SERVICE PATHWAYS: THE SYSTEM CHANGE NYC NEEDS NOW

A Roadmap for Breaking Crisis Cycles and Building Stability for High-Acuity New Yorkers

Presented by the Collaborative on Housing for Health

November 2025

www.housingforhealthnyc.org

EXECUTIVE SUMMARY

THE OPPORTUNITY

A small number of New Yorkers experiencing homelessness – about 1% of single adults over a two-year period – are caught in a costly and destructive cycle between hospitals, jails, shelters, and the streets. When behavioral health conditions are poorly managed and housing remains unstable, these individuals experience repeated crises that strain emergency departments, correctional facilities, and shelter systems. They face devastating health outcomes, create safety challenges for frontline staff and peers, and generate enormous public costs through emergency interventions that fail to produce stability.

Yet New York City has the resources, expertise, and capacity to break these cycles. The solution does not require entirely new programs or substantial new funding streams. It requires **coordination and realignment**: connecting existing housing and health services into functional pathways that meet people where they are, and realigning resources to support these pathways.

This is the moment for that coordination. Fiscal constraints are focusing attention on cost-effectiveness. Field momentum is building but remains fragmented. A new mayoral administration is defining priorities. These conditions rarely align. The opportunity is to transform how existing resources work together – maximizing return on public investment while improving outcomes for New Yorkers with the most complex needs.

A service pathway framework offers incoming public leaders a clear win: reduced spending on costly crisis interventions, improved capacity for service providers, visible progress on community safety concerns, and a replicable model that can extend to other populations – all built on resources that already exist.

WHAT ARE SERVICE PATHWAYS?

A service pathway is a contracted continuum of existing housing, care coordination, and clinical services, led by qualified and accountable providers, that addresses the needs of high-acuity New Yorkers as they move from common discovery points to stabilization in permanent housing.

Service pathways solve three critical system gaps:

THE GAP	THE PATHWAY SOLUTION	THE RESULT
No one sees the full picture Frontline staff lack data and tools to identify individuals cycling through public systems	**Shared definitions + practical tools** Data-driven "flags" visible to providers across hospitals, shelters, jails	High-acuity individuals are identified early and connected to specialized pathways
No one owns the outcome Providers are not accountable for client outcomes; coordination ends at organizational boundaries	**One accountable provider** One specialized provider delivers coordinated care from discovery through permanent housing	Seamless support across transitions; specialized services; clients do not fall through cracks
No one can fix the bottlenecks Programs span multiple agencies; leaders lack data to prioritize investments	**Clear pathway structure + performance data** Quantify where capacity falls short; align investments to outcomes	Evidence-based resource allocation; maximum impact from existing funding

OUR COLLABORATIVE COMMITMENT

The Collaborative on Housing for Health brings philanthropic resources, analytical capacity, provider partnerships, and a neutral platform for coordination. Over the next 2-3 years, we will advance the service pathway framework through three complementary initiatives:

1. **Pilot service pathways with qualified providers:** Working with leading housing and health providers, we will pilot the service pathway model for high-acuity clients.
2. **Develop identification tools for frontline staff:** Working with City and State agencies, we will create practical tools that enable frontline staff to identify high-acuity individuals using shared, data-based criteria.
3. **Build system capacity insights for policymakers:** Working with experts, we will develop analytics that quantify access bottlenecks to enable evidence-based decisions about resource allocation and system expansion.

WHAT IS NEEDED FROM PARTNERS

GOVERNMENT	PROVIDERS	PHILANTHROPY
Partner with the Collaborative to pilot and refine pathways in partnership with public agencies	**Partner in piloting** pathway models	**Fund pathway pilots** that test innovations before government can scale them
Commit to regulatory adjustments that enable pathways to function	**Embrace coordinated care delivery** across organizational boundaries	**Fund data sharing infrastructure** and analytical capacity to quantify bottlenecks
Allocate resources strategically based on evidence	**Take accountability** for client outcomes	**Convene and facilitate** – bringing stakeholders together
Enable data sharing for identification tools and pathway performance metrics	**Invest in specialized capacity** to develop staff expertise for serving individuals in acute crisis	**Document and disseminate** learnings that advance the field

WHAT SUCCESS LOOKS LIKE

Service pathways deliver measurable outcomes across three dimensions:

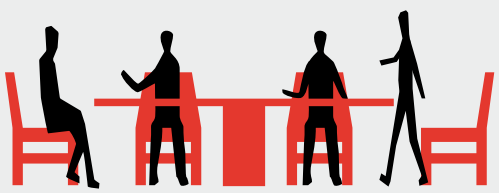
For clients: Improved crisis care resulting in reduced emergency department visits, fewer shelter incidents, decreased incarceration, sustained housing stability, improved health

For systems: Lower crisis intervention costs, improved provider capacity, reduced staff burnout, better coordination across agencies, increased efficiency of existing investments

For communities: Visible progress on community safety concerns, demonstration of effective approaches, replicable model for other populations

> TOGETHER, WE CAN TRANSFORM HOW NEW YORK SERVES ITS HIGHEST-ACUITY RESIDENTS—CREATING PATHWAYS FROM CRISIS TO STABILITY THAT WORK FOR CLIENTS, SYSTEMS, AND COMMUNITIES.
>
> **Supportive housing CEO**

CONTENTS



INTRODUCTION: SMALL POPULATION, LARGE OPPORTUNITY

THE FACE OF HOMELESSNESS HAS CHANGED

Over recent decades, the behavioral health profile of some single adults experiencing homelessness has grown more complex. Multiple morbidities are now common: bi- and tri-morbidity – co-occurring physical, mental health, and substance use conditions – occur in nearly half of adults experiencing homelessness.[1] Rates of serious mental illness, personality disorders, and substance use disorders have increased substantially. One study in Minnesota found that psychiatric illness (especially depression, schizophrenia, and personality disorders) and substance use disorders are now the dominant drivers of acute care utilization for homeless adults, and multi-morbidity has surpassed morbidity within a single domain.[2]

When individuals lack access to care to manage these complex behavioral health conditions and housing remains unstable, individuals enter vicious cycles of acute crisis, bouncing between hospitals, jails, shelters, and the streets. **We call this problem "high-acuity homelessness" – New Yorkers caught in repeated cycles of behavioral health crisis across multiple public systems.**

Crucially, this population is not homogeneous. While many experience psychotic illnesses like schizophrenia that today's supportive housing models were designed to address, new population segments have emerged. One notable new segment presents with conditions stemming from severe childhood trauma – including personality disorders, mood disorders, and co-occurring substance use – that require vastly different clinical approaches. These conditions are less responsive to medication alone and can severely affect an individual's ability to maintain stable interpersonal relationships, creating challenges for traditional team-based care models.

