



# Responding to High Acuity Challenges in Supportive Housing

Part 1 of 2

April 23, 2026

# Before we begin

- Chat, video, and audio of attendees is disabled
- Please use Q&A function for questions
- Slides and a link to the recording will be shared via email by next week

# About CSH

Corporation for Supportive Housing (CSH) is a national nonprofit organization and Community Development Financial Institution. Our mission is to advance affordable housing aligned with services as an approach to help people thrive. We do this by advocating for effective policies and funding, investing in communities, and strengthening the supportive housing field. **Visit us at [csh.org](https://www.csh.org)**



# About the National Center for Housing + Health

The National Center for Housing + Health (NCH+H), powered by CSH, is an innovative resource dedicated to advancing the alignment between affordable housing and healthcare. The Center brings together innovations, proven models, and practical strategies and policies that help housing providers, healthcare organizations, policymakers, and community and system leaders work better together — and make a bigger difference for people and communities. **Visit us at [housinghealthcenter.org](https://housinghealthcenter.org)**



# Agenda

- **Welcome & Introductions**
- **Background**
- **Challenges & Recommendations**
  - Community Presentations
- **Panel Discussion and Q&A**
- **Closing**



# CSH Presenters



**Andrew Spiers**

Senior Program Manager

Special Projects

Philadelphia, PA



**Janis Ikeda**

Director

Special Projects

Ewa Beach, HI



**Katie Bonamasso**

Director

Mountain West

Denver, CO



**Theresa Tanoury**

Senior Program Manager

Pacific Northwest

Seattle, WA

# Presenters



**Rachel Wilson**

*Senior Policy  
Transformation Analyst*  
Housing Forward  
Dallas, TX



**Alexis Chettiar**

*CEO & Co-Founder*  
Cardea Health  
Bay Area, CA



**David Langgle-Martin**

*Chief Housing Officer*  
Park Center  
Nashville, TN

# Defining “High Acuity”

Refers to the severity of an individual’s physical, mental, and/or behavioral health condition(s), *relative* to the amount and intensity of care needed to retain housing and ensure safety for themselves, fellow tenants, and staff.

# Why we started this work

In our work across the country, we heard a growing interest in finding solutions to help housing and services providers better support tenants with high acuity needs.

# What we've done so far



Focus groups and informational interviews with internal and external partners



Synthesized information to identify high-level challenges and recommendations



Developed overview paper, two-part webinar series, and plans for future work

# Five Major Challenges

High acuity client needs in supportive housing



## Identifying the population

We estimate that roughly 5–10% of people in supportive housing meet the definition of high acuity at any given time. This population is not static, because tenant needs change, moving between levels of acuity.



## Meeting medical and ADL needs

Programs are often not equipped to meet the needs of tenants who have significant medical concerns and/or challenges with activities of daily living (ADLs).



## Workforce challenges

Workforce challenges, including high rates of turnover, inadequate staff training, and various impacts of COVID, have made it more difficult for programs to serve tenants with high acuity concerns.



## Behaviors that impact safety

Providers struggle the most with high acuity behaviors that impact safety, like violence, hoarding, and fire-setting. These behaviors take a heavy toll on both staff and resources.



## SUD and severe mental illness

Providers also note significant challenges related to chaotic substance use and severe mental illness, such as psychosis. These behaviors strain resources and contribute to moral injury for staff.

# Promising Practices

How Communities Across the Country are  
Meeting High Acuity Needs in Supportive Housing

## Challenge

**Not all tenants in supportive housing have high acuity challenges.** We estimate that roughly 5–10% of people in supportive housing meet the definition of high acuity at any given time. This population is not static, because tenant needs change, moving between levels of acuity.

## Recommendation

We need **flexibility** within and between programs and systems to meet the needs of tenants as they change. We also need **intermediate levels of care** that can exist between supportive housing and institutionalization, such as harm reduction oriented medical respite and crisis stabilization.

