SCALE TO STABILITY: A FRAMEWORK FOR SYSTEM TRANSFORMATION

Supporting Participants with High-Acuity Needs

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Table of Contents

Authors 1
Table of Contents....2
Introduction....4
Why The History of Supportive Housing in Los Angeles County Matters 5
How Service Models Evolved, and What Was Lost 8
Policy Landscape Changes to Date 9
CalAIM 9
Measure HHH, Measure H, and Measure A....10
Proposition 1 (Behavioral Health Services Act) 10
H.R. 1 10
CoC Changes 11
Problem Statement....12
Defining High Acuity in Supportive Housing 12
What is Acuity? 12
What is High Acuity? 12
High Acuity in Los Angeles County 13
Coordinated Entry System Challenges 13
Workforce Crisis: An Ethical and Structural Failure 14
Workforce Development and the Classroom-to-Field Divide 15
System Incentives and Policy Misalignment 17
Lack of Intermediate Levels of Care 17
Fragmentation and Structural Vulnerability....18
Who the High Acuity Pilot Should Serve....18
Proposed Solution Framework....21
Service Delivery Standards & Accountability....21
How services should be delivered, monitored, and improved....21
Workforce Development, Supervision, & Culture 21
Focus on training, supervision, and organizational culture, led by executive leadership 21
Cross-Sector Coordination & Integration....22
Opportunities for collaboration across departments and providers....22
Contracts, Policy, & Financing Reform 23

Includes policy, funding, and contract language changes to support fidelity 23
Learning, Community, and Storytelling 23
Ways of learning and sharing that humanize and help shift public narrative 23
Participant-Centered Practice & Voice 24
Centering choice, autonomy, dignity, and tenant leadership 24
About CSH 25
About Housing Works of California 25

Introduction

This paper emerged from a clear and urgent need within the homeless services sector: a shift in how we support the most vulnerable people who require supportive housing and long-term services. The COVID-19 pandemic intensified existing gaps, revealing that the sector was not fully equipped to provide the level of tailored, persistent, and sustainable support required for individuals with the highest acuity needs.

In response, leaders from across Los Angeles County, including the Department of Health Services (DHS); Housing for Health (HFH), now part of the Los Angeles County Department of Homeless Services and Housing (HSH); Department of Mental Health (DMH); the Los Angeles County Development Authority (LACDA); and developers and service providers came together to create space for reimagining what effective, person-centered care could look like.

From these conversations, two CSH staff members, Jaline Gilliam and Sabrina F. Alesana, partnered with Celina Alvarez, Executive Director of Housing Works of California (Housing Works), to **develop a high acuity pilot framework designed to strengthen service delivery by drawing on the Los Angeles Mobile Integrated Services Team (MIST) model, which closely reflects the evidence-based Pathways to Housing's Housing First model.** Their goal was to design an approach that not only improves outcomes for participants but also supports and sustains the workforce responsible for delivering these services. The goal is not to rely on heroic workers; it is to build a system in which responsibility is shared, roles are clear, and support is intentionally structured.

This paper examines the historical, policy, and operational factors that have shaped supportive housing in Los Angeles County and contributed to the growing challenges in serving individuals with high-acuity needs. It also proposes a framework for strengthening supportive housing services, workforce capacity, and cross-system coordination to better support housing stability for participants with the most complex needs.

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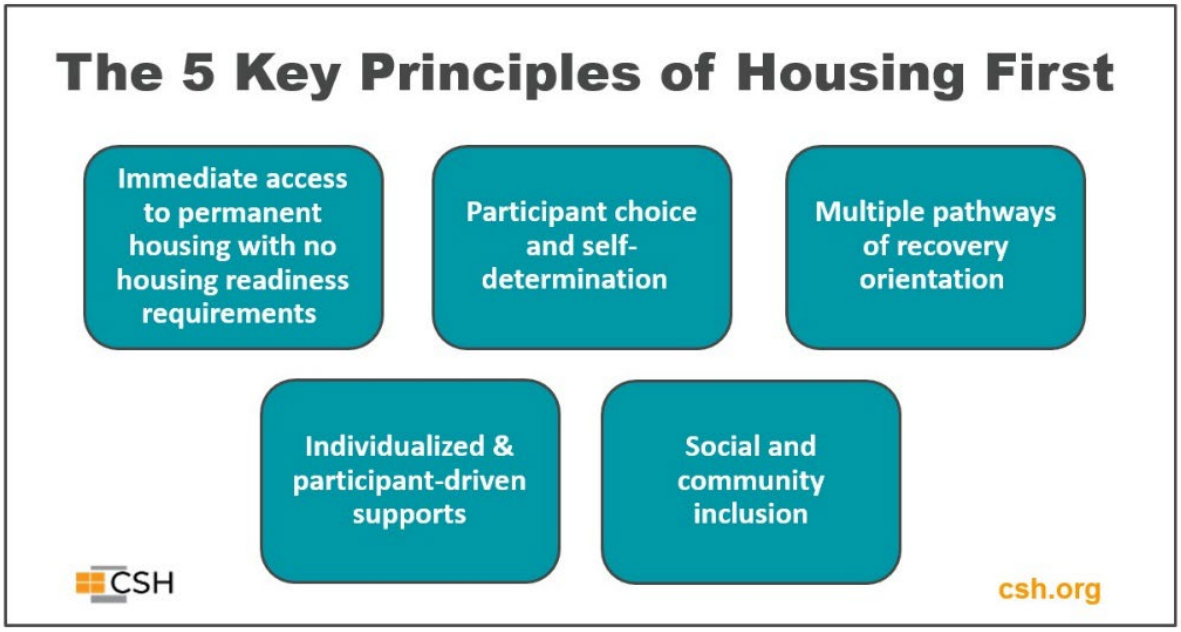


