COVID-19 Homeless System Response:
Primer on Serving People with High-Acuity Needs

The COVID-19 pandemic has accelerated the need to safely house all people experiencing homelessness and the Coronavirus Aid, Relief, and Economic Security (CARES) Act has provided funding and resources to make this possible for communities. The vast majority of funding, such as Federal Emergency Management Agency (FEMA), Community Development Block Grants (CDBG), Emergency Solutions Grants (ESG), and Coronavirus Relief funds, allows for shorter-term housing programs like shelter and rapid rehousing (RRH). As communities work to quickly and safely house people experiencing homelessness in RRH, it is critical that RRH services are responsive to the needs and preferences of high-acuity populations who may receive RRH as a part of the COVID-19 accelerated housing response.

Coordinated entry (CE) systems working to safely house people experiencing homelessness should be preparing to serve individuals with high-acuity needs in shorter-term housing programs while honoring individual choice and working toward solutions for long-term housing options for people awaiting permanent supportive housing (PSH) openings. This document serves as a primer on high-acuity populations, staffing models, and service approaches, especially as they relate to service provision for high-acuity populations in RRH.

Definitions

Acuity

When used in healthcare settings, "acuity" refers to an individual's level of illness severity or their severity of needs. Acuity levels are classified numerically or into high/medium/low groups to translate the level of care needs and assessment findings into a classification system to help determine staffing patterns, practice approaches, care coordination, and resource allocation to best serve clients with the right level of care provided in the best manner in the most appropriate setting.

When used in reference to individuals receiving housing supports and housing-related services, acuity measures should include:

- The severity and chronicity of the illness and/or disability;
- The level of care needed to support activities of daily living, including assessing assistance required to support communication, decision-making, mobility, and managing challenging behaviors; and
- Recognition of the exponential effects that multiple co-occurring chronic health and behavioral health conditions can have, particularly when coupled with the effects of systemic racism and historical trauma, adverse childhood experiences, isolation from family and friends, the lack of a safety net in times of crisis, and disconnection from mainstream community health providers.

It is important to note that acuity levels can fluctuate over time. A person's needs might change/improve once housed and provided with intensive services for a time. Likewise, due to factors both controllable and uncontrollable, service needs can intensify and require flexibility in staffing and regular assessments from the service provider. It is critical to keep engagement with all residents at a level where acuity needs can be monitored and assessed regularly. In addition to funding requirements, experience and data show that regular, recurring case management and critical time intervention improve housing outcomes.

High-Acuity Households

High-acuity households are those needing the highest level of resources and staffing to successfully access housing, stabilize in housing, and remain housed. Indicators that impact acuity determination include:

- Illness and physical, mental, and behavioral health (diagnoses, chronicity of illness, severity);
- Cognitive functioning (memory, thinking, reasoning, decision-making, and communication skills);
- Independence in activities of daily living (e.g., showering/tending to personal hygiene, cleaning/maintaining living space, taking out the trash, shopping for groceries, cooking/preparing food, taking medications);
- History of trauma and adverse childhood experiences;
- Levels of natural supports and connectedness to family, friends, community, resources; and
- Housing history (chronicity of experience of homelessness) and past tenant experiences.

Staffing for Acuity

The level of staff expertise and dedicated resources designated for specific populations—through a formal assessment process— will differ based on acuity. Staffing is based on medical complexity, level of care needs (including activities of daily living dependence, comorbidities, and co-occurring conditions), and behavioral supports required to promote independence, choice, stability, recovery, and housing retention.

Distinctions Between Vulnerability and Acuity

Vulnerability in housing-related service assessments often refers to the level of increased exposure to harm a household faces if remaining unhoused while acuity often refers to the increased level of care needs that require greater resource allocation and support to access housing and remain housed.

Acuity Classifications and Needs in Housing-Related Services

High Acuity

High acuity needs require small caseload sizes (1:10–1:15), high levels of coordination with other care providers (especially mental/behavioral health), and staff expertise in behavioral health and medical care coordination, fair housing for people living with disabilities, and evidence-based practices and service approaches. Individuals assessed and meeting high-acuity classifications will likely require PSH as a long-term approach to support their housing stability and health outcomes. Assertive Community Treatment and Intensive Case Management staffing models best serve individuals classified as being high-acuity in housing-related services.

