NATIONAL CENTER FOR HOUSING + HEALTH
POWERED BY CSH

CSH

Responding to High Acuity Challenges in Supportive Housing

Part 2 of 2

May 7, 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**

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

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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

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Pacific Northwest

Seattle, WA

Presenters

Noah Fay
Senior Director of Housing Programs

DESC

Seattle, WA

Amy Berg
Deputy Executive Director of Social Services

St. Nicks Alliance

Brooklyn, NY

Maria Bell
Senior Director, Integrated Care & Housing Services

Pathways to Housing PA

Philadelphia, PA

Adam Fussaro
Clinical Director

Pathways to Housing PA

Philadelphia, PA

Sarah Gillespie
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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 a 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

Providers seem to 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.

Recommendation

Training and skill building for the workforce and adequate levels of funding for evidence-based levels of service can help to address these needs. Communities have also highlighted how embedding mobile **Crisis Intervention and Response teams** into local systems can assist in addressing these concerns. In the case of violence, individuals may need to be transferred to other settings, either temporarily or permanently.

Seattle, WA

DESC

Augmenting supportive housing staffing with crisis response teams and stabilization specialists to address behavioral health decline

DESC PSH Program Enhancements to Address Behavioral Health Crisis

Noah Fay

Senior Director of Housing Programs

Impacts on PSH tenants and programming

- Fentanyl and overdose crisis
- **Increases in behavioral health crisis**
- Deterioration in living conditions

Increase in Behavioral Health Crisis

The situation:

- Tenant supports declined during the pandemic:
  - Limits to visiting tenants in apartments
  - Pause on face to face group activities
  - Reduction in natural community supports (libraries, coffee shops, etc.)
  - Crisis system limitations
- Rise in personal deterioration and difficult behaviors in PSH community
- Housing case managers overtaxed

Increase in Behavioral Health Crisis

The response:

- Housing Stabilization Specialists and Housing Crisis Specialists
  - Additional services for tenants with needs that put housing at risk
  - No formal caseload, assigned for temporary support based on need
  - Design and implement Housing Retention Plan
    - Assigned flexibly to sites with emerging intervention needs

- Mobile Crisis Team
  - Result of advocacy to enhance community wide crisis response
  - Dedicated response to PSH
  - Multi-disciplinary crisis and follow up support

PSH Staffing Augmentations

Some results and future state:

- Less unit damage
- Reduced need to call 911
- More support for evening and weekend staff
- Evolution of the crisis system and need to ensure PSH tenants are prioritized

Brooklyn, NY

St. Nicks Alliance

Leveraging a multidisciplinary Mobile Wellness Outreach Team to support tenants with complex needs in scattered-site housing

St.Nicks Alliance

Where Opportunity Grows

Integrated Mobile Response Team Within Scatter Site Supportive Housing

Amy Berg LCSW
Deputy Executive Director of Social Service
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Table of Contents

Community Development Organization

St.Nicks Alliance
Where Opportunity Grows

- Youth & Education
- Affordable & Supportive Housing
- Workforce Development
- Elder Care

Scatter Site Supportive Housing (SSHP)

Provides essential support to **536 formerly homeless households** living in independent apartments throughout New York City.

- Populations served include individuals and families living with complex medical, behavioral health, substance use and social needs.
- **Four dedicated case management pods**, each led by a licensed clinician ensure integrated wellness focused services.
- **Provide services across four (4) domains: clinical, social services, residential and maintenance.** Address health access, economic empowerment, housing stability and a comfortable living environment.

SSHP Challenges

St.Nicks Alliance
Where Opportunity Grows

Population

95% **cope with chronic health issues**; many with co-occurring mental illness and substance use

14% **experience poor health outcomes** due to inconsistent engagement with primary care

58% with mental health diagnosis are **not engaged in behavioral health treatment**

30% **are over 60** with early functional decline & diminished ability to care for self and environment

Program

Standard caseload levels do not allow time for those with the **greatest need**

Staff experience **stress and burnout** due to poor case management outcomes

Housing is lost due to safety risks and inability to maintain apartments.