1 Chilman N, Schofield P, Laporte D, Ronaldson A, Das-Munshi J. The prevalence of multimorbidity with mental and physical health for people who experience homelessness: a systematic review. Eur J Public Health. 2025 Aug 28:ckaf144. doi:10.1093/eurpub/ckaf144. PMID: 40875566

2 Vickery KD, et al. Trends in Trimorbidity Among Adults Experiencing Homelessness in Minnesota, 2000-2018. Med Care. 2021;59(4):316-324. doi:10.1097/MLR.0000000000001435

Figure 1
The high-acuity population is not homogeneous; segments bring distinct service needs

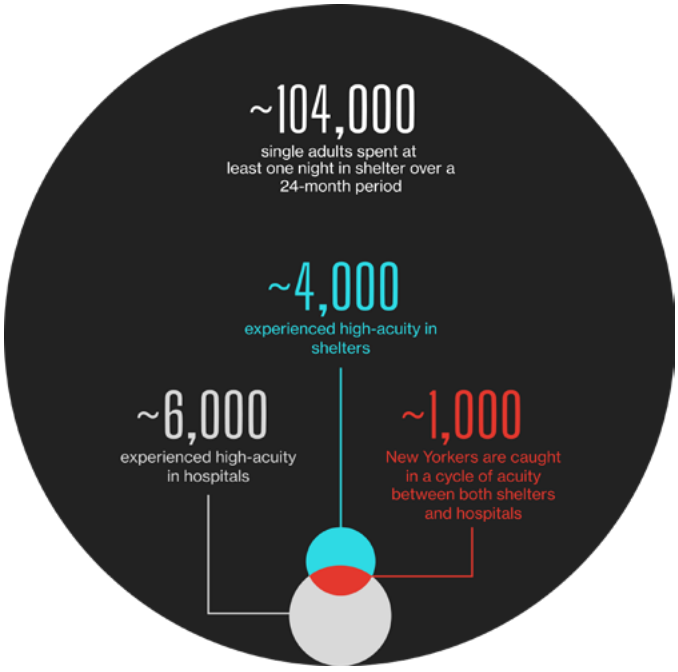
	PSYCHOSIS SYMPTOMS	CONDUCT AND PERSONALITY SYMPTOMS
	Some high-acuity individuals have underlying psychotic disorders like schizophrenia or schizoaffective disorders that result in psychotic episodes, frequent mental health emergencies, and high rates of hospitalization	Some high-acuity individuals have trauma-induced personality and conduct disorders like borderline personality disorder that can result in emotional instability, aggressive behavior, and high rates of hospitalization and incarceration
COMMON CHALLENGES	• **Hallucinations, delusions**, and other symptoms of psychotic episodes • **Limited illness insight and paranoia**, which can contribute to service declination • **Mania and/or depression** (e.g., schizoaffective disorders) • **Co-occurring substance use** disorders	• **Intense mood swings**, often including anger • **Frequent incidents of violence**, aggression, self-harm, and/or suicidal behavior • **Difficulty maintaining stable interpersonal relationships**, including care teams and cohabitants • **Co-occurring substance use** disorders
FIRST-LINE TREATMENT	• **Psychiatric medication**, with supplementary psychotherapy (e.g., cognitive behavioral therapy) to help manage symptoms	• **Specialized psychotherapy** (e.g., dialectical behavioral therapy), with supplementary psychiatric medication to help manage symptoms

HIGH-ACUITY INDIVIDUALS ARE A SMALL SLICE OF NYC'S HOMELESS POPULATION

To understand the scale and characteristics of this population in New York City, the Department of Social Services (DSS) Office of Research and Policy Innovation conducted a groundbreaking administrative analysis. They developed multiple indicators of shelter acuity using data over a recent two-year period – including frequency of shelter incidents and exits from shelter. They also matched single adults who had spent at least one night in shelter with State Medicaid records, identifying individuals who had experienced at least four behavioral health emergency department visits or three inpatient psychiatric stays over a 13-month period – existing indicators of high health acuity.[1]

1 The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the New York State Department of Health or New York State Office of Mental Health. Examples of analysis performed within this article are only examples. They should not be utilized in real-world analytic products.

Figure 2
~1% of New Yorkers experiencing homelessness are caught in a cycle of acuity



Their analysis revealed that approximately 9,000 individuals – roughly 8% of single adults in shelter – met one or more of these acuity thresholds. Most importantly, **about 1,000 individuals, approximately 1% of the single adult population in that two-year period, were caught in cycles of acute crisis in both shelters and hospitals**.

This analysis is a snapshot, and the total population experiencing high-acuity cycles will shift over time as individuals stabilize or enter crisis. But the finding is crucial: a very small segment of NYC's homeless population experience acute crises across systems and account for disproportionate strain on multiple systems. Serving this small segment of New Yorkers will not put an end to street homelessness, but it can reduce crisis cycles and drive multiple benefits.

ENDING CRISIS CYCLES BENEFITS US ALL

This high-acuity population is critical to serve. Interviews with housing and health experts consistently encouraged the Collaborative to focus here, because when people lack true connection to behavioral health services and housing, it leads to unaddressed crises and the consequences ripple across systems:

For individuals in crisis: Devastating health outcomes, repeated traumatic experiences, barriers to stability, loss of dignity and hope

For systems: Higher service costs, unnecessary emergency interventions, provider staff burnout, reduced capacity to serve others effectively

For communities: Safety concerns in shelters and public spaces, strain on emergency services, visible suffering that erodes public trust

Serving people caught in crisis cycles more effectively improves outcomes across all these dimensions. It is a humanitarian imperative and a fiscal necessity. And it is achievable with resources that already exist – if we can coordinate and allocate them better.