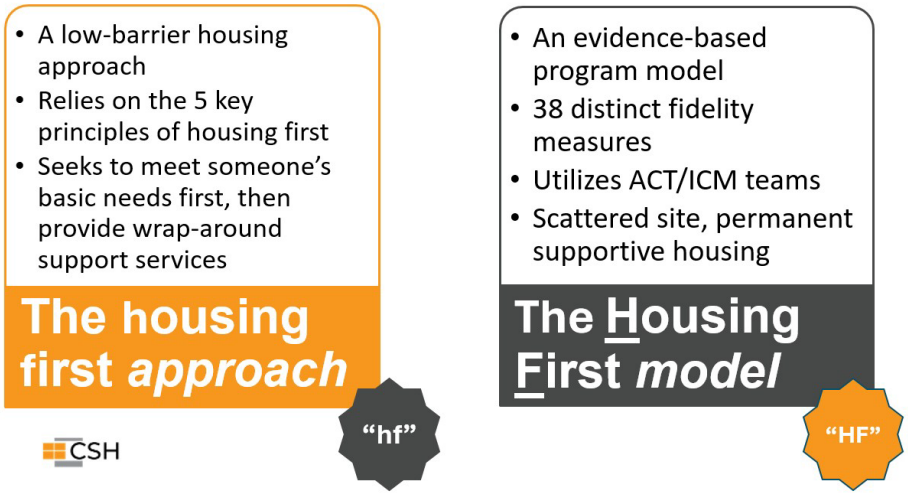
Why The History of Supportive Housing in Los Angeles County Matters

Homelessness in Los Angeles is not a sudden crisis, but the product of decisions made across decades. In the mid-1970s, the City of Los Angeles, led by the Community Redevelopment Agency (CRA), formalized a "containment" approach for Skid Row, codified in the City's 1976 *Blue Book* community plan. That plan preserved single-room-occupancy housing and clustered services, but it also concentrated poverty geographically, shaping where and how supportive housing would operate for generations.

In the years that followed, waves of enforcement-focused policies, redevelopment efforts, and public order strategies, ranging from nuisance abatement to data-driven policing, repeatedly reinforced Skid Row's role as a district of concentrated disadvantage rather than encouraging a broader distribution of housing and supportive services across the region.

This history intersects with the evolution of Housing First, which began as a programmatic practice before becoming federal and state policy. In 2008, the U.S. Department of Housing and Urban Development (HUD) formally incorporated Housing First principles into federal homelessness policy and funding priorities. California subsequently adopted Housing First through the Housing First Act of 2016, and Los Angeles County further affirmed its commitment by declaring itself a Housing First county in 2022. Together, these policy developments shifted systems away from housing-readiness models and toward immediate access to stable housing paired with supportive services.





At the same time, Los Angeles was building one of the nation's largest homeless response systems. In 2013, the Los Angeles Continuum of Care implemented the Coordinated Entry System (CES), managed by the Los Angeles Homeless Services Authority (LAHSA), to coordinate housing access and homeless services across the city and county. Through CES, individuals are assessed, prioritized, referred, and connected to housing resources using standardized processes intended to promote fair access to limited housing opportunities.

The scale of this effort is significant. The City of Los Angeles serves nearly 4 million residents, while Los Angeles County serves approximately 9.6 million residents across 88 incorporated cities and numerous unincorporated communities.[i] The regional system was therefore tasked with coordinating housing access across one of the largest and most complex jurisdictions in the United States while simultaneously implementing Housing First at scale.

As CES matured, housing resources were increasingly prioritized for individuals experiencing the highest levels of vulnerability, including people with long histories of homelessness, serious mental illness, substance use disorders, complex medical conditions, and co-occurring behavioral health needs. While this prioritization aligned with Housing First principles and ensured that those with the greatest needs received access to housing, it also fundamentally changed both the population entering supportive housing and the processes used to make housing referrals. In many communities, placement decisions that had historically been made by local providers with knowledge of individual households and available housing resources became increasingly centralized through coordinated entry systems. These changes improved consistency and fairness in prioritization but also reduced the flexibility providers previously had to consider local context, program fit, and individual housing preferences when making referrals. In some cases, the scale and centralization of matching processes also limited opportunities for participant choice and informed decision-making regarding housing options.

As a result, supportive housing increasingly became home to residents requiring intensive, ongoing, and multidisciplinary supports to maintain housing stability. This shift had important implications for staffing, service delivery, funding, and building operations. While prioritizing

individuals with the greatest needs expanded access to housing for populations that had historically been underserved, the systems responsible for supporting housing stability did not evolve at the same pace. Many supportive housing programs continue to navigate the consequences of serving increasingly complex populations with staffing models, service structures, and funding levels that were not designed for the level of need present today.

Understanding the history is important because it helps explain why many supportive housing providers are now serving residents with increasingly complex needs within systems that were not designed or funded to provide the level of support required today.

Importantly, the challenges facing supportive housing today are not the result of prioritizing people with the highest needs for housing. Rather, they reflect a longstanding mismatch between resident needs and the resources available to support successful tenancy. As CES increasingly prioritized individuals with the highest levels of vulnerability, operating and service budgets did not expand proportionately to support the intensive engagement, care coordination, behavioral health services, and tenancy-sustaining interventions necessary to achieve long-term housing stability. The result is not a failure of prioritization, but a gap between the complexity of resident needs and the capacity of supportive housing systems to consistently meet those needs.

Beginning in 2016, voters approved major investments to expand housing and services through Proposition HHH and Measure H. Housing production increased dramatically, and supportive housing systems grew to meet unprecedented demand. However, rapid expansion also revealed tensions between housing more people and maintaining the quality and intensity of services required by residents with the most complex needs. The emphasis on scale created more housing but also surfaced challenges in sustaining the individualized, relationship-based, and clinically informed services that are central to effective supportive housing practice, intended by the Pathways to Housing First model. As a result, many providers found themselves serving residents with increasingly complex needs without corresponding increases in staffing, clinical capacity, or operational resources.

