Real Supportive Housing Need in New York State

A Statewide Supportive Housing Needs Assessment

Based on data collected & evaluated by CSH

CSH
The Source for Housing Solutions

"This report takes many pieces of the puzzle, collected from all over the State, and builds a complete picture of supportive housing need for everyone to see. We know we must have more supportive housing to address the alarming rise in homelessness across New York State, and we now have the hard data showing what our leaders must do to help the very vulnerable New Yorkers who need access to stable homes and community services."

Deborah De Santis
President and CEO
CSH

"As New York's largest poverty-fighting organization, Robin Hood recognizes the vital role that housing plays in giving families the stability to build better lives. We applaud Corporation for Supportive Housing in its efforts to improve the quality and accuracy of data regarding the need for supportive housing in New York."

David Saltzman
Executive Director
Robin Hood Foundation

"Stable housing and strong social support services can have a tremendous impact on people who are homeless, helping them to lead healthier, safer, and more productive lives. We know that supportive housing results in improved health outcomes and decreased emergency room use for people who are homeless, which in turn also saves money in the long run. This assessment is an important resource to inform appropriate strategies to integrate housing and health for some of the most vulnerable New Yorkers."

James R. Knickman
President and CEO
New York State Health Foundation

Executive Summary

Background

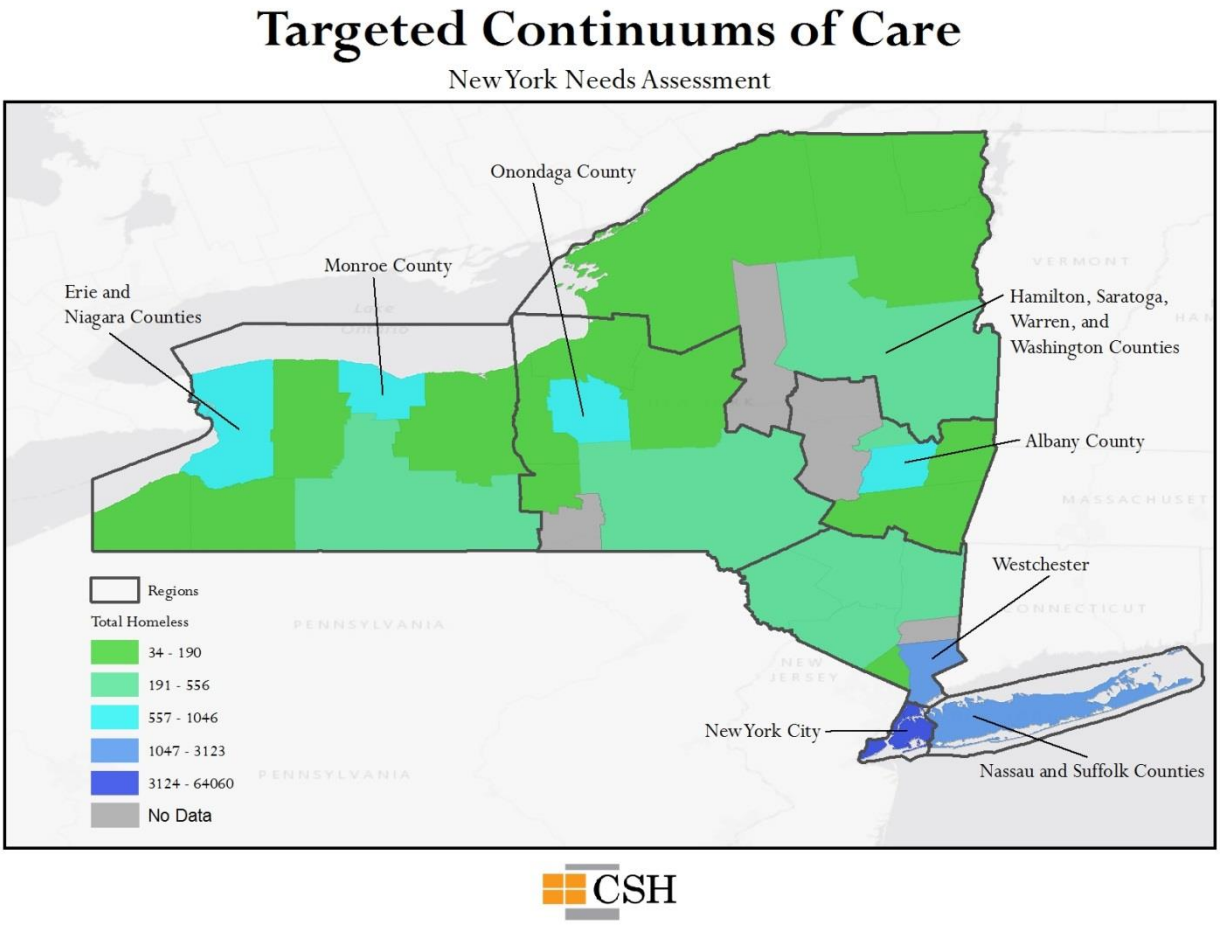
Supportive housing is a proven intervention offering vulnerable individuals and families access to affordable housing and services to help them overcome complex challenges such as homelessness, mental illness, physical disabilities, substance use, and often times a combination of all of these factors. With $1 billion invested to date, New York State has a well-established history of leveraging supportive housing to improve the lives of thousands who want stability, autonomy and dignity. More recently, New York State led the way in demonstrating the strong link between stable housing and health outcomes by reinvesting nearly $400 million in state-only Medicaid savings to create supportive housing targeted for high utilizers of Medicaid, with the twin goals of reducing costs and improving patient outcomes.