> **"It was so frustrating and exhausting to go from the hospital to the streets or from the hospital to a traumatic shelter because I would always end up right back in the hospital...I was always feeling so nervous because I knew my life was at stake, whether I was going to kill myself or someone else was going to kill me."**
>
> **Lived expert focus group participant**

THE PROBLEM: THREE SYSTEM GAPS

NYC has extraordinary assets to meet the needs of individuals experiencing crisis cycles: a remarkable legacy of innovation, a right-to-shelter framework, approximately 42,000 supportive housing units[1], a dense network of talented service providers, and billions of dollars in public support. Effective housing and health services exist, and excellent providers are delivering them.

But the system was not designed for this. Decades ago, when the NYC supportive housing ecosystem was established, it was not built to address the complex, co-occurring behavioral health challenges that characterize today's highest-acuity population. The changing face of homelessness – combined with the housing crisis, dramatic growth in shelter populations, and the introduction of dozens of new programs across City and State agencies – makes coordination uniquely challenging.

> "IF WE WERE TO DESIGN THIS SYSTEM FROM SCRATCH TODAY, WE WOULD NOT DESIGN IT THE WAY WE DID 25 YEARS AGO."
>
> **Supportive housing CEO**

1 2025 State of Supportive Housing Report, accessed at: https://shnny.org/images/uploads/State_of_Supportive_Housing_5.19.25_FINAL_.pdf

Through extensive research and stakeholder engagement, the Collaborative has isolated three system gaps that prevent us from functioning effectively for high-acuity New Yorkers:

GAP #1: FRONTLINE PROVIDERS LACK RELIABLE MEANS TO IDENTIFY HIGH-ACUITY INDIVIDUALS

Two factors make it difficult for frontline providers to identify individuals caught in a cycle of acuity.

No shared definitions

Research by the Collaborative and others found no shared approach to defining high-acuity – in NYC or anywhere else. This stems from inherent complexity: many individuals with behavioral health conditions can access services to manage their needs successfully. High-acuity emerges when engagement barriers emerge and behavioral health conditions are poorly managed, which is compounded by housing instability and other factors. Thus, identification requires looking at patterns of interaction with crisis systems and mental health diagnoses over time.

Further complicating matters, diagnoses themselves can be misleading. Individuals experiencing chronic homelessness often have limited contact with healthcare professionals who can observe them over time. Evidence shows that trauma-related conditions like borderline personality disorder are frequently underdiagnosed, while co-occurring substance use and acute crisis presentations can lead to misdiagnosis.

No reliable tools for frontline staff

Even if shared definitions existed, frontline staff lack tools to apply them. Staff in hospitals, jails, shelters, street outreach teams, and law enforcement frequently encounter individuals cycling through crisis, yet they rarely have access to the information or expertise needed to recognize these patterns and effectively refer clients to the right services.

Relevant data – clinical history, emergency department visits, diagnoses, arrests, shelter incidents – are siloed within discrete public agencies. Even if accessible, tools to interpret this data and determine whether someone meets high-acuity criteria do not exist.

The result is missed opportunities to identify and engage individuals at moments that could prevent the next crisis.

GAP #2: FRAGMENTED SERVICE SYSTEMS LIMIT PROVIDER COORDINATION AND ACCOUNTABILITY

NYC has world-class housing and health providers and dozens of effective, publicly funded programs. Yet the current governance model for necessary services is designed around individual programs, not client outcomes. For many people, this works well. For those cycling through crisis, it creates significant gaps.

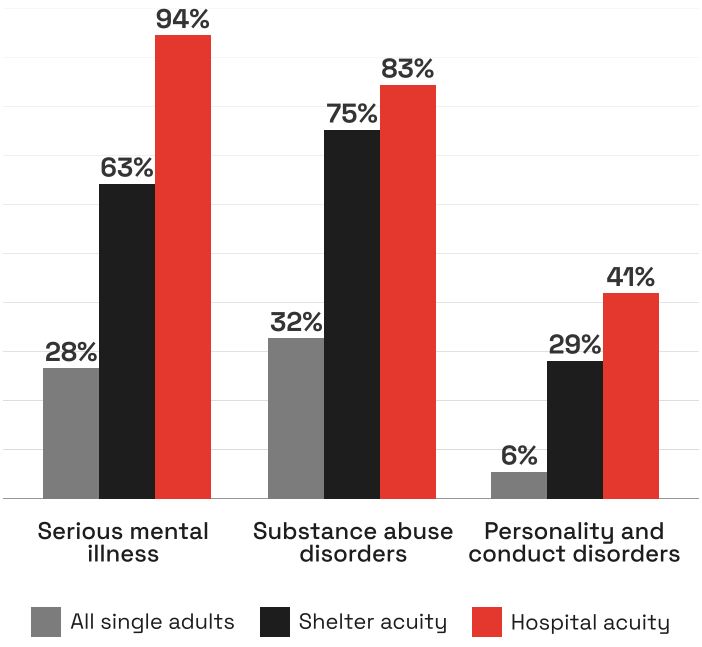
> **"THROUGH OUR DOZENS OF CONVERSATIONS WITH STAKEHOLDERS, WE FOUND NO SINGLE DEFINITION OF 'HIGH ACUITY.'"**
>
> **Corporation for Supportive Housing**

Programs and placements limit provider specialization

Serving individuals in acute behavioral health crisis requires specialized expertise. In Figure 3 below, we use a simplified shelter high-acuity flag (identifying approximately 2,000 individuals over 2 years) and a simplified health high-acuity flag (identifying approximately 5,000 individuals over 2 years). The DSS analysis illustrates that compared to the average homeless single adult, these high-acuity populations are more than 2x as likely to experience any major behavioral health disorder, 2-3x as likely to be diagnosed with serious mental illness, 2-2.5x as likely to have a non-tobacco substance use disorder diagnosis, and roughly 5-7x as likely to have a diagnosed personality or conduct disorder. Multiple morbidities, though not measured in this analysis, are almost certainly common.

> "Rather than seen as vulnerable, we are seen as a threat (by doctors and hospital staff)."
>
> **Lived expert**

Figure 3
High-acuity individuals need specialized care for complex behavioral health issues



Not all programs are suited to these needs, and not all providers have relevant expertise to serve these specialized needs. The Collaborative's landscape review identified 100+ active housing and health programs; after screening for aligned eligibility, specialized staffing, and adequate reimbursement rates, only about 40 programs appeared highly relevant for high-acuity populations.