The 2023 collapse of the Skid Row Housing Trust exposed significant structural vulnerabilities within Los Angeles's supportive housing system, including insufficient and inconsistent rental subsidy values, aging housing stock, and the lack of sustainable long-term operating and preservation models. The collapse demonstrated that housing production alone is insufficient to achieve lasting housing stability. Without adequate supportive services, reliable operational funding, and ongoing investments in resident well-being, even the strongest housing initiatives can struggle to achieve their intended outcomes. These lessons are particularly important as Los Angeles seeks to strengthen supportive housing systems for residents with increasingly complex service needs.

Why name this history? Because meaningful change requires healing and accountability for policy choices that concentrated poverty, under-resourced care, and normalized process over people. Only with that recognition can today's solutions center dignity and repair. Understanding

how supportive housing evolved in Los Angeles County helps explain why stronger service models, workforce investments, and cross-system coordination are needed now. Investments in services should be understood as smart, long-term investments; when the well-being of participants is adequately funded and sustained, the physical building is also more likely to remain stable, viable, and well cared for over time.

Photo Credit/Caption:
Housing First Sharing Exchange Event
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How Service Models Evolved, and What Was Lost

Supportive housing services in Los Angeles evolved from Residential Services Coordinator (RSC) models—often light-touch and building focused on affordable housing—to Intensive Case Management Services (ICMS) designed for high-touch individualized services for tenants living in supportive housing. A Residential Services Coordinator (RSC) may help a tenant identify a local dental provider, whereas an ICMS case manager will help schedule the appointment, coordinate transportation, and often accompany the tenant to ensure successful engagement. As caseloads grew and compliance requirements multiplied, service delivery too often became bureaucratic and process-driven, diluting the relational, healing-centered care that sustains housing stability.

As supportive housing systems expanded, service models were increasingly shaped by funding requirements, performance measures, documentation standards, and cross-system coordination demands. While these changes brought new resources and opportunities, they also increased administrative complexity. Over time, frontline staff were expected to navigate a growing number of reporting requirements, funding streams, and service systems, reducing the time available for relationship-building, community integration, and direct participant support.

Policy Landscape Changes to Date

CalAIM

CalAIM transformed Medi-Cal by introducing Enhanced Care Management (ECM) and Community Supports, including housing transition and tenancy-sustaining services. These reforms built on earlier Medicaid initiatives, most notably California's Whole Person Care waiver (2015-2021), which tested approaches to integrating health, behavioral health, housing, and social services for people with complex needs. CalAIM expanded and institutionalized many of these efforts within the state's broader Medi-Cal system. These reforms created new opportunities to address social drivers of health and strengthen coordination between housing, healthcare, and behavioral health systems. However, implementation remains complex in Los Angeles County. Multiple Managed Care Plans (MCPs), variations in Community Supports offerings, differing reimbursement structures, and the need for coordination across county agencies, health plans, and community providers can create barriers to timely referrals and consistent service delivery. The recent addition of Transitional Rent as a mandatory Community Support expands access to housing-related assistance for eligible Medi-Cal members and reflects the state's growing recognition of housing as a key factor in health and long-term stability.[ii]

Measure HHH, Measure H, and Measure A

A series of voter-approved initiatives dramatically expanded resources for housing and homelessness services in Los Angeles County.

Measure HHH is a 2016 City of Los Angeles voter approved measure that authorized the City to issue $1.2 billion in bonds to support the development of supportive housing for people experiencing homelessness.

Measure H is a 2017 County of Los Angeles voter approved quarter-cent sales tax increase aimed at increasing the revenue stream to support homelessness services across the county.

Measure A is a 2024 voter approved measure that replaced measure H (set to expire in 2027) and increased the quarter-cent sales tax to half-cent sales tax that funds countywide homeless services, supportive housing, and related programs. Measure A took effect in 2025.[iii]

Proposition 1 (Behavioral Health Services Act)

This modernizes California's behavioral health funding structure and creates new opportunities for counties to invest in evidence-based practices such as ACT, Housing Interventions, and Full-Service Partnerships beginning July 1, 2026.[iv] BHSA also establishes minimum funding requirements for key program areas, including Full-Service Partnerships and Housing Interventions, prompting counties to realign existing behavioral health investments. While these changes may strengthen services for people with the highest needs, they are being implemented largely through a restructuring of existing funding rather than through new funding streams, creating transition challenges for some counties and providers.

H.R. 1

H.R. 1 introduces new Medicaid renewal and eligibility requirements that may have significant implications for individuals experiencing homelessness and those living in supportive housing. Beginning January 1, 2027, adults ages 19-64 enrolled through the ACA Medicaid expansion will be required to complete eligibility renewals every six months rather than annually.[v] In addition, adults ages 19-64 must meet qualifying community engagement requirements through employment, education, job training, community service, or other approved activities.[vi] [vii]

Although many individuals experiencing homelessness or living in supportive housing are expected to remain eligible for Medicaid, maintaining coverage may become more challenging. Many participants lack a fixed address, reliable access to technology, or the documentation needed to verify eligibility and comply with renewal requirements. Additional reporting and verification requirements may also increase administrative burdens on an already strained workforce and create challenges for individuals whose income is derived from informal or cash-based work that may not be readily documented. [viii]

These changes may increase the risk of coverage disruptions for some individuals, potentially affecting access to healthcare, behavioral health services, medications, and housing-related supports that are critical to long-term stability.[ix]

CoC Changes

Recent changes to Continuum of Care funding policies, from July 2026 through the date of this publication, could have a direct impact on Los Angeles by limiting investments in supportive housing and rehousing programs that are central to the region's homelessness response strategy. These changes have prompted legal challenges from local jurisdictions and service providers, who argue that they could undermine critical housing resources and evidence-based approaches to addressing homelessness. Potential reductions in supportive housing and rehousing investments could further strain systems that are already attempting to serve participants with increasingly complex needs.