In spite of these far-sighted initiatives, there is not nearly enough supply to meet the record-level of need for supportive housing. In New York City alone is it estimated **four out of every five people found eligible for supportive housing have to remain in shelter or on the street because of the lack of available units.** Experts and advocates agree efforts to increase access to safe and affordable housing could be greatly enhanced if driven by better data on statewide and regional need.

Until now, policy-makers, advocates, developers and other key housing stakeholders throughout New York lacked accessible, adequate data to better assess the regional needs of populations that should be served by supportive housing. This report establishes the foundation on which we can continue to build such data to greatly enhance strategic planning and resource allocation to increase the supply of supportive housing.

Data Collection Challenges

Although this report now forms the nucleus to move forward, CSH faced a number of obstacles in collecting numbers from various sources. No uniform data exists to comprehensively assess supportive housing need at either the regional or statewide level and there is no centralized clearinghouse to collect such numbers and enforce commonality in definitions of groups targeted for supportive housing. State and local agencies collect their own diagnosis-specific data on the homeless populations they serve. As such, governmental agencies, providers and housing advocates must rely on a patchwork of data that often fails to capture individuals who cross multiple systems and amass high costs to public agencies. As a result, no accurate estimates of housing needs in communities exist across New York State.



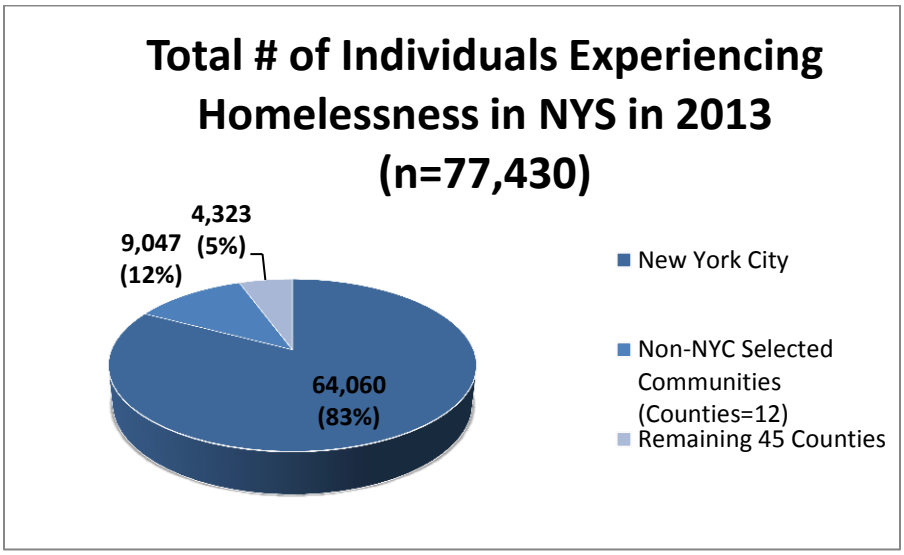
How We Approached the Data Challenges

CSH examined data from New York's 30 Continuum of Care (CoC), from which eight communities were selected. The communities were chosen as a result of their high concentration of relative need and higher prevalence of homelessness in their respective regions. We identified data used for this assessment through secondary sources and input from stakeholders with expertise on homelessness who formed our Advisory Group members for each community.

- Albany County (Capital District Region)
- Bronx, Kings (Brooklyn), Manhattan, Queens and Richmond (Staten Island) Counties (New York City)
- Erie and Niagara[1] Counties (Western NY)
- Monroe County (Western NY)
- Nassau and Suffolk Counties (Long Island)
- Onondaga County (Central NY)
- Saratoga, Hamilton, Warren and Washington Counties (North Country)
- Westchester County (Hudson Valley Region)

[1] Niagara County CoC merged with Erie CoC in July 2013. Point- in-Time data used only includes Erie County; however some data from Niagara is included in the AHAR reported numbers. Only Erie County is assessed in the assessment of need charts that follow.