Moreover, even within single programs, substantial variation exists across providers in program design, staff capabilities, and experience with individuals in acute crisis. This diversity could be a strength if the system matched clients to programs and providers based on specialized fit. Unfortunately, matching mechanisms like the Coordinated Assessment and Placement System (CAPS) or Single Point of Access (SPOA) prioritize program availability and eligibility over specialized expertise. Centralized information about which providers have the experience, capabilities, and commitment to serve high-acuity clients effectively does not exist.

When individuals cycling through crisis are not connected with providers equipped to support them, the mismatch creates breakdowns.

Service governance focuses on delivery, not outcomes

Most housing and health services operate on fee-for-service government contracts: public agencies specify program requirements and pay nonprofit service providers for successful delivery. Efforts to align delivery with outcomes happen through program evaluations. This approach works in many contexts but creates coordination gaps for people cycling through crisis.

Since accountability is to program delivery, most programs do not allow providers to adapt service intensity as clients' acuity increases or decreases – which is highly relevant for populations that by definition experience fluctuating crises. One notable exception: City-funded Intensive Mobile Treatment (IMT) teams, which offer significant flexibility.

> **"IF YOU DON'T HAVE EXPERIENCE [WITH BORDERLINE CLIENTS]...IT'S VERY DIFFICULT TO GET YOUR MIND AROUND HOW QUICKLY THINGS CHANGE WITH THEM....[TREATMENT] IS VERY SPECIALIZED AND USUALLY NOT OFFERED OR OFFERED ON A VERY LIMITED BASIS IN INPATIENT UNITS."**
>
> **Hospital psychiatrist**

Additionally, program requirements rarely include coordination with other services or providers. For individuals cycling through multiple systems, this creates dangerous gaps at transition points: hospital discharge, jail release, moves between shelter and housing placements.

An analysis by the Jewish Board illustrates the care integration imperative: among over 1,700 high-Medicaid-utilization clients (less complex on average than the Collaborative's high-acuity focal population), 52% received multiple health services, and 75% of those receiving multiple services got them from more than one agency. Notably, utilization of acute healthcare services was significantly higher for individuals served by multiple agencies – the more agencies involved, the more acute health crises they experienced.

Qualified providers face disincentives to serve this population

Even highly qualified, mission-driven providers experience active disincentives to working with individuals in acute crisis. These clients can be challenging to serve, contribute to staff burnout, and introduce safety risks for staff, peers, and communities. Given that the other 99% of the population experiencing homelessness also needs services, most providers – facing these systemic gaps – would not choose to specialize in high-acuity care. This makes it especially important for public agencies to realign incentives.

GAP #3: POLICYMAKERS' ABILITY TO ADDRESS ACCESS BOTTLENECKS IS LIMITED

Bottlenecks limit access to effective services

Even when services exist, individuals cycling through crisis cannot always access them quickly enough – or at all. Bottlenecks come in multiple forms: supply gaps that cause long waitlists for necessary services (e.g., IMT teams, psychiatric beds, permanent supportive housing beds), barriers to system flow (e.g., lack of step-down programs to free up high-acuity programs), and care gaps that prolong client acuity (e.g., lack of effective models to treat personality disorders). These bottlenecks limit access into needed services and keep individuals stuck in crisis instead of moving toward stability.

Fragmented governance hinders coordinated action

High-acuity services involve a complex web of government agencies at City and State levels, each with distinct mandates, funding streams, and regulatory frameworks.

At the City level, for example: Department of Homeless Services (DHS) manages shelters and street outreach. Department of Social Services (DSS) manages access to supportive housing and health services for persons experiencing homelessness. Department of Health and Mental Hygiene (DOHMH) funds supportive housing services and IMT teams, and manages other substance use and harm reduction programs. NYC Health + Hospitals operates hospitals, clinics, outreach and street medicine teams, mobile crisis teams, and correctional health services. The Mayor's Office of Criminal Justice (MOCJ) coordinates reentry. Each has separate intake processes, eligibility criteria, data systems, and provider relationships.

At the State level, for example: Office of Mental Health (OMH) governs mental health services, oversees shelter-partnered Assertive Community Treatment (ACT) teams, and funds numerous programs and outpatient services. Office of Addiction Services and Supports (OASAS) governs substance use treatment and funds programs locally. These agencies operate largely independently with separate regulations, training systems, and provider networks – despite most high-acuity clients having co-occurring needs.

This fragmentation creates tangible barriers. A single client moving from jail to hospital to shelter to supportive housing may interact with four or five different City agencies and multiple State systems, each operating with incomplete information. These boundaries fracture care continuity, force repeated storytelling, create gaps in responsibility and make warm handoffs difficult – both for clients and for policymakers seeking to align policies across systems. Most importantly, it diffuses the responsibility to address supply bottlenecks in a coordinated way (e.g., scale up effective programs, disinvest in ineffective ones, and create functional step-down pipelines that free up waitlists for key programs).

No reliable methodology exists to quantify bottlenecks

Targeted funding increases and regulatory changes could unlock systemwide improvements – including significant cost savings. Yet the scale and complexity of the NYC housing and health ecosystem make it virtually impossible to estimate the scale of unmet need or the downstream impacts of potential changes on other parts of the system. This limits policymakers' ability to make informed resource allocation decisions for billions of dollars in housing and health services funding. Without tools to quantify bottlenecks and model system flow, investments tend to increase faster than people served – a common pattern in complex systems lacking performance visibility.

> **"Cycling from jail to [supportive housing] and then to a shelter was the most difficult and hardest transition I've ever experienced. With lack of support from the system, I had to find my own way without crossing paths with the judicial system."**
>
> **Lived expert**

THE SOLUTION: SERVICE PATHWAYS

To address these systemic gaps, the Collaborative recommends a new model for contracting and delivering existing services: **"service pathways."**

Service pathways can solve the three system gaps:

They address identification gaps by giving frontline staff at discovery points the ability to identify and refer eligible individuals using shared, data-based criteria.

They address coordination and accountability gaps by ensuring qualified providers have the accountability, flexibility, and incentives to support clients from discovery through stabilization.

They address access bottlenecks by providing City and State policymakers with tools to address regulatory barriers and quantify supply gaps.