Medical and Functional Decline | WM

St.Nicks Alliance
Where Opportunity Grows

Barriers

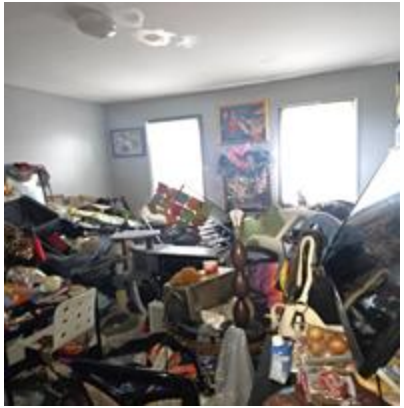
- Increasing medical fragility and declining health
- Difficulty engaging with case management services
- Severely unkept and unsafe living conditions
- Ongoing health deterioration requiring higher level of care

Attempted Interventions

- Assigned multiple case managers and peer specialists
- Leveraged maintenance supervisor relationship to build trust and increase cooperation
- Connected client to rehabilitation and are coordinating increased support at discharge

Hoarding/ Disorganization | ABW

St.Nicks Alliance
Where Opportunity Grows



Barriers

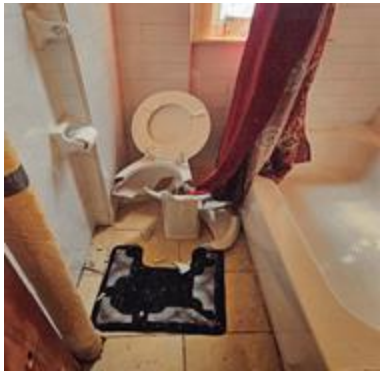
- Unsafe and severely compromised living conditions
- Refusal to engage in behavioral health services
- Unit condition results in landlord and neighbor complaints

Attempted Interventions

- Referred to organizational support resources
- Attempted coordination with landlord to address maintenance
- Moved to new unit, but no change in living situation

Mental Health & Substance Abuse | SS

St.Nicks Alliance
Where Opportunity Grows



Barriers

- Schizophrenia with high risk of relapse
- Non-adherence to prescribed psychiatric medications
- Crystal meth. use contributes to worsening of symptoms
- Severe psychotic episodes associated with unsafe and destructive behaviors (e.g., property damage, fire-setting)

Attempted Interventions

- Assertive outreach and repeated attempts to connect client to treatment
- Close collaboration with external systems including court-mandated interventions
- Crisis response and safety monitoring to link client to higher levels of care

Solution | Wellness Outreach Team

St.Nicks Alliance
Where Opportunity Grows

Open Referrals

All staff encouraged to complete simple referral form

Mobile Wellness

Bring intensive medical & social services directly into the home

Support Existing Case Management

Prioritize building trust and enhancing engagement to provide short term crisis management

Interdisciplinary Team

Staff team with the skills and knowledge to address complex needs

Facilitate Referrals

Warm transitions to community resources to ensure continuity of care

Wellness Outreach Team Pilot Design

St.Nicks Alliance
Where Opportunity Grows

Funding & Timeline

- Funded by CSH and Helmsley Foundation for **2 Year Pilot**
- **Track population served, methods and short- and long-term outcomes** to determine efficacy of model to implement more broadly

Team Actions

- **Brief assessment** to identify and prioritize 40 high acuity tenants
- Assigned to **Interdisciplinary Team** led by LMSW including LPN, Case Manager, CASAC, and Peer Specialist
- **Comprehensive in-home assessment** covers medical, psychiatric and function barriers
- **Collaborative support plan** guides ongoing intensive support services
- **Regular in-home visits** establishes trust and supports increased engagement particularly for those historically resistant to services
- **Clinical Coordination** through weekly case management meetings to ensure seamless communication.

Client Progress

- **Track Goals** Use quarterly functional assessments to document clinical improvement
- **Step Down Approach**: Transition stable tenants to ongoing community providers and traditional case management services

Proposed Outcomes | Wellness Outreach Team

St.Nicks Alliance
Where Opportunity Grows

- Housing Retention
- Increased Social Service Engagement
- Crisis Reduction
- Physical and Emotional Stability
- Improved Ability to Care for Self and Home Environment

Challenge

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

Recommendation

Enhanced substance use treatment services focused on **overdose prevention** and Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) have been useful for some providers. **Training and skill building** around Mental Health First Aid, psychosis, and other related topics is also strongly recommended.