Dallas, TX

# Housing Forward

Leveraging a Complex Needs Workgroup to address the needs of individuals with high acuity concerns



# COMPLEX NEEDS WORKGROUP

*ADDRESSING THE NEEDS OF HIGH ACUITY NEIGHBORS*

APRIL 2026

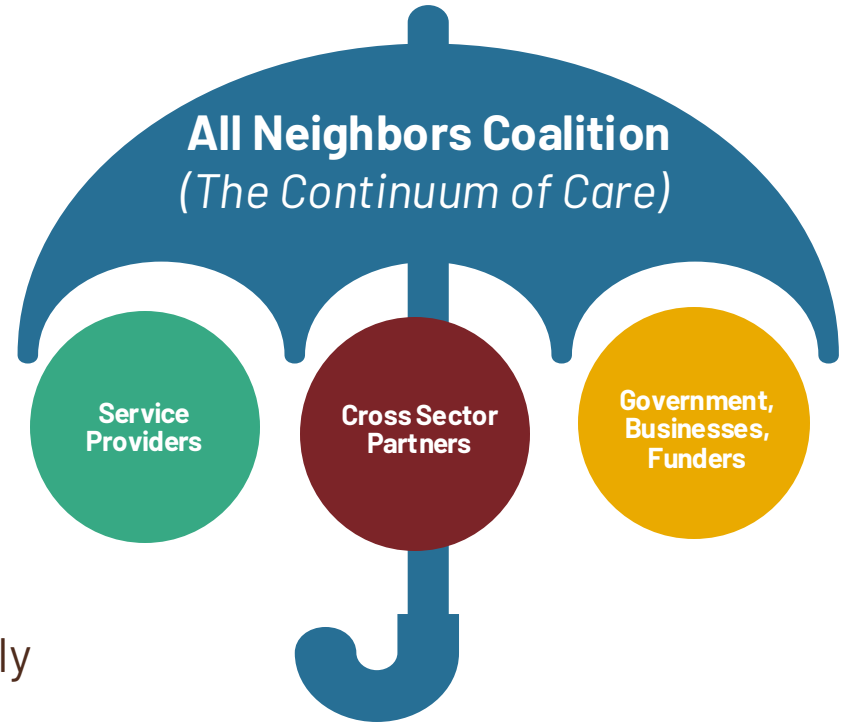
# housing forward works to end homelessness in north texas

## Who Are We?

- **Federally appointed lead agency** for Dallas and Collin County
- Coordinator of the 150+ member **All Neighbors Coalition** (our "continuum of care")
- **Strategic problem solvers** for our unhoused neighbors and service provider partners

## What Do We Do?

- **Unite** government, nonprofit, and private partners
- **Align** federal, local, and private dollars
- **Implement** data-driven strategies



Since 2021, the Coalition has supported nearly **23,000 people to exit homelessness.**

# OUR 'STREET TO HOME' INITIATIVE HAS REDUCED street homelessness and IMPROVED public safety

By scaling a **site-by-site encampment approach** in Downtown Dallas that brings:

- **mental health supports,**
- **street medicine,**
- and **homeless services**

directly to the streets, **our community has achieved:**

## Zero

Downtown  
encampments

## 87%

Drop in daily  
downtown street  
counts<sup>1</sup>

*Even with this success, it was clear **our community's highest acuity unsheltered individuals still needed more support.***

## 18%

Drop in violent  
crime<sup>2</sup>



<sup>1</sup> Downtown Dallas Inc. field teams, rolling averages as of 4/26

<sup>2</sup>Dallas Police Dept. Data comparing Q1 of 2024 and 2025



## OUR COMPLEX NEEDS WORKGROUP SERVES TO MEET THE NEEDS OF OUR HIGH-ACUITY NEIGHBORS

### Target Population:

All individuals are unsheltered and:

- Have severe behavioral health issues that prevent them from engaging; or
- Are refusing housing or not engaging.

### Group Members:

- North Texas Behavioral Health Authority
- Meadows Mental Health Institute
- Metrocare
- Parkland
- Baylor Street Medicine
- Downtown Dallas Inc
- Housing Forward
- City of Dallas Right Care/Medic 1
- City of Dallas Community Court
- Dallas Police Department
- Homeward Bound
- Dallas County Department of Criminal Justice
- Adult Protective Services