A SERVICE PATHWAY IS A CONTRACTED CONTINUUM OF EXISTING HOUSING, CARE COORDINATION, AND CLINICAL SERVICES, LED BY ONE ACCOUNTABLE PROVIDER, THAT ADDRESSES THE UNIQUE NEEDS OF HIGH-ACUITY NEW YORKERS AS THEY MOVE FROM COMMON DISCOVERY POINTS TO STABILIZATION IN PERMANENT HOUSING.

SERVICE PATHWAYS MEET INDIVIDUALS WHERE THEY ARE

They align pathway eligibility with shared definitions of acuity

Service pathways will enable housing and health stakeholders to establish shared definitions of high-acuity for determining pathway eligibility. These definitions should include longitudinal indicators of behavioral health crisis – frequent shelter incidents, repeated behavioral health emergency visits, patterns of incarceration related to untreated mental illness or substance use.

Initially, we propose modeling definitions on the shelter and healthcare thresholds developed by DSS in their groundbreaking administrative analysis. These definitions can expand over time, incorporating additional indicators (e.g., interactions with street outreach or law enforcement) and linking to pathway design criteria (e.g., presence of borderline personality disorder diagnosis might qualify someone for pathways providing specific forms of care).

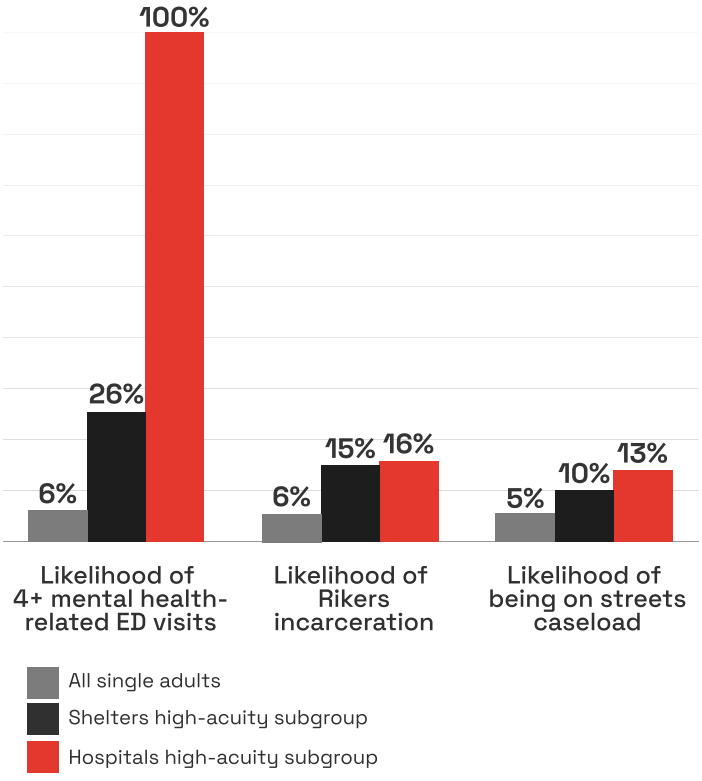
They enable practical tools for frontline identification and referral

By incorporating system interactions into pathway eligibility, pathways can be linked to specific types of discovery points. DSS's analysis shows that individuals in acute crisis interact much more frequently with frontline staff in shelters, hospitals, jails, and street outreach than the average homeless single adult.

This provides valuable information about which discovery points should be equipped with identification tools. These tools can build on existing data-sharing resources (e.g., PSYCKES) to surface high-acuity "flags" for individuals meeting shared definitions – providing necessary visibility for frontline staff without requiring historical analysis or unrealistic data sharing. Continuing with the simplified high-acuity groups shown in Figure 3 above, Figure 4 highlights the common basis for these discovery points across systems of health care, jail, and street outreach.

> **"RIGHT NOW, WE'RE PRESENTING [HOSPITAL STAFF WITH] WHATEVER INFORMATION OUTREACH TEAMS OR DHS STAFF HAPPEN TO HAVE. A TOOL LIKE THIS COULD BE A GAME CHANGER."**
>
> **DHS Administrator**

Figure 4
High-acuity groups interact often with frontline staff at common discovery points



PATHWAY CONTRACTS SUPPORT SPECIALIZATION, COORDINATION, AND ACCOUNTABILITY

Service pathways will address coordination gaps by ensuring qualified providers have accountability, flexibility, and incentives to support clients from discovery through stabilization. They accomplish this by evolving existing intensive case management (IMT, ACT) in three ways:

They assign clear accountability to qualified providers

Service pathway contracts could designate a "Pathway Lead" — nonprofit service providers primarily accountable for delivering the care required to engage, support, and stabilize high-acuity clients from referral through permanent housing.

One way to achieve this is by modifying existing programs with embedded care and coordination resources (e.g., IMT or ACT team). Further, since only 12 organizations in NYC currently operate either of these programs and permanent supportive housing programs (and only 8 also operate transitional housing), Pathway Leads would need to partner with transitional and supportive housing providers to deliver care in these settings.

This approach could enable the agencies contracting with Pathway Leads (e.g., City DOHMH, State OMH) to prioritize organizations with demonstrated experience and capabilities, while allowing specialized providers to opt in to serving the high-acuity population.

They give providers control and flexibility to specialize

In exchange for accountability, service pathways could allow Pathway Leads more control over pathway design and delivery. Public contracting agencies could stipulate requirements based on population needs (e.g., ensuring access to specialized healthcare and permanent supportive housing), while enabling Pathway Leads to retain control over care models and partner selection.

By defining pathways from discovery points through supportive housing, Pathway Leads would have natural incentives to establish partnerships with providers of key services along the continuum (e.g., transitional and permanent housing) to facilitate data sharing, care coordination, and shared metrics.

They incentivize successful delivery of client outcomes

The current fee-for-service model significantly limits incentives for coordination and innovation. To accelerate the cycle of accountability and control, we recommend adding modest financial incentives to pathway contracts for achieving pre-defined client outcomes.

Adding modest pay-for-success incentives is reasonable given the complexity of high-acuity needs and the level of coordination and care required. If triggers are tied to cost-saving outcomes (e.g., stabilization in supportive housing, reductions in acute care utilization), added expenses should be more than recovered in public savings.

SERVICE PATHWAYS HELP POLICYMAKERS ADDRESS BOTTLENECKS

They align core elements to City or State programs

The Collaborative recommends establishing multiple pathways, with contracts anchored by either City-funded or State-funded programs. Concretely: one pathway type leveraging City programs (IMT and NYC 15/15 supportive housing, controlled by NYC DOHMH), and another leveraging State programs (ACT and OMH-licensed housing, controlled by NYS OMH).