Bottom line: Supportive housing systems today have more funding sources, more housing units, and more service tools than at any point in their history. Yet many providers are serving participants with increasingly complex needs while operating within fragmented funding systems, evolving policy requirements, and workforce constraints. The result is a growing gap between what participants need and what existing service models were designed and funded to provide. At the same time, supportive housing providers are navigating a period of significant system transformation across housing, healthcare, and behavioral health sectors. While these changes create important opportunities to improve outcomes, they also increase the risk that individuals with the most complex needs may experience gaps in services, care coordination, or support during transitions. Ensuring that these individuals remain connected to housing and services will be critical to realizing the promise of these reforms.

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Problem Statement

Supportive housing providers are increasingly expected to support individuals with high acuity needs that significantly impact daily functioning, housing stability, and community safety. In single-site supportive housing, these challenges extend beyond service provision and into housing operations. Property management and service provider teams are routinely tasked with responding to complex behavioral health needs and crises without adequate training, clinical support, or institutional authority. The resulting conditions often include escalating conflict, avoidable evictions, staff burnout, and growing mistrust among tenants, site operators, service providers, government entities, and surrounding neighborhood community members.

Defining High Acuity in Supportive Housing

What is Acuity?

In supportive housing, acuity refers to the severity and complexity of an individual's physical health, mental health, substance use, cognitive, functional, and social service needs relative to the amount and intensity of support required to maintain housing stability and overall well-being. Acuity exists on a continuum rather than as a fixed condition. An individual's level of acuity may increase or decrease over time as health conditions stabilize or worsen, support systems strengthen or weaken, or life circumstances change.

Acuity is related to, but distinct from, vulnerability. Vulnerability generally describes a person's risk of experiencing adverse outcomes, while acuity reflects the intensity of needs, interventions, and supports required to maintain stability. Individuals with high vulnerability may not always have high acuity needs, and individuals with high acuity needs may experience varying levels of vulnerability depending on available supports and resources.

What is High Acuity?

CSH defines high acuity as a level of need in which the severity of an individual’s physical, mental, and/or behavioral health conditions requires intensive, ongoing, and often multidisciplinary supports to maintain housing stability and ensure safety for the individual, fellow tenants, and staff.

Individuals with high acuity frequently experience severe or co-occurring mental health conditions, substance use disorders, complex medical conditions, cognitive impairments, functional limitations, or combinations of these challenges. These needs can be life-threatening, highly disruptive to daily functioning, and difficult to address through traditional supportive housing service models alone.[x]

High acuity is not simply a crisis state. Rather, it often reflects the cumulative effects of unmet needs across multiple systems—health care, behavioral health, substance use treatment, housing, and social services—over time. Many individuals identified as “high acuity” have experienced repeated system failures, service fragmentation, or barriers to care that have allowed conditions to worsen before effective interventions are available.

Importantly, high acuity is dynamic. Individuals may move into and out of periods of high acuity as conditions improve, relapse, stabilize, or deteriorate. Even when needs decrease, many individuals continue to benefit from ongoing supports and safety nets that help prevent future crises and maintain housing stability.

CSH's experience suggests that a relatively small but significant portion of supportive housing tenants experience high-acuity needs at any given time. While estimates vary across programs and communities, this population often requires a disproportionate amount of staff time, service coordination, crisis response, and cross-system collaboration. At the same time, providers report that high-acuity needs are increasing due to factors including the fentanyl-driven overdose crisis, an aging tenant population with complex medical conditions, and the lasting impacts of the COVID-19 pandemic.

High Acuity in Los Angeles County

In Los Angeles County, discussions of high acuity often overlap with local definitions of service intensity and levels of care within supportive housing, particularly Intensive Case Management Services (ICMS) models. While no single countywide definition exists, the term is generally used to describe tenants whose needs exceed what traditional supportive housing staffing models were originally designed to support and who require frequent coordination across housing, healthcare, behavioral health, crisis response, and other service systems.

The local context is particularly important because supportive housing providers are increasingly serving individuals with complex co-occurring conditions while navigating multiple service systems, funding streams, and referral pathways. As a result, high acuity in Los Angeles is often discussed not only as an individual characteristic, but also as a system-level challenge that requires stronger coordination across housing, healthcare, behavioral health, and crisis response systems.[xi]

Coordinated Entry System Challenges

The introduction of the Coordinated Entry System (CES) in 2013 fundamentally changed how individuals experiencing homelessness access housing resources. CES was designed to create a fairer and more standardized process for matching people to housing interventions through four core functions: access, assessment, prioritization, and referral. By prioritizing individuals with the highest levels of vulnerability and acuity based on standardized assessment scores,

CES has helped ensure that limited supportive housing resources are directed toward those most at risk of mortality, chronic homelessness, and overall housing instability.

However, the long-term implementation of assessment and prioritization practices has also produced unintended consequences. As referrals increasingly prioritize individuals with the highest service needs, many project-based supportive housing sites have become concentrated communities of residents with high-acuity needs, experiencing complex medical conditions, serious mental illness, substance use disorders, unresolved trauma, and histories of chronic homelessness. While the prioritization of these populations aligns with efforts to ensure that individuals with the greatest needs have access to housing, the concentration of residents with high-acuity needs within a single building has often occurred without a proportional increase in staffing levels, workforce training, clinical supports, security resources, or operational funding.