## OUR HIGH-ACUITY NEIGHBORS NEED **FREQUENT, CONSISTENT TOUCHPOINTS** TO REACH LONG-TERM SOLUTIONS

### What does the group do?

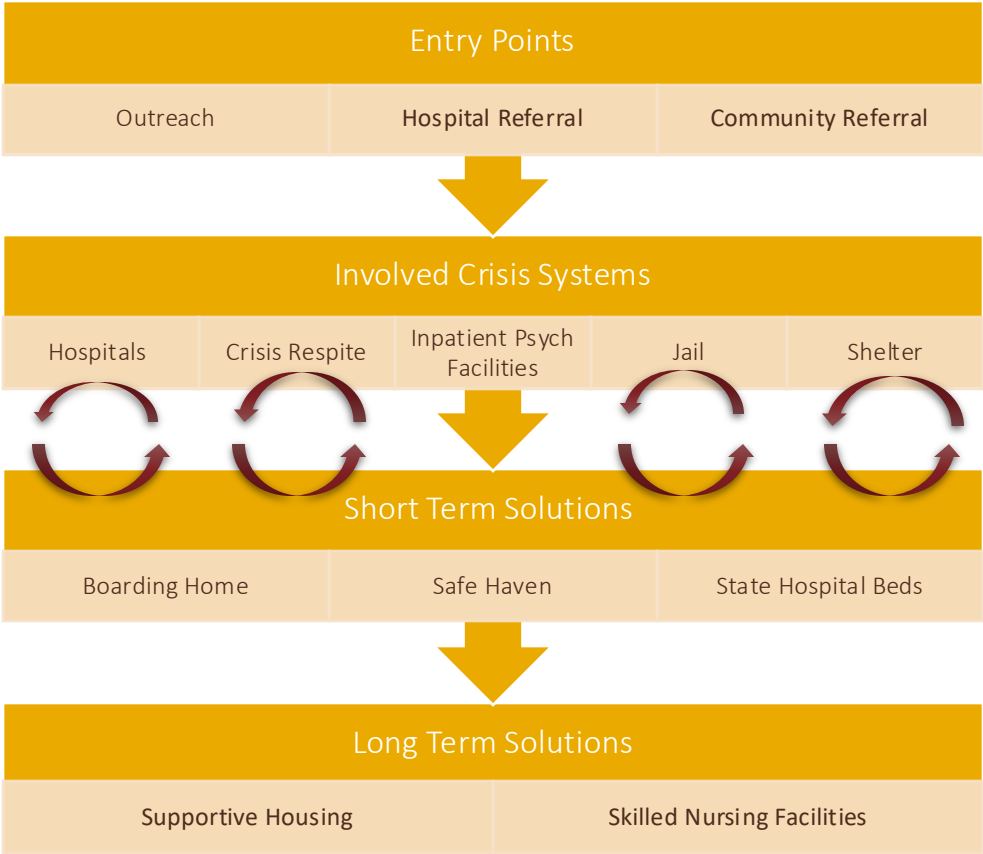
- Outreach teams comprised of **housing-focused outreach** and critical time **intervention behavioral health specialists** work with clients **daily**.
- **Case conferencing groups** meet **twice a week**
  - Address everyone on our by name list
  - Coordinate next steps for care
  - Mandate flexibility in all partnering systems
  - Conduct warm handoffs from system to system

### How is it funded?

- More about connecting already existing resources than developing new streams of funding
- \$20-million-dollar investment from Dallas city and county will fund new positions to manage coordination
- New crisis respite beds funded by North Texas Behavioral Health Authority and Austin Street Center