The eight communities selected for the needs assessment accounted for nearly 95% of the State's total homeless population (n=77,430) in 2013.[2] While New York City accounts for a lion's share of the total homeless percentage (83%), the remaining seven selected communities (n=12 counties) compose 12% of the State's homeless population, and the remaining 45 counties account for approximately 5% of the State's homeless population. This is important for understanding where the State's highest concentrations of homeless individuals and families reside and also that there are significant pockets of homelessness in areas outside of New York City representing higher than average levels of housing need.



What We Found

The sources analyzed for this report were pursued in conjunction with recommendations from the community Advisory Groups after assessing local variables, data and other factors to provide informed assumptions on supportive housing need. We were asked to focus on specific homeless subpopulations: Health Home members, individuals with mental illness, individuals with substance use disorders, individuals with HIV/AIDS, adults (55+), veterans, youth aging out of foster care, and individuals living in long term care facilities preferring to live in the community. (Other subpopulations benefitting from supportive housing, such as those reentering communities from prisons/jails or those seeking refuge from domestic violence, are not necessarily reflected in the data.)

Data sources include homeless numbers from New York's 30 Continuums of Care (CoCs) 2013 Point-in-Time Counts (PiT), the federal 2013 Annual Homeless Assessment Reports (AHAR), and additional data sets provided by State and local government agencies on targeted homeless sub-populations. Further comparison of each CoC's supportive housing inventory data with the estimated supportive housing need provides the basis for calculating the estimated number of supportive housing units to be added to the housing stock. The Housing Inventory Count includes supportive housing units dedicated explicitly for homeless individuals and families, as such this Count does not reflect the complete list of supportive housing units in NY, but does represent those specifically designated for homeless individuals and was the most appropriate data set to use when examining homeless

[2] U.S. Department of Housing and Urban Development (2013). The 2013 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness. U.S. Department of Housing and Urban Development, Office of Community Planning and Development. Available at: https://www.hudexchange.info/resources/documents/AHAR-2013-Part1.pdf

individuals and families. The following table consolidates the information on populations facing homelessness across the eight targeted communities in New York State. **CSH's calculations estimate 36,164 homeless households (30,311 Adult, 5,853 Families) were in need of supportive housing in 2013 and that nearly 32,000 supportive housing units must be created in the near future just to meet this identified need.**

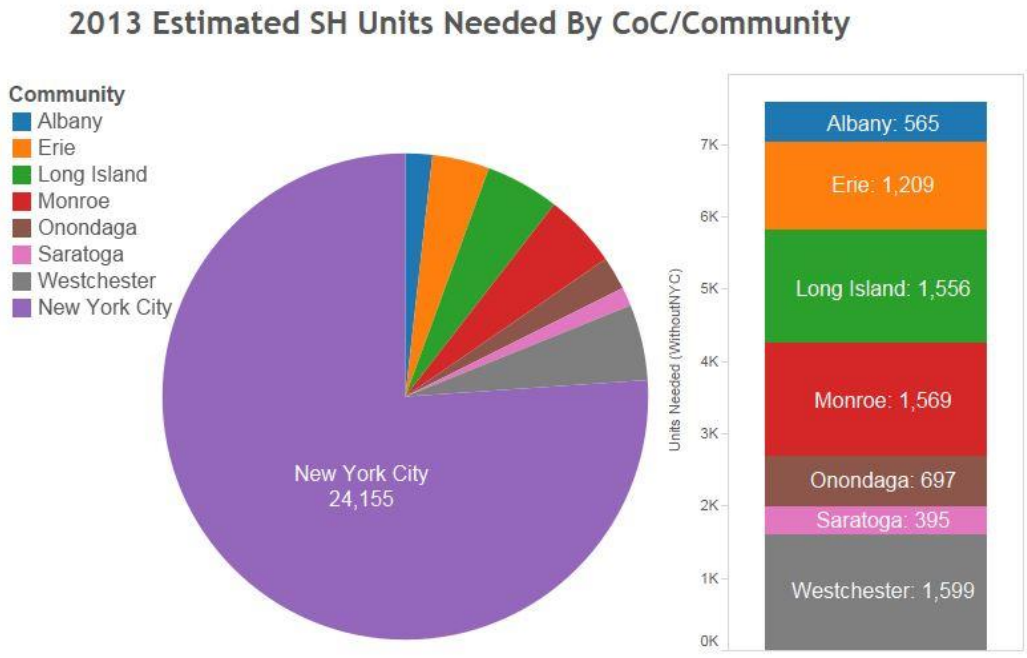
Estimating Statewide Need for Supportive Housing (SH) (All 8 Targeted CoC Communities)		
Homeless Population		
Statewide (8 Targeted CoC Communities)	**Households over Course of a Year**	**Households In Need of SH**
		#
Homeless Adult Households*		
Chronic[3] Adult Households	9,385	9,041
Non-chronic Adult Households	64,138	17,977
Nursing Home Population	363	322
Homeless Unaccompanied Youth	3,281	2,971
Total Homeless Adult + Nursing Home Households	**77,167**	**30,311**
Homeless Families Households		
Chronic Families	1,474	1,440
Non-chronic Families	25,049	4,413
Total Homeless Family Households	**26,523**	**5,853**