Philadelphia, PA

Pathways to Housing PA

Providing ancillary support services to tenants managing Opioid Use Disorder in scattered-site housing

Pathways to Housing PA

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Chaotic Substance Use: Medications for OUD (MOUD)

Pathways to Housing PA

COE + MOUD Pilot | Housing First • Harm Reduction

www.PathwaystoHousingPA.org

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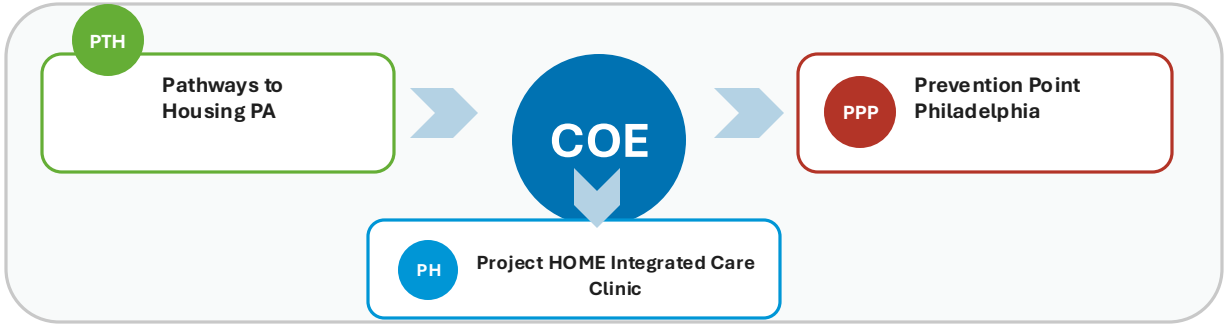
COE: Community-Based OUD Care

A Philadelphia Center of Excellence extends treatment and support into the places participants already are.



What the COE adds

+ Treatment Support

Enhances services already provided to people with substance use disorders.

↔ Low-Barrier Access

Care in traditional and non-traditional settings, including community-based engagement.

∞ Integrated Care

Connects OUD treatment with housing, primary care, behavioral health, and social needs.

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COE Mission, Goals & Funding

Mission

Advance health equality for people and communities affected by opioid use disorders.

Accessible, high-quality, person-centered clinical care in traditional and non-traditional settings — paired with community partnerships to develop, implement, and evaluate integrated programs for people who use drugs.

Program Goals

- Engage Pathways participants with OUD and define OUD clearly
- Maintain 90% retention for engagements
- Increase access and adherence to MOUD
- Maintain housing stability through harm reduction and treatment linkage
- Support complex care needs across systems

Funding & Eligibility

2018 COE opened; initially funded by the State of PA at a PMPM rate.

Now Oversight shifted to Philadelphia's BHMCO, Community Behavioral Health (CBH) in 2025; payment is through Medicaid.

Access Participants need Medicaid to receive services; the COE serves Medicaid-enrolled community members.

PMPM = per member per month payment model

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COE Team & Core Services

The COE gives Pathways a dedicated team focused on MAT/MOUD engagement, treatment linkage, and cross-system coordination.

Team Structure

PM

COE Program Manager

4 MAT Care Managers

Part-time Admin

Team focus: engagement, linkage, and follow-through.

+ Clinic Collaboration

Collaborate closely with the onsite Integrated Care Clinic and clinical teams.

AS ASAM + Treatment Linkage

Complete ASAMs and link participants to all levels of D&A treatment.

HV Home Visits + Outreach

Home visits, SDOH resource linkage, and outreach when participants cannot be found.

↔ Cross-System Coordination

Coordinate care with inpatient treatment, prison systems, and external MAT providers.

✓ COE staff attend rounds and keep clinical teams informed about participant-specific treatment goals and engagement efforts.

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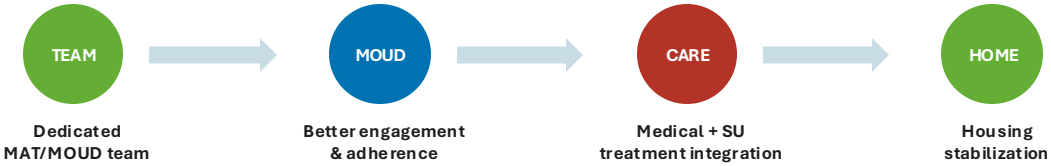
COE Benefits & MOUD Stability

A specialized COE team creates the engagement infrastructure that made a Sublocade pilot possible.



MAT engagement
Specialized focus encourages participants to engage with MAT services.

Withdrawal intelligence
Team tracks withdrawal experience and street-level D&A trends.

Primary care
Higher engagement in primary care and integrated medical support.

Housing success
Stabilizes participants so they can be successful in housing.

Fewer tenancy impacts
Less drug-use-associated apartment damage and fewer squatters in units.