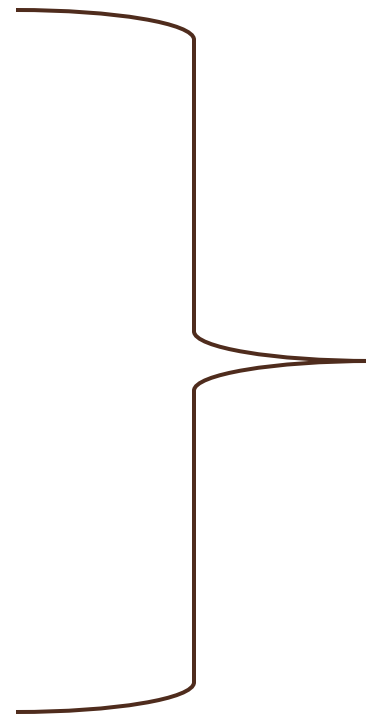


OUR HIGH-ACUITY NEIGHBORS REQUIRE THE COORDINATION OF **MULTIPLE INTERLOCKING SYSTEMS** TO REACH LONG-TERM SOLUTIONS



OUR **COMPLEX NEEDS WORKGROUP** HAS SERVED 40 HIGH-NEEDS INDIVIDUALS TO DATE

Category	Count
Supportive Housing	8
Skilled Nursing Facility	2
State Hospital	2
Crisis Respite	3
Boarding Home	1
Incarcerated	7
Hospital	1
Unable to locate	9
Unsheltered	6
Deceased	1
Total Served	40



*Data is a snapshot as of 4/16*



**THANK YOU!**



## Challenge

Programs are often not equipped to meet the needs of tenants who have significant **medical concerns** and/or challenges with **activities of daily living (ADLs)**.

## Recommendation

Rather than moving tenants to “higher levels of care,” which are often ill-equipped to deal with co-occurring disorders, we must promote **cross-sector partnerships**. Intentional collaboration and cultivating a shared operating language will enable providers to better meet the needs of supportive housing tenants by **alleviating system-strain**. This could include funding and training for home health aides and/or occupational therapists, better equipping them to manage co-occurring disorders.

Bay Area, CA

# Cardea Health

Integrating Medicaid-funded healthcare services  
into supportive housing to address high acuity challenges



# Integrated Health and Housing; Medicaid- funded Services in PSH

Alexis Chettiar, PhD, ACNP-BC

CEO and Co-Founder of Cardea Health



## Lessons from Project Roomkey

In Alameda County, Project Roomkey housed thousands of unsheltered individuals, all of whom had a chronic illness qualifier

***NOT ONE was enrolled in the intensive home-based Medicaid and Medicare programs that they were eligible for, such as:***

- Program of All-Inclusive Care for the Elderly (PACE)
- Home and Community Based Services (HCBS) Medicaid Waiver programs



## Pilot Project

- Alameda County funded start-up costs for a PSH site that included a site-based care team of nurses and caregivers
- To be eligible for referral, clients must have nursing home level care needs, defined as
  - Functionally impaired; requiring a wheelchair or bedbound. Can also be debilitated by behavioral health challenges
  - Complex chronic illness
  - High utilizer of healthcare services; 2 or more inpatient admissions, or 8 or more ED visits in the last 12 months
- During the start-up period, clients were enrolled in a Medicaid waiver program that provides up to 24h/day of care
- Program allows individuals who have experienced homelessness to age in place, and provides care to residents in their home, through the end of their life

# Outcomes

- Program is sustainably funded by Medicaid program enrollment
- Results in a 79% reduction in use of hospitals, emergency rooms, and nursing homes
- Saves ~\$88k in healthcare costs per enrollee annually
- 99% housing retention among individuals who had cycled long-term through hospitals, nursing homes, incarceration, and unsheltered homelessness
- Residents have improved health outcomes and report improved quality of life
- ***Provides a safe and stable place in our community for people who otherwise have no options for living stably in the community***



# Current Status

## Wins

- Model has demonstrated success
- Increased from 40 units at pilot site 245 sites across two counties; serves more nursing home eligible residents than the county-funded nursing home system
- Embedded in the coordinated entry system, for integration with housing resources

## Challenges

- Medi-Cal program enrollment is capped at a state level; 3 year waiting list currently
- PACE programs have not yet been willing to engage in serving people who have experienced homelessness at scale

CARDEA  HEALTH

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## Challenge

**Workforce challenges**, including high rates of turnover, inadequate staff training, and various impacts of COVID, have made it more difficult for programs to serve tenants with high acuity concerns.

## Recommendation

This can be addressed through standardized **training and skill building**. Additionally, we must continue to advocate for increased funding, shared caseloads, and **right-sizing of caseloads** to reduce staff overwhelm.