*Includes single adults and single adult families of 2 or more with no children under the age of 18

Household Unit Type	Estimating SH Units Needed in the Community					
	Estimated Households In Need of SH	Estimate Existing SH Units	Estimate SH Units Pipeline	Annual Estimate Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families	5,853	2,970	293	1% -10%	411	**5,442**
Adult & Unaccompanied Youth	30,043	19,916	1,937	1% -18%	3,740	**26,303**
Total SH units needed						**31,745**

[3] CSH utilized the United States Department of Housing and Urban Development's (HUD) definition of "chronic" homelessness. Refers to an individual with a disability who has been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years.

Estimated SH Units Need was calculated by taking the Estimated Households In Need of SH less the SH Units Available in 2013 (new units that opened in 2013 + existing stock that became available in 2013 via turnover). For the seven communities outside of NYC, the estimated Supportive Housing Unit need is **7,590**; representing about 24% of the total estimated supportive housing unit need.



Recommendations

- Improvements in data collection and quality are needed at all levels to allow for a more comprehensive understanding of supportive housing need.
    - The State of New York should establish a clearinghouse agency or unit where uniform and complete data encompassing all populations served by supportive housing are reported and collected to effectively assess supportive housing need on an ongoing basis and make appropriate, data-driven decisions on resource allocation.
    - In the meantime, State and local decision-makers should consider the findings from this assessment to inform near-term resource allocations that are data-driven and deploy resources within each of the communities/regions identified in this report.
- In its data collection, the State of New York should focus on capturing useful information on individuals and families crossing multiple systems in their search for assistance and amassing high costs to public agencies in the process of doing so. We believe the State and local governments have missed opportunities to find even greater cost savings because there is no consistent, uniform policy for data matching across systems.
- The State of New York should issue an annual comprehensive assessment of supportive housing need that relies on a whole-person and person-centered approach, encompassing a holistic understanding of the multiple complexities individuals and families face, versus an over-reliance on diagnosis-specific categories of need.

- It is clear that even the current stock and pipeline of supportive housing does not come close to meeting the unmet supportive housing unit need in 2013. A long-term plan and commitment to create supportive housing is needed from all levels of government to begin to address this large gap in supply as compared to the supportive housing market demand.

About CSH

For over 20 years, CSH has led the national supportive housing movement. CSH's mission is to advance solutions that use housing as a platform to improve the lives of the most vulnerable people, maximize public resources, and build healthy communities. CSH develops innovative program models, provides research-backed tools and training, offers development expertise and funding, and collaborates on public policy and systems reform. CSH is a certified community development financial institution (CDFI). To date, CSH has made over $500 million in loans and grants, and has been a catalyst for over 200,000 units of supportive housing. For more information, visit csh.org.

CSH wishes to thank the New York State Health Foundation and The Robin Hood Foundation for their generous support for this project. CSH would also like to thank the Supportive Housing Network of New York and the following State and City agencies for their support in providing the necessary data to complete this needs assessment: New York State Department of Health (DOH), the AIDS Institute, Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Health (OMH), Office of Temporary and Disability Assistance (OTDA), New York City Department of Homeless Services (DHS), and New York City Human Resources Administration/ HIV/AIDS Services Administration (HASA).

Permission request

Inquiries

Readers interested in learning more about supportive housing are encouraged to also visit CSH's website at www.csh.org for additional on-line resources and materials.

Real Supportive Housing Need in New York State

By CSH

Content

Project Purpose & Charter

Support for this work was provided by the New York State Health Foundation (NYSHealth) and the Robin Hood Foundation. The views presented here are those of the authors and not necessarily those of the funders, their directors, officers, and staff. *The purpose of this needs assessment is to measure