This ensures policymaker effort aligns with programs within their control. For example, to establish a City-anchored pathway, NYC DOHMH might evolve IMT program requirements to designate Pathway Leads, set aside IMT slots for eligible participants, and facilitate supportive housing placements into NYC 15/15 units. The policy director of the Supportive Housing

Network of New York highlighted at a recent testimony: "Supportive housing currently has 46 different eligibility criteria across 19 different programs overseen by eight government agencies. It is already too hard to access. Instead of pretzeling ourselves into all these different eligibility criteria, we need to be flattening eligibility and making it easier."

The Collaborative's landscape analysis suggests that there is already relatively high provider specialization in one funding source or the other, reinforcing this approach and ensuring candidate Pathway Leads exist for both options.

They help policymakers quantify and address bottlenecks

Given the scale and complexity of NYC's housing and health ecosystem, it is virtually impossible to estimate how capacity shifts in one area impact unmet need elsewhere. This limits policymakers' ability to make informed resource allocation decisions for billions of dollars in services funding, including to address care gaps, supply gaps, and other access bottlenecks.

Service pathways improve these decisions by providing a framework to model "stocks and flows" of individuals and services over time. By defining pathways and gathering performance data, we can model eligible population size (including inflow), service utilization along pathways, bottlenecks preventing progress, and estimated impact of expanding capacity at constraint points.

We need to view our housing and health system as a river, not a pool. When we quantify need, we give system leaders the insights they need to address bottlenecks in a more targeted and coordinated way: to scale up effective programs, disinvest in ineffective ones, and create functional step-down pipelines that free up waitlists and expand the impact of services we know already work well. Service pathways are the key to unlock this approach.

THE ROADMAP: NOW IS THE TIME

THIS IS THE MOMENT FOR TRANSFORMATION

Three powerful forces are converging to create an unprecedented window for systemic change in how New York City addresses high-acuity homelessness.

Fiscal constraints are focusing attention on cost-effectiveness. Federal funding cuts to prevention programs will increase demand on an already strained system, while core services for individuals in crisis remain relatively protected. This environment creates urgency to demonstrate that investments in effective pathways can reduce costly crisis interventions – ED visits, incarceration, prolonged shelter stays – that burden budgets and fail to produce stability.

Field momentum is building but lacks a unifying vision. Multiple initiatives address discrete gaps: hospital discharge planning, supportive housing innovation, crisis response enhancement, care coordination pilots. The previous mayoral administration made targeted investments in IMT expansion and congregate supportive housing. Providers and philanthropic funders are collaborating on promising models. Yet these efforts remain fragmented, definitions of "high-acuity" vary widely, and pathways still end at organizational boundaries. The field is ready for a comprehensive framework to connect these efforts.

Political attention to behavioral health and public safety is intensifying. With a new mayoral administration taking office in January 2026, there is both opportunity and urgency to make recommendations that inform the policy agenda. Voter concerns about community safety and the mental health crisis intersect directly with the needs of individuals experiencing repeated crises, yet political discourse often lacks nuance and comprehensive solutions. The transition offers a critical window to establish evidence-based approaches that address public concerns while centering client dignity and health outcomes.

These conditions – fiscal necessity, field momentum, and political will – rarely align. Organizations that provide clear, actionable solutions grounded in fiscal reality and human dignity will shape New York City's approach to high-acuity homelessness for the next decade. The service pathway framework offers exactly this: a practical roadmap leveraging existing resources, coordinating scattered efforts, and demonstrating measurable impact.

The window is open, but it will not remain so for long. Early 2026 will see the new administration's defining initiatives take shape. **This is the moment.**

THE COLLABORATIVE WILL PILOT AND REFINE THE SERVICE PATHWAY MODEL

The Collaborative on Housing for Health is uniquely positioned to advance this transformation. As a neutral, multi-stakeholder effort bringing together public agencies, leading nonprofit service providers, and philanthropy, we convene the range of actors necessary to make service pathways work. Our rigorous analysis and stakeholder engagement – evidenced by this roadmap – demonstrate capacity to translate complex system challenges into actionable solutions. Our access to philanthropic support and 2–3-year time horizon give us the flexibility to pilot, learn, and adapt.

Over the next 2-3 years, the Collaborative will advance the pathway framework through three complementary initiatives:

We will organize and fund service pathway pilots with qualified providers

Working directly with leading providers, we will pilot and refine pathway models for individuals facing acute crises in shelters and on the streets.

Working closely with DSS, DOHMH, and OMH, we will test how to operationalize the framework outlined in this roadmap: ensuring warm handoffs between systems, maintaining care continuity during transitions, housing people first, and providing transitional housing where necessary, and matching clients to permanent housing with the right service intensity. Rather than asking clients to navigate fragmented systems alone, these pathways will actively guide them through each step.

Crucially, we will document both what works and what gets in the way. Pilots will surface regulatory barriers that prevent smooth transitions, identify funding constraints that create service gaps, and reveal coordination challenges that fragment care. We will track client outcomes – housing retention, service engagement, reduction in crisis episodes – alongside system costs to demonstrate return on investment. These learnings will translate directly into policy recommendations: specific regulatory changes, funding reallocations, and system reforms needed to make pathways function at scale.

Pilots will also establish replicable models and implementation tools: for example, shared protocols for pathway navigation, standardized intake and assessment processes, and templates for cross-system data sharing. This infrastructure will enable pathways to spread beyond initial pilots.

We will collaborate with City agencies to develop identification tools

Effective pathways require early identification of clients who need them. Working with DSS and New York State's PSYCKES system, we will explore creating new "high-acuity flags" that make clients' complex needs visible to frontline providers across systems, as well as predictive modeling approaches using existing administrative data to identify individuals at highest risk of cycling through crisis systems before patterns become entrenched.

When clients interact with shelters, hospitals, outreach teams, or other services, such flags would allow providers to see that individuals have been identified as experiencing crisis cycles and qualify for specialized pathways, enabling proactive rather than reactive engagement. This work will produce practical outputs supporting pathway implementation: for example, standardized screening protocols frontline workers can use, data-sharing agreements enabling coordinated care, and clear processes for flagging clients across systems. These tools will ensure the right clients can be connected to pathway services at the right time.

