managers
Shelter Direct Service Staff

Appendix C - Question Guide for Interviews on High Acuity Supportive Shelter Residents and Housing Tenants

Organization/Agency Name:

Interviewee(s) Name:

Interview Date:

Interviewers:

Overview of Project:

CSH, The Supportive Housing Network of NY (The Network), and The Health & Housing Consortium (The Consortium) are working together to improve outcomes for high-acuity New Yorkers in need of or living in supportive housing. Over the next three years, we will:

1. Conduct a landscape analysis of NYC homeless and housing services and systems and identify best practices for serving high-acuity tenants,
2. Create and release an "Enhancing Care for High-Acuity New Yorkers Pilot" RFP informed by the analysis, and
3. Pilot and evaluate programs selected through the RFP.

*This interview is part of our **landscape analysis** and will help inform us how we construct the RFP and pilot programs.*

Key Takeaways: *capture highlights and major takeaways from your conversation here!*

Interview Questions

1. How would you define the most challenging population/demographic that you serve?
2. Have you noticed an increase in the intensity of the needs of the tenants/clients/patients that you normally serve since pre-COVID?

a. If yes, has this led to increased difficulty in accessing resources?

3. What services or resource connections are **most needed** for this population?
4. What services or resource connections are **the most difficult to connect** this population to?

5. What kind of interventions have you been implementing to support this population?
6. Do you have any feedback for us on innovative ways we can support the following:

a. This population getting access to housing?

b. The staff that work directly with this population?

7. Is there anyone else (another agency or program you know of) that we should be talking to about how to best support people with histories of homelessness and intense service needs?