It is very likely that caseloads across an RRH program will need to be mixed to meet the needs of the populations being served. If one case manager in a program only has high-acuity residents, the 1:10–1:15 ratio should apply for that worker, while supervisors could expand the ratios for other case managers serving lower-needs residents.

Moderate-Acuity Needs

Moderate-acuity needs allow for caseload sizes to be slightly larger (1:16–1:30). Similar to high acuity, moderate-acuity needs require high levels of coordination with other care providers and staff expertise in behavioral health and medical care coordination, fair housing for people living with disabilities, and evidence-based practices and service approaches. Some individuals assessed and meeting moderate-acuity classifications served in RRH may need more than time-limited rental subsidy and services support as crises ebb and flow, especially given the ongoing public health and socioeconomic impact of COVID-19. This is especially true for Black, Indigenous, and people of color (BIPOC)—particularly Black people—who experience homelessness at disproportionate rates and who are more affected by the pandemic's impact than the White population. Intensive Case Management and team-based behavioral health approaches to coordination are recommended for this acuity level.

Low-Acuity Needs

Low-acuity needs allow for the largest caseload sizes (1:31–1:50). Care coordination and warm handoffs to other community providers remain essential, though the length of time support services are needed to stabilize may be less. The need for RRH services for low-acuity populations should be reassessed every 3–6 months to determine the need for continued services to promote housing stability and retention.

Assessing for Acuity

Coordinated Entry (CE) and Acuity

It is the goal of CE to assess people and match them to rehousing options based on the level and type of supports and accommodations required by the household to successfully transition into housing and remain housed. This goal is unchanged during the pandemic; however, CE policies may need to be changed to allow for the placement of some higher-scoring people into RRH. Although RRH is typically reserved for people with less intensive service needs, the urgency of COVID-19 response highlights the need for communities and providers to assess service needs regularly and plan for serving higher-acuity tenants in RRH. Similarly, RRH programs should be designed, staffed, and scaled in a way that is responsive to the needs of people awaiting resources. This requires a dynamic approach in fitting clients to a diverse range of possible long-term housing options on a client-by-client basis.

Assessment Tools for Determining Acuity Levels

While a CE assessment tool can provide a good first start in understanding tenants' needs, RRH providers should also employ service assessments commonly used in PSH projects after a tenant is housed to gain a deeper understanding of service needs and acuity levels. A comprehensive assessment approach that includes information about specific individuals' needs and vulnerabilities to assure safety from potential COVID-19 exposure through opportunities for self-isolation and quarantine. Additionally, it should include a comprehensive biopsychosocial assessment of acuity

that includes needs related to chronic medical conditions, mental health and substance use conditions, limited mobility, visual impairment, hearing impairment, memory issues, natural supports, history of housing, and independence in activities of daily living.

Examples of Assessment Tools from the Field

- Connecticut DMHAS Supportive Housing Acuity Index
  - Connecticut Supportive Housing Assessment/Acuity Index Guidance and Manual
- Columbus/Franklin County Severity of Service Needs Assessment Tool
  - Columbus Severity of Service Needs Interview Tool
  - Columbus Severity of Service Needs Summary
  - Columbus Severity of Service Needs Submission

It is important to recognize that assessment tools are often normed on white males and may not accurately reflect the unique needs of BIPOC populations. Communities need to examine the racial breakdown of their acuity cohorts to determine if their assessment process and/or tools might be inherently biased.

High- and Mixed-Acuity Service Approaches and Staffing Models

A service approach is distinct from a staffing model in that it is a best practice technique or engagement style requiring training for staff involved in any staffing model that is providing housing-based case management. Staffing models refer to the adoption of fidelity standards in staffing patterns, requirements of staff expertise, coordination across services, and the organization of caseload sizes and mix of acuity levels assigned to staff in service provision.