We will develop actionable insights for regulators and policymakers

Understanding where system capacity falls short is essential for scaling pathways effectively. We will develop a system model mapping the supply of housing and services against the needs of individuals in acute crisis, making bottlenecks visible and quantifiable.

This model will answer critical questions about resource gaps: How many IMT team slots are needed to stabilize high-acuity individuals? What is the right mix of specialized transitional housing for ending crisis cycles? How many specialized providers are needed to be Pathway Leads? Which specialized services constrain pathways? By quantifying these gaps, we will enable evidence-based decisions about investments and system expansion, and support scenario planning as the new administration sets priorities.

WE NEED PARTNERSHIP TO MAKE THIS VISION A REALITY

Transforming how New York City serves its highest-acuity residents requires commitment and partnership across the entire ecosystem. The Collaborative has developed the roadmap; now we need leaders from government, provider organizations, and philanthropy to join in implementation.

The fiscal environment demands efficiency. The human imperative demands dignity. Service pathways deliver both. The public sector will always be the primary funder of these services, but the Collaborative's unique platform – combining analytical rigor, provider partnerships, philanthropic resources, and neutral convening power – can enable the innovation and coordination that make public investments more effective.

WHAT IS NEEDED FROM PARTNERS

GOVERNMENT	PROVIDERS	PHILANTHROPY
Partner with the Collaborative to pilot and refine pathways in partnership with public agencies	**Partner in piloting** pathway models	**Fund pathway pilots** that test innovations before government can scale them
Commit to regulatory adjustments that enable pathways to function	**Embrace coordinated care delivery** across organizational boundaries	**Fund data sharing infrastructure** and analytical capacity to quantify bottlenecks
Allocate resources strategically based on evidence	**Take accountability** for client outcomes	**Convene and facilitate** – bringing stakeholders together
Enable data sharing for identification tools and pathway performance metrics	**Invest in specialized capacity** to develop staff expertise for serving individuals in acute crisis	**Document and disseminate** learnings that advance the field

THE INGREDIENTS FOR TRANSFORMATION ARE IN PLACE:

A clear framework, proven models, stakeholder attention, and economic necessity. What we need now is collective commitment to implementation.

The window of opportunity will not remain open indefinitely. Let us act together, now, to create lasting change.

> **"Having a sense of security [and] a place to exist in has brought me unimaginable solace and confidence. It's allowed me to see a positive future. It grants one the opportunity to plan ahead."**
>
> **Lived expert, speaking about their supportive housing experience**

ABOUT THE COLLABORATIVE

The Collaborative on Housing for Health was convened with funding from The Leona M. and Harry B. Helmsley Charitable Trust to pursue better outcomes for homeless New Yorkers experiencing sustained behavioral health crises. As a coalition of senior leaders from the nonprofit, government, and philanthropic sectors, we bring an independent systems-level perspective, access to resources, and a commitment to act in support of our recommendations.

Our Steering Committee members include government leaders from New York City's Department of Social Services and four innovative housing and health service providers – including the Institute for Community Living, Urban Pathways, the Jewish Board of Family and Children's Services, and the Center for Urban Community Services.

The Collaborative exists to serve multiple constituencies. For government leaders, we offer a path to maximize return on existing public investments by improving coordination and redirecting spending from expensive crisis interventions toward effective, sustained solutions. For health and housing providers navigating daily challenges of staff safety, high turnover, and inadequate systems, we provide a framework that reduces duplication and ensures clients access appropriate levels of care. For our broader community, we are working toward a city where every New Yorker – especially those with the most complex needs – can access the coordinated care necessary to exit homelessness and achieve health stability.

This roadmap represents our commitment to moving from analysis to action, from fragmented efforts to coordinated pathways, and from crisis management to lasting solutions.

STEERING COMMITTEE LEADERSHIP

Dr. Jeffrey Brenner, CEO of The Jewish Board of Family and Children's Services. Dr. Brenner is a primary care physician and has spent his career innovating health care delivery models to meet the medical and service needs of the most vulnerable citizens.

Kinsey Dinan, Deputy Commissioner of the Office of Research and Policy Innovation at the NYC Department of Social Services. She oversees research projects across the homelessness and housing spaces on behalf of DSS, including the first-of-its-kind administrative data analysis conducted for the CH4H.

Jody Rudin, President and CEO of the Institute for Community Living. Ms. Rudin has two decades of experience working in the social services sector across nonprofits and in government.

Frederick Shack, CEO of Urban Pathways. A seasoned housing leader, Mr. Shack has dedicated his career to launching innovative housing models and services to help single adults experiencing homelessness.

Molly Wasow Park, Commissioner of the New York City Department of Social Services. She oversees the Human Resources Administration that manages the supportive housing placement process and the Department of Homeless Services that supports shelter and outreach programs around the city.

Van Yu, Chief Medical Officer from the Center for Urban Community Services and Janian Medical Care. Yu is a psychiatrist with 20-plus years serving individuals in New York City with high-acuity health needs.

ACKNOWLEDGEMENTS

This roadmap is the product of extensive collaboration, dialogue, and shared commitment from individuals and organizations across New York City's housing and health ecosystem. While the Collaborative on Housing for Health authored the contents and conclusions presented here, this work would not have been possible without the generous contributions of time, expertise, and insight from many partners.

PRE-LAUNCH ADVISORS

Prior to the Collaborative's official launch in July 2024, four individuals served as advisors to the initiative, helping to guide the group's landscape research and to establish the focus on high-acuity homelessness. They include Bonnie Mohan (Consortium on Housing for Health), Chad Shearer (United Hospital Fund of NY), Pascale Leon (Supportive Housing Network of NY), and Patricia Hernandez (formerly Corporation for Supportive Housing).

GOVERNMENT PARTNERS

We are grateful to current and former officials from New York City and New York State agencies who provided data, conducted analyses, participated in interviews, reviewed drafts, and offered critical feedback: from the NYC Department of Social Services, including the Department of Social Services Medical Director's Office the Department of Homeless Services, and the Human Resources Administration; NYC Health + Hospitals; NYC Department of Housing Preservation and Development, NYC Department of Health and Mental Hygiene; NYC Mayor's Office; NYC Mayor's Office of Criminal Justice; and New York State Office of Mental Health. Particular thanks go to the Department of Social Services and Kinsey Dinan for conducting groundbreaking administrative data analysis that illuminated the characteristics and service patterns of high-acuity clients. Your willingness to engage with this work, share information, and consider recommendations reflects a shared commitment to improving outcomes for New Yorkers.