In addition, increasingly centralized matching processes may reduce opportunities for providers and residents to consider factors such as housing preferences, neighborhood connections, building environment, and perceived fit when a housing referral is made. Although these changes have improved consistency and fairness in access to scarce housing resources, they can also affect resident engagement, housing satisfaction, and long-term housing stability. Beyond these operational challenges, the Black People Experiencing Homelessness Committee noted that assessment and prioritization practices may also reflect implicit biases and recommended greater representation of people with lived experience among outreach and service deliver staff.[xii] Together, these factors have significant implications for service delivery, staffing, resident outcomes and building operations.

Workforce Crisis: An Ethical and Structural Failure

The supportive housing workforce is operating under extreme and ongoing strain. Low wages, high turnover, inconsistent supervision, limited mentorship, and insufficient access to trauma-informed and resilience-oriented supervision erode consistency and quality across agencies. Despite these conditions, staff routinely show up in the midst of trauma, psychosis, relapse, violence, grief, and death.

Historically, the homelessness and supportive housing systems have relied on a culture that asks workers to “do whatever it takes,” without providing the structure, training, staffing ratios, or emotional support necessary to sustain that expectation. Many long-term workers learned the profession by pushing through exhaustion, absorbing trauma, and prioritizing tenants regardless of what was happening in their own lives. At the same time, staff are often expected to serve as case managers, crisis responders, behavioral health navigators, housing specialists, advocates, mediators, and community builders. While this flexibility is frequently essential to supporting tenants with complex needs, it is highly skilled work that requires ongoing training, supervision, mentorship, and professional development. This model is not sustainable or ethical and does not honor the workforce that holds housing stability together.

If staff are expected to sit with death, navigate court systems, respond to crisis, hold trauma, and maintain long-term relationships, then the workforce itself must be treated as critical infrastructure. Without consistent training, mentorship, and reflective supervision, staff may struggle to navigate complex issues such as harm reduction, behavioral health crises, trauma responses, and substance use, resulting in inconsistent practices and avoidable workforce strain across programs and systems.

This requires investment in structured training pathways, reflective and trauma-informed supervision, real-time debriefing and aftercare, sustainable compensation, and clear career pathways. The demands of this work also require trauma-informed organizational practices and workforce development on par with the investments made in other essential professions such as nursing, emergency medical services, firefighting, and law enforcement.[xiii] Without this support, the homeless services response system will continue to fail both workers and the people they serve.

Workforce Development and the Classroom-to-Field Divide

The supportive housing workforce extends far beyond clinicians and case managers. It includes property managers, intensive case management services (ICMS) staff, resident coordinators, peer support workers, outreach workers, maintenance personnel, security staff, supervisors, and administrators. Each plays a critical role in maintaining housing stability and responding to the complex needs of residents. Yet workforce development efforts often focus narrowly on clinical or case management roles, overlooking the interdisciplinary nature of supportive housing operations.

Workforce preparation occurs through multiple pathways, including colleges and universities, certificate programs, agency onboarding, peer training programs, field placements, and on-the-job learning. At the same time, many supportive housing workers enter the field with limited preparation for the realities of high-acuity housing environments. Some receive formal academic training but struggle to apply classroom concepts in complex real-world settings. Others enter the field through lived experience, community work, or nontraditional career pathways and may receive little formal training at all, often learning through trial, error, mentorship, and experience.

Academic institutions contribute to this gap. While many programs provide important theoretical foundations, they often do not fully prepare students for the relational, community-based, and crisis-responsive nature of supportive housing practice. Training frequently remains classroom- or virtual-learning centered rather than grounded in the day-to-day realities of housing operations, crisis response, system navigation, and community engagement. As a result, staff must learn how to translate concepts such as trauma-informed care, harm reduction, behavioral health interventions, and person-centered housing principles into the organizational cultures and operational environments in which they actually work.

County departments, provider agencies, and system partners across Los Angeles, including organizations such as the Department of Homeless Services and Housing, continue to navigate challenges in developing consistent workforce development frameworks that prepare staff for the realities of high-acuity supportive housing. While important training resources exist, opportunities vary across organizations and do not always reflect local cultural contexts, emerging substance use trends, mental health needs, or the practical navigation of housing, healthcare, social services, and legal systems. Frontline staff, already overburdened by field demands and documentation requirements, often have limited time and support to participate in training or translate into daily practice.

Training alone, however, is not enough. The ability of staff to apply evidence-based practices, harm reduction principles, trauma-informed approaches, and person-centered housing values is heavily influenced by organizational culture. Supervisory practices, workplace expectations, informal norms, and peer learning often shape service delivery as much as formal training. Even when staff receive strong foundational education, organizational cultures that prioritize compliance, documentation, crisis management, or productivity metrics over relationship-based practice can undermine effective implementation and contribute to staff frustration, turnover, and burnout.

As a result, the field continues to produce a workforce that is often expected to navigate court systems, respond to behavioral health crises, advocate across multiple bureaucracies, build trust with residents, coordinate complex service systems, and address community concerns with limited preparation and support. The gap is not simply between classroom learning and field practice; it is also between what supportive housing workers are asked to do and the systems that prepare and support them to do it[xiv]

These challenges are particularly acute for staff who enter the field through lived experience pathways. Many supportive housing programs intentionally hire individuals with lived experience of homelessness, behavioral health challenges, recovery, incarceration, or system involvement. These practitioners often bring some of the field's most valuable expertise, credibility, and capacity for engagement, yet they frequently receive inadequate training, limited professional development opportunities, insufficient organizational support, and compensation that fails to reflect the complexity of their work. Peer support workers in particular are often treated as junior case managers rather than recognized as specialists whose lived experience represents a distinct and essential form of expertise. The lack of intentional career pathways, supervision models, and workforce infrastructure to support peer professionals contributes to high turnover and burnout across the sector.