Service Approaches

Evidence-based service approaches for all acuity levels include:

- Trauma-informed care;
- Training for anti-bias, cultural humility and cultural competency;
- A person-centered, holistic approach to assessments and service delivery that honors client choice and self-determination;
- Harm reduction;
- Motivational interviewing;
- Care coordination across multiple service sectors; and
- A focus on including people with lived expertise in decision-making:
  - All staffing models for high-acuity services should include staff members with lived expertise as full team members, prioritize hiring peers, and examine pay scales to ensure that salaries for staff with lived expertise are equitable and commensurate with staff bringing other expertise to the program.
  - Including community members with lived expertise in assessment tools, services, and funding decision-making.

Staffing Models

High acuity populations require time dedicated to assertive engagement, outreach, building trust/rapport, coordinating care across multiple providers, small caseload sizes and the integration of behavioral health, nursing, employment and legal specialists, in addition to housing case managers; these functions are more difficult, yet more critical, during the time of COVID-19. It is important to consider racial equity in representation of staffing and to ensure that staff are reflective of the population an organization is serving.

High-Acuity Staffing Models

For systems that are looking to staff caseloads by acuity levels, rather than using a mixed-acuity staffing model, multiple evidence-based staffing models exist:

- **Integrated Team Staffing Models for High-Acuity Populations**
  - There is a strong evidence base for high-acuity populations to be served in the team-based behavioral health staffing model Assertive Community Treatment (ACT). The shared caseload for ACT is 10–12 team members per 100 clients.
  - There is a moderate evidence base for Intensive Case Management (ICM) approaches to serving people experiencing homelessness with high-acuity needs. ICM staffing models vary across the country and include both team-based shared caseload staffing models and individual caseload staffing models. ICM caseload sizes are typically 1:15–1:20 for high-acuity clients.
  - Fidelity to both ACT and ICM staffing models include people with lived expertise as full team members. Pay should be commensurate with other housing case manager salaries.

- **Individual Caseload Staffing Models for High-Acuity Populations**
    - When an integrated team approach is not possible, time for coordination, discharge follow-up, transportation to and from care appointments, and benefits counseling fall on the housing case manager to coordinate and require the smallest caseload size in order to provide pre-tenancy, tenancy sustaining, and service coordination services.

    - Critical Time Intervention and Tenancy Support Services (also known as housing case management) can be utilized for serving high-acuity populations when caseload sizes are between 1:10–1:15.

Mixed-Acuity Staffing Models

CE systems, providers, and RRH program supervisors must consider acuity levels when assigning clients to direct service staff caseloads.

Homelessness service providers should review caseload assignments to ensure equitable staffing that considers both caseload sizes (the number of households an RRH case manager is responsible for) and acuity level in the assessment of each household. A review of caseload sizes and acuity levels can help to ensure that staff have adequate time to provide the correct level of service—based on acuity—when it is needed, with fewer staff members understaffed or overstaffed.

Example of Mixed-Acuity Staffing Review Activity

	Case Manager A	Case Manager B	Case Manager C
Low-Acuity (1–3)	4 households=12	30 households=90	0 households
Moderate-Acuity (4–7)	1 household=5	2 households=11	20 households=113
High-Acuity (8–10)	10 households=92 total acuity score	1 household=9	0 households
Caseload Size	15 households	33 households	20 households
Caseload Acuity Total	107	110	113

Caseload acuity totals are calculated by adding the caseload acuity assessment scores assigned to each case manager together to get a caseload acuity total per case manager. These caseload acuity totals are then compared to each other to determine the total difference in acuity with which various case managers are working. In this case, the difference in acuity scores between the lowest total (Case Manager A) and the highest total (Case Manager C) is 6 (about one moderate-acuity household); therefore, these caseloads are fairly even. Adjustments to caseload sizes should be made when caseloads are not even in order to achieve similar caseload acuity scores for all case managers, regardless of the actual number of clients served by each. This comparison of caseload acuity can help to ensure adequate and equitable staffing for mixed-acuity caseloads.

Resources

For further information on evidence-based staffing models for high-acuity populations:

- HUD Case Management Ratios
- HUD High Acuity Grid, transitions from short term to long term subsidies
- HUD Homeless System Response: Evidence-Based Service Delivery
- Staffing Model Resources