Nashville, TN

# Park Center

Modifying staffing patterns and billing partnerships to meet the needs of tenants with high acuity needs



# When the Standard Model Isn't Enough:

Two Innovations for Serving High Acuity PSH Members

David Langgle-Martin, MSW, CPRP

Chief Housing Officer

Park Center, Nashville, TN

April 23, 2026



# Who We Are

- Founded in 1984, programs span psychosocial rehab, employment, SOAR, substance use treatment, and housing
- Largest PSH provider in Middle Tennessee
- ~200 residents across owned and partner-operated properties
- **Population:** members with mental health and substance use disorders, many with chronic homelessness histories
- **Context:** TN has no Medicaid authority covering housing-related services—no waiver, no state plan amendment





# Identifying the Challenge

**Our standard PSH staffing model was not built for this population.**

- Staff were absorbing:
  - Members in escalating crisis with no backup responder who knew them well
  - Caseloads of 20-25, insufficient relational depth for highest acuity members
  - Position turnover that created cold handoffs at the worst possible moments
- The result:
  - Burnout, turnover, and a staffing model working against itself
  - Members needing the most relational continuity were most likely to lose it

***We needed a structural response. Not just a training response.***



# Solution 1: Paired Provider Model

Each cluster of 40–45 members is served by a dedicated pair:

- **Case Manager:** clinical training, academic knowledge base
- **Certified Peer Recovery Specialist:** lived experience, therapeutic personal connection

## What this required:

- Elevating the CPRS as a full counterpart to the CM
- Equal responsibility for housing stability and recovery support
- Enhanced training to prepare CPRS staff for a primary (not supplemental) role

## What this creates in practice:

- Two complementary skillsets and ways of relating
- Two-person escalation capacity when a high acuity situation develops
- Relational redundancy that makes the program more effective and resilient

***No new funding required***



## Solution 2: MCO Partnership

### Context:

- Wellpoint authorizing services that didn't meet medical necessity; the alternative was worse
- We offer a housing portfolio with the scale and flexibility to meet complex needs
- We offer a service infrastructure to support members at this acuity level

### Mechanism:

- TN's managed care policy includes a cost-effective alternative/in lieu of services framework
- This policy exists in some form in most managed care states
- Established the basis for a pilot arrangement without a waiver or state plan amendment

### Result:

- A modified billing code for a cost-effective alternative to higher-level care
- A caseload ratio of 10 for enrolled members
- A per diem rate that supports high-intensity care

***“We didn't have any options. But now, having partners like you guys, we do have some other options for our members.” — Wellpoint***



# How It's Going

## **Paired Provider Model**

- Operational across Park Center's PSH portfolio
- Staff report meaningful change, no longer absorbing crises alone
- Member relationships demonstrably more resilient through staff transitions

## **MCO Partnership**

- Billing infrastructure functional and generating new revenue
- Early data promising: one member had 16 inpatient visits in the prior 12 months; hospitalizations have decreased significantly since enrollment
- Wellpoint featuring the partnership in their annual TennCare presentation, June 2026

**David Langgle-Martin, MSW, CPRP**  
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**[parkcenternashville.org](http://parkcenternashville.org)**

# Panel Discussion

Q & A

# Training Center

## **Comprehensive Series**

[Case Ready Certification: Core Skills for Case Managers](#)

[Trauma-Informed Approaches Professional Certification](#)

[Supervision in Action Series](#)

[Skillful Supervisors Training Series](#)

## **Effective Practices**

[Assertive Engagement & Motivational Interviewing](#)

[Working with Aging Tenants](#)

[Crisis Intervention & De-Escalation](#)

## **Behavior Focused**

[Complex Needs, Dual Diagnosis and Addressing Challenging Behaviors](#)

[Hoarding Unpacked](#)

[Mental Health Fundamentals](#)



**TRAINING CENTER**

*Training & Professional Development Solutions*

## To learn more:

- Remember to join us for Part Two of the webinar series on Thursday, May 7!
- View our 2-pager: [Responding to High Acuity Challenges in Supportive Housing](#)
- Contact us to discuss how we can assist your community with training, consulting, or technical assistance: [consulting@csh.org](mailto:consulting@csh.org)

# Sign up for updates



<https://insights.csh.org/center-sign-up>

# Thank You

- [Please complete our High Acuity Webinar Attendee Survey](#)

Ready to learn more?

Contact us to get connected



[www.housinghealthcenter.org](http://www.housinghealthcenter.org)



[contact@housinghealthcenter.org](mailto:contact@housinghealthcenter.org)