Ultimately, supportive housing requires more than technical knowledge or compliance with program requirements. It requires a workforce capable of building trust, navigating complex systems, responding to crisis, supporting recovery, advocating for residents, and sustaining long-term relationships. Developing that workforce requires more than classroom instruction. It requires intentional onboarding, field-based learning, mentorship, reflective supervision, organizational cultures that reinforce effective practice, and career pathways that recognize both

professional and lived expertise. Without these investments, the gap between workforce preparation and the realities of high-acuity supportive housing will continue to undermine service quality, staff retention, and resident outcomes.

System Incentives and Policy Misalignment

Systemically, funding and compliance regimes often emphasize documentation, service units, compliance measures, and program outputs that are easier to track and reimburse than participant-defined outcomes such as trust, community integration, recovery, or long-term housing stability. As a result, providers can find themselves balancing administrative requirements with the relational work that often drives successful outcomes for tenants. Because policy, funding, and oversight decisions are frequently made at levels removed from day-to-day operations, there can be a disconnect between how programs are designed on paper and how services are delivered in practice. Frontline providers often must navigate competing requirements from multiple systems while responding to the complex and changing needs of residents.

Within California, CalAIM's plan-by-plan variability, workforce shortages, and limited capacity within community mental health systems can restrict timely access to care, particularly for Medi-Cal beneficiaries. In practice, providers often report that successful service connections depend on personal relationships, informal problem-solving, and knowledge of local systems rather than clear and consistently available referral pathways. This places additional burdens on supportive housing staff and can create unequal access to services for tenants whose providers have fewer system connections.[xv]

Lack of Intermediate Levels of Care

Supportive housing providers are also operating within a system that lacks flexible intermediate levels of care between supportive housing and institutional settings. When tenant needs escalate, there are few viable options beyond emergency departments, incarceration, or eviction. Critical resources such as medical respite, subacute stabilization, and crisis residential programs are insufficient, inconsistently available, or administratively inaccessible. When these resources are unavailable, supportive housing often becomes the default setting for needs that require a higher level of clinical intervention.

Even when higher levels of care are available, transitions can be difficult. Tenants and providers may be reluctant to pursue temporary placement in more intensive settings if doing so could jeopardize housing stability, disrupt established support networks, or create uncertainty about returning to housing afterward. As a result, supportive housing is often expected to manage periods of escalating need that might be more appropriately addressed through a flexible continuum of care.

As a result, supportive housing is increasingly expected to function as a de facto treatment setting, despite not being designed, staffed, or funded for that role. This gap places tenants, staff, and housing stability at significant risk.

Fragmentation and Structural Vulnerability

Finally, coordination failures across homelessness response systems, housing operations, and behavioral health providers leave tenants and staff navigating a fragmented and exhausting maze. This fragmentation is particularly evident in the transition from outreach to housing navigation and ultimately to supportive housing services. Participants often build trust through long-term relationships with outreach teams, only to experience multiple transitions as they move into housing and ongoing services. Each handoff introduces opportunities for miscommunication, loss of trust, and disruption in care. Service intensity also frequently decreases after housing placement, creating gaps between the supports that helped people engage and the supports available to help them remain stable.

Compounding the challenge, the level of support available during outreach is often not sustained once a participant is housed. Outreach teams frequently operate with multidisciplinary staffing models that include clinicians, housing specialists, peer workers, and intensive field-based supports. Yet after housing placement, participants may encounter reduced service intensity, fewer clinical resources, and a markedly different approach to care. As a result, housing stability is often expected to rest on a level of service coordination and continuity that the system itself is not designed to provide.

Taken together, these challenges reflect more than individual program limitations. They reveal systemic gaps between participant needs, workforce capacity, funding structures, and available levels of care. Without intentional investments in service delivery, workforce development, and cross-system coordination, supportive housing providers will continue to be asked to manage increasingly complex needs without the resources necessary to do so effectively.

Who the High Acuity Pilot Should Serve

The High Acuity Pilot is intended to serve individuals experiencing the most significant and persistent barriers to housing stability, safety, and engagement with traditional service systems. Consistent with this paper's definition of high acuity, eligibility should be based not on diagnosis alone, but on the intensity of supports required to maintain housing stability, support daily functioning, and ensure safety for the individual, fellow tenants, and staff. Participants should be identified through a multidisciplinary review process involving supportive housing providers, behavioral health partners, healthcare providers, and relevant county agencies.

The pilot is intended to serve **populations with high acuity needs** whose current service needs exceed the capacity of traditional supportive housing models. These are individuals who

have been unable to achieve stability despite existing housing and service interventions and who require a more specialized, flexible, and intensive approach. While not exhaustive, examples of individuals who may be appropriate for the pilot include those who are:

- High utilizers of emergency departments, crisis services, hospitals, and other public systems (e.g., LAHSA, HSH, DMH, DPH, schools, and law enforcement) due to chronic illness, physical decline, and complex behavioral health needs
- Repeatedly involved with law enforcement or the legal system, including incarceration, multiple 5150 holds, and frequent incident reports in supportive housing
- Long-term participants in street outreach teams and/or ICMS services whose needs remain unmet despite ongoing engagement efforts and existing supports
- Experiencing significant mental health symptoms, including trauma-related impairments, unresolved grief, intense anger, aggression, and behavioral dysregulation
- Experiencing significant substance use disorders, including repeated overdoses, drug-induced psychosis, safety events, or the need for stabilization, detoxification, or medication-assisted treatment (MAT)
- Living with untreated complex medical conditions, severe chronic diseases, or other health conditions requiring intensive behavioral health and medical support
- Experiencing functional impairments that limit the ability to complete documentation (i.e. benefits, ID renewal, housing documents), manage activities of daily living (ADLs), maintain employment, or live safely in the community
- Living in unsafe, non-habitable, or severely deteriorated environments, including situations involving hoarding or age-related functional decline
- At imminent risk of eviction due to housekeeping challenges, lease violations, unauthorized guests, or inability to comply with housing requirements
- Caregiver-dependent or requiring advanced medical support, including end-of-life care
- Facing structural barriers that complicate access to housing, healthcare, behavioral health, or public-benefit systems, including limited English proficiency and immigration-related challenges
- Experiencing other significant barriers that threaten housing stability, safety, or quality of life and require intensive, coordinated, and specialized intervention

While this framework identifies a broad range of populations with high-acuity needs, the pilot is not intended to create separate programs for each population. Rather, it is designed to test a flexible, cross-sector model capable of addressing complex and overlapping needs through multidisciplinary supports. Pilot implementation may initially focus on specific subpopulations to allow for the development and testing of tailored service packages, alignment with population-specific funding opportunities, and clearer evaluation of participant outcomes.

This approach can help identify which interventions are most effective for particular populations while generating lessons that can inform broader implementation and future scaling efforts. Because the needs of this population are diverse and often intersect across multiple systems, successful implementation will likely require varying levels of service augmentation, cross-sector coordination, and targeted funding strategies tailored to different participant needs.

Overall, the pilot prioritizes individuals whose needs exceed the capacity of traditional supportive housing or outreach models and who require a more specialized, flexible, and intensive approach to stabilization and community integration.

Photo Credit/Caption: Housing Works of California 23rd Annual Dinner
Housing Works



Proposed Solution Framework

The proposed solution framework is designed to respond to the growing gap between participant needs, workforce capacity, service delivery systems, and available resources. It is anchored in a set of core commitments that shape every decision, practice, and partnership. The framework emerged through CSH's Housing First Sharing Exchange (HFSE) community dialogues, where Los Angeles-based housing practitioners and individuals with lived experience of homelessness identified service-related priorities, gaps, and improvement opportunities grounded in real-world practice, accountability, and impact. These commitments are not optional principles; they are the foundation of a supportive housing system capable of serving individuals with increasingly complex and high-acuity needs.

We draw upon the evidence-based principles of the Pathways to Housing model, grounded in trauma-informed and healing-centered practices. The framework prioritizes what truly improves lives and strengthens community, ensuring that accountability systems reinforce meaningful outcomes rather than administrative burden. Together, these values define both the foundation and direction of the entire approach.

Service Delivery Standards & Accountability

How services should be delivered, monitored, and improved

- **Establish consistent implementation and accountability standards** for ICMS intensity, warm handoffs, cross-sector case conferencing, and participant feedback loops to reduce variation in service delivery across programs, providers, and jurisdictions.
- **Implement evidence-based practices,** including Housing First Fidelity, Motivational Interviewing, Assertive Engagement, Trauma-Informed Care, and Harm Reduction, supported by lower participant-to-staff ratios and frequent engagement.
- **Adopt relationship-centered service delivery standards** that prioritize trust, dignity, mutuality, and whole-person care, recognizing relationships as the foundation for meaningful change.
- **Align service expectations and staffing models with participant acuity**, including lower caseloads for individuals with the most complex needs.

Workforce Development, Supervision, & Culture

Focus on training, supervision, and organizational culture, led by executive leadership

- **Create mentorship networks**, **case consultation circles**, **and learning collaboratives** to support continuous improvement.

- **Develop tiered learning pathways** that combine classroom instruction, field practice, and coaching, covering severe and persistent mental illness, substance use, neurology, chronic medical conditions, de-escalation, trauma-informed practice, harm reduction, understanding gang culture, reasonable accommodation, tenancy law, and strategies for creating welcoming community environments.
- **Provide sustainable compensation**, **career pathways, and tuition or certification supports**.
- **Invest in staff wellness programs** that address the impacts of chronic stress, secondary trauma, and provide access to practices, resources, and supports that promote well-being, resilience and retention.
- **Implement a coordinated workforce development approach** that cross-trains service providers, property managers, and leadership teams to build shared language, aligned expectations, and a unified understanding of how each system's roles, constraints, and decision-making processes shape service delivery.
- **Strengthen supervisor development** through trauma-informed management practices that promote staff well-being, professional growth, and retention through ongoing coaching, structured debriefing, and aftercare.

Cross-Sector Coordination & Integration

Opportunities for collaboration across departments and providers

- **Establish a standardized, countywide linkage protocol** integrating homelessness response, supportive housing operations, behavioral health, CalAIM ECM/Community Supports, hospitals, and on-site property management where appropriate.
- **Integration of In-Home Supportive Services (IHSS)** as a formal resource within the navigation system to ensure timely coordination of personal care, stabilization supports, and functional-needs assistance for supportive housing residents.
- **Integrate occupational therapy into supportive housing services** to help individuals develop skills related to daily living, home management, community integration, and adaptation to new living environments, thereby strengthening long-term housing stability.
- **Create a shared navigation and referral infrastructure** across departments, health plans, and service providers to promote seamless coordination, real-time communication, and fair access to services regardless of an individual's knowledge or connection to the system.
- **Conduct joint training with Medi-Cal Managed Care Plans (MCPs)** to improve understanding of plan-specific authorization processes, covered services, documentation requirements, and referral pathways. These efforts can reduce delays in care coordination, improve communication across systems, and increase access to available supports.
- **Strengthen pathways to intermediate levels of care**, including medical respite, crisis residential programs, subacute stabilization, and other supports that help prevent unnecessary emergency department utilization, incarceration, or eviction.