SUMMIT PARTICIPANTS

In July 2025, the Collaborative convened a summit that brought together expertise and operational knowledge from across the housing and health ecosystem. We thank the dozens of participants who contributed to these crucial discussions, including representatives from: Breaking Ground (Brenda Rosen), Bowery Residents' Committee (Tim Long), BronxWorks (Genesis Pena), Care for the Homeless (George Nashak), CASES (Jonathan McLean), Community Access (Iliana Lugo, Jordyn Rosenthal), Corporation for Supportive Housing (Lauren Velez), Center for Urban Community Services (Dr. Van Yu), Institute for Community Living (Jody Rudin, Troy Boyle), Jewish Board (Crystal McCrorey, Dr. Jeffrey Brenner), Montefiore Medical Center (Deirdre Sekulic), NYC Department of Health and Mental Hygiene (Jamie Neckles), NYC Department of Social Services (Molly Wasow Park, Dr. Fabienne Laraque, Kinsey Dinan), NYC Health + Hospitals (Ellie Epstein, Jason Hansman, Patricia Hernandez), NYC H+H Kings County (Priscilla Swan), NY State Office of Mental Health (Bob Moon, Julie Duncan), Phoenix House (Ann-Marie Foster), Supportive Housing Network of New York (Pascale Leone), The Bridge (Susan Wiviott), The Health & Housing Consortium (Tess Sommer, Bonnie Mohan), United Hospital Fund of NY (Chad Shearer), Urban Pathways (Fred Shack, Dr. Mardoche Sidor), B-HEARD (Natalie Winicov), lived experts (anonymous), and others. Your insights about what works, what does not, and what clients need were essential to developing practical recommendations grounded in operational reality.

INTERVIEW PARTICIPANTS AND SUBJECT MATTER EXPERTS

Many individuals generously shared their time and expertise through interviews that informed our understanding of system challenges and opportunities. We thank: Gwen Abney Cunningham (Behavioral Tech Institute), Irfan Ahmed (NYC Human Resources Administration), Jonay Argier (Behavioral Tech Institute), Cathy Batista (Anthos Home), Troy Boyle (Institute for Community Living), Nicole Branca (New Destiny Housing), Tony Carino (Center for Urban Community Services), Richard Cho (Manatt, Phelps, & Phillips LLP), Dennis Culhane (University of Pennsylvania), Lisa Dailey (Treatment Advocacy Center), Tricia Dawson (NYC Human Resources Administration), Bea de la Torre (Trinity Church Wall Street), Kelly Doran (NYU Health x Housing Lab), Emily Engel (NYS Department of Health - Bureau of Social Care and Community Supports), Ellie Epstein (NYC Health + Hospitals Correctional Health Services), Scott French (NYC Human Resources Administration), Carmela Fridman (The Jewish Board of Family and Children's Services), Joanna Fried (Center for Urban Community Services), Annie Hanford (Urban Pathways), Jason Hansman (NYC Health + Hospitals), Irfan Hasan (New York Community Trust), Cal Hedigan (Community Access), Adena Hernandez (Robin Hood Foundation), Nathalie Interiano (Care for the Homeless), Mark Jennings (Project FIND), Nirah Johnson (NYC Department of Homeless Services), Leora Jontef (NYC Health and Hospitals), Jessica Katz (former Chief Housing Officer for the City of New York), Kim Keaton (Corporation for Supportive Housing), Erin Kelly (Office of Deputy Mayor for Health and Human Services), Jihoon Kim (InUnity Alliance), John Kimble (Fund to End Youth and Family Homelessness), Fabienne Laraque (NYC Department of Social Services), Laura Lazarus (Anthos Home), Lisa Lombardi (Urban Pathways), Diane Louard-Michele (Lantern Community Services), Marcella Maguire (Corporation for Supportive Housing), Shambhavi Manglik (Robin Hood Foundation), Laura Mascuch (Council of State and Territorial Epidemiologists), Jonathan McLean (CASES), Kristen Mitchell (NYC Department of Social Services), Jamie Neckles (NYC Department of Health and Mental Hygiene), Kathleen Noonan (Camden Coalition), Chymeka Olfonse (Robin Hood Foundation), Emily Osgood (NYC Department of Housing Preservation and Development), Andrew Pearson (The Jewish Board of Family and Children's Services), Craig Retchless (NYC Human Resources Administration), Stanley Richards (Fortune Society), Brenda Rosen (Breaking Ground), Eric Rosenbaum (Project Renewal), Muzzy Rosenblatt (Bowery Residents' Committee), Giselle Routhier (NYU Health x Housing Lab), Jeannette Ruffins (HomewardNYC), Linda Sacco (The Jewish Board of Family and Children's Services), Laura Savino (Institute for Community Living), Maryanne Schretzman (Center for Innovation through Data Intelligence), Shali Sharma (Bronxworks), Jessie Shwartz (NYC Department of

Homeless Services), Norm Siegel (formerly NYCLU), Nancy Southwell (Urban Pathways), Brian Stettin (NYC Mayor's Office), Dan Treglia (Rutgers University), Lauren Velez (Corporation for Supportive Housing), Cassandra White (NYC Department of Homeless Services), Alyson Zikmund (NYC Human Resources Administration), and Sara Zuiderveen (NYC Department of Social Services).

PHILANTHROPIC SUPPORT

We are grateful to the Leona M. and Harry B. Helmsley Charitable Trust, particularly Tracy Perrizo and Emilie Fidock, for convening, funding, and advising the Collaborative and making this work possible.

CLIENT VOICE

Most importantly, we acknowledge the thousands of New Yorkers with lived experience of homelessness, mental illness, substance use disorders, and involvement in the criminal justice system whose stories and struggles animate this work. We are especially grateful to Community Access for their leadership in engaging 65+ people with lived expertise of homelessness throughout this process. While confidentiality prevents us from naming individuals, we have learned from clients through provider partnerships, case reviews, and existing research that centers lived experience. This roadmap is ultimately for you, and its success will be measured by whether it creates pathways that truly meet your needs and support your stability.