Financial stability
Supports greater participant financial stability over time.

Special Project: COE implementation support for the Sublocade pilot

The COE's MAT/MOUD engagement model helped connect the pilot to housing stabilization goals.

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Emerging Challenge: Medetomidine

! **The drug supply changed during the study.**

MED

What medetomidine adds

A veterinary sedative increasingly detected in illicit opioid supplies. It can intensify sedation and contribute to severe cardiovascular, respiratory, and nervous system risks.

RX

Why this matters clinically

Sublocade supports OUD treatment, but it does not address the distinct withdrawal profile associated with medetomidine exposure.

Original goal: reduce hospitalizations → **Recalibrated priority: life-saving acute care when needed**

Participant concern is understandable: withdrawal can be severe, and hospital care may begin only once withdrawal is acute.

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Recalibrated Strategy: Keep what works, adapt what must change

The intervention still has value—but the care pathway must adapt to the drug supply.

1 Sustain MOUD access

Continue Sublocade and other MOUD options for OUD and fentanyl-related opioid use.

2 Practice harm reduction

Trust, incentives, and participant choice remain core engagement tools.

3 Build acute-care pathways

Coordinate with hospitals for severe medetomidine withdrawal and medical supervision.

4 Protect housing stability

Use clinical engagement to reduce tenancy crises, damage, and relocation burden.

Housing First + Harm Reduction + MOUD = a flexible platform for survival, stability, and recovery.

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Questions?

What questions do you have? We welcome follow-up conversation.

Contact Information

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Denver Housing to Health

Social Impact to Pay for Results Act (SIPPRA) Program

Enhancing supportive housing services model to
meet the needs of tenants with substance use challenges

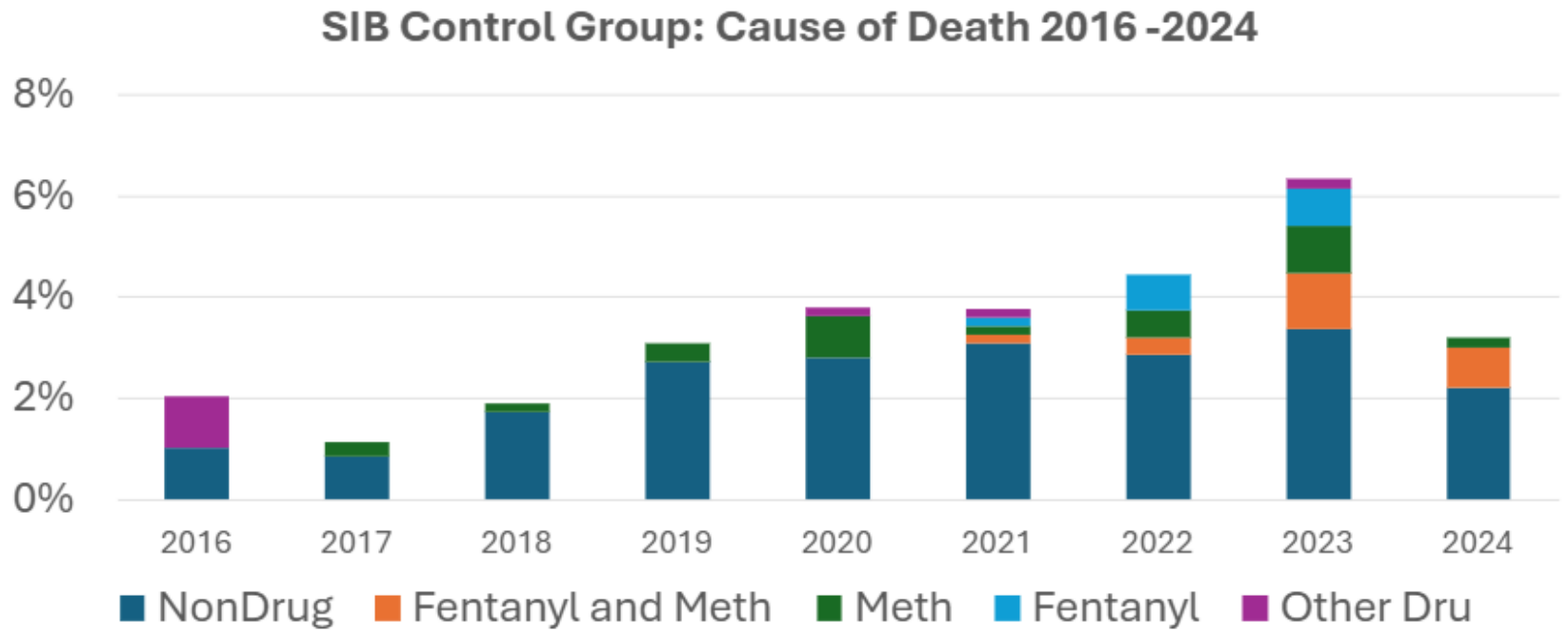
Participants have many unmet health care needs at baseline