Contracts, Policy, & Financing Reform

Includes policy, funding, and contract language changes to support fidelity

- **Modernize operating subsidies** through transparent rate-setting, portfolio-based approaches, and reserve requirements to reduce the risk of future system failures, including challenges highlighted by the collapse of Skid Row Housing Trust (SRHT).[xvi]
- **Shift funding models from billable units to outcome-based purchasing**, including measures such as housing retention, crisis prevention, connection to care.
- **Align Measure A allocations with supportive housing sustainability and CalAIM integration**, funding onsite and community-based services, clinical partnerships, and tenancy-preserving supports that promote housing stability and reduce avoidable crises, hospitalizations, and evictions.
- **Require contract language that funds the true cost of high-acuity services** and requires fidelity to evidence-based supportive housing practices and trauma-informed care, as measured in audits and outcomes.
- **Establish a continuous service fund**, supported through Measure A allocations, philanthropy, managed care partnerships, and flexible county resources, to prevent disruptions in service delivery during contract transitions, renewals, procurement delays, or other funding interruptions, drawing on lessons learned from previous efforts to provide bridge financing and service continuity during system transitions.

Learning, Community, and Storytelling

Ways of learning and sharing that humanize and help shift public narrative

- **Develop community-building programming** co-designed by tenants and staff (e.g., community dinners and peer-led activities) to strengthen connection, belonging, and mutual support, particularly in a region characterized by high levels of social isolation.
- **Expand public education efforts** to increase accountability among system partners, elected officials, and philanthropy, bridging the gap between policy rooms and frontline realities.
- **Use storytelling strategically** to humanize supportive housing residents and frontline staff, deepen understanding of participant experiences and system realities, and provide practical teaching tools that strengthen cross-sector learning and reinforce trauma-informed, person-centered practices.
- **Incorporate qualitative data, storytelling, and lived expertise alongside quantitative measures** to deepen understanding of community needs, humanize outcomes, and inform more responsive policies and programs.

Participant-Centered Practice & Voice

Centering choice, autonomy, dignity, and tenant leadership

- **Prioritize participant voice, choice, autonomy, and self-determination**.
- **Embed participant leadership** in program design, hiring, evaluation, and accountability efforts.
- **Measure success through meaningful outcomes**, including stability, safety, well-being, and community connection, rather than compliance alone.
- **Recognize that participant needs change over time** and ensure services can be adjusted to reflect changing levels of acuity, support needs, and personal goals.

Rooted in community wisdom, this framework calls on partners across housing, healthcare, behavioral health, and homelessness response systems to align practice, policy, funding, and accountability structures around a common goal: ensuring that individuals with high-acuity needs can achieve stability in housing while receiving the level of support necessary to thrive. By investing in service delivery, workforce development, cross-system coordination, and sustainable funding, Los Angeles County can build a more responsive system that supports both participants and the workforce responsible for serving them.



Photo Credit/Caption: Emerging Developer Celebration Event
Brandon James, C2R Productions LLC

About CSH

CSH (Corporation for Supportive Housing) advances affordable housing aligned with services by advocating for effective policies and funding, investing in communities, and strengthening the supportive housing field. Since our founding in 1991, CSH has been the only national nonprofit intermediary focused solely on increasing the availability of supportive housing. As an intermediary, we do not directly develop or operate housing but center our approach on collaboration with a wide range of people, partners, and sectors.

About Housing Works of California

Housing Works is one of Los Angeles' most effective providers of permanent supportive housing, serving individuals facing severe mental illness, chronic homelessness, disabling health conditions, and substance use disorder. With a housing retention rate near 100% for more than 1,500 individuals, HW helps participants become integrated into their communities, reducing isolation and addressing social determinants of health.

Housing Works is also a driving force behind the Frontline Worker Movement, advocating for better training, wages, and working conditions for homeless service professionals, many of whom bring lived experience of being unhoused to their roles. This commitment gave rise to the Santa Monica College Homeless Services Certificate Program, established to professionalize and elevate the field.

Housing Works has long distinguished itself as an innovator in the homeless services space as an early adopter of Housing First and the creator of the first service protocols for the delivery of trauma-informed care to individuals with mental illness. In 2025, HW partnered with CSH to expand In-Home Support and In-Home Caregiving Services for people with lived experience of homelessness, including the development of training and toolkit materials for IHSS workers. The two organizations are now partnering to pilot AI-supported workflows to reduce administrative burden on frontline workers so they can devote more time to the people they serve—what Housing Works calls "the art of human engagement."

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[i] U.S. Census Bureau QuickFacts: Los Angeles County, California
[ii] Enhanced Care Management and Community Supports | DHCS
[iii] Measure A - LA County Homeless Services & Housing)
[iv] DHCS, *Behavioral Health Services Act Funds for Housing*; CALBHB/C, *BHSA Implementation Timeline*. [dhcs.ca.gov], [calbhbc.org])
[v] California Street Medicine Collaborative, *HR1 & the CMS Interim Final Rule: What Street Medicine Needs to Know* (PowerPoint presentation, July 2026), slide 4.
[vi] California Street Medicine Collaborative, *HR1 & the CMS Interim Final Rule: What Street Medicine Needs to Know* (PowerPoint presentation, July 2026), slide 6.)
[vii] California Street Medicine Collaborative, *HR1 & the CMS Interim Final Rule: What Street Medicine Needs to Know* (PowerPoint presentation, July 2026), slide 6.)
[viii] California Street Medicine Collaborative, *HR1 & the CMS Interim Final Rule: What Street Medicine Needs to Know* (PowerPoint presentation, July 2026), slide 17.
[ix] Responding to High Acuity Challenges in Supportive Housing - National Center for Housing + Health
[x] Ibid.
[xii] Report And Recommendations Of The Ad Hoc Committee On Black People Experiencing Homelessness
[xiii] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0309866 and https://pmc.ncbi.nlm.nih.gov/articles/PMC10940250/
[xiv] https://www.latimes.com/california/story/2019-08-27/homeless-audit-lahsa-outreach-performance?utm_source=chatgpt.com
[xv] Department of Health Care Services
[xvi] Lessons for Permanent Supportive Housing from Skid Row Housing Trust Buildings - Hilton Foundation