	Share of population
Health needs	
Substance use disorder	94%
Mental health condition	80%
Any chronic physical condition[a]	86%
Current smoker	83%
Neurological disorder	70%
Brain injury	42%
Wounds	80%
Poisoning (including overdose)	39%

Participants are using the ED but other types of services are rare at baseline

	Share of population	Average utilization
Emergency department	95%	33.3 visits
Physical health	95%	26.9 visits
Behavioral health	67%	6.4 visits
Ambulance	88%	23.7 days
Inpatient visits[b]	64%	3.1 admits
Inpatient days		21.6 days
Primary care	64%	3.9 visits
Physical health specialist	69%	17.7 visits
Mental health outpatient	62%	14.1 visits
Substance use disorder outpatient	56%	37.1 visits
Other physical health outpatient care[c]	92%	21.8 visits
Behavioral health withdrawal	41%	2.8 admits
Withdrawal days	N/A	10 days
Behavioral health residential	6%	5.7 days
Prescriptions	79%	24.4 fills
Nursing facility	3%	1.9 admits
Home and community-based services	2%	2.2 days

For this target population, overall mortality increased over last 10 years driven by fatal overdoses



Exit analysis shows opportunities to intervene through overdose prevention, MAT, and crisis response

All SIPPRA Exits 2022-2024 (n=69)			
Exit Reason	**Share of all Exits**	**Mean time in Housing Before Exit**	**Notes**
Death	30%	312 days	
Non Drug	17%	376 days	blunt force, cardiovascular, other, chronic alcohol use
Drug	13%	204 days	combo, meth, fentanyl
MIA	26%	50 days	~Half within 30 days (22/23) ~Quarter within 60 days (22/24) ~Quarter 60-150 days (22/24)
Incarceration	25%	241 days	
Lease violation, safety, or voucher loss	15%	309 days	
RTP or skilled nursing	3%	90 days	Both died after exit, 1 from overdose
Other	1%	18 days	

Strategies to Meet Client Needs

To better meet the needs of program participants and save lives, the SIPPRA project partners implement and subsequently evaluate emerging best practices to better serve vulnerable individuals who are experiencing acute behavioral health or substance use crisis and whose housing is in jeopardy. To do so, partners will employ two primary strategies:

- Intensify drug overdose prevention and intervention.
- Enhance access to low barrier opioid and methamphetamine treatment.

Intensify Drug Overdose Prevention & Early Intervention

1. Expand Naloxone availability significantly.
    - Aim to double current supply
    - Order naloxone for all clients in the program, every client at move-in and for every staff to carry
    - Add naloxone boxes/dispensers to property hallways and lobbies
2. Increase psychiatric support to help with prescriptions as supply is used or new people move into the buildings.
3. Boost training and education activities for staff and clients.
    - Regular presentations at supportive housing sites
    - Broad promotion of “never use alone” hotline
    - Meet with each program participant on the risks of overdose during the transition into housing at the time of move in and at all client encounters.
    - Harm reduction supplies – safe use test kits, etc.
    - Staff training and education

Improved Access to Care: Enhance Access to Low-Barrier Opioid & Methamphetamine Treatment

1. Bolster participation in CCH & WellPower Medication Assisted Treatment (MAT) programs and emerging best practices like long-acting buprenorphine for methamphetamine use.
    - Increase psychiatric time to ensure prescriptions are written for those who need them in a timely manner.
    - Increase Nurse Practitioner time to support Medication Management, coordination of MAT services and in-home outreach.
2. Add Medical Coordinator position to support the coordination of MAT services; assist with hospitalization discharge and follow-up; coordinate in home care as needed; schedule psych and nursing appts; and support triage for immediate crisis.
3. Coordinate with Denver Health outpatient SUD services and for ED/hospital admittance & discharge.
4. Implement Contingency Management Program
    - Incentives for treatment incentives and drug abstinence

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

CSH TRAINING CENTER
Training & Professional Development Solutions

To learn more:

- 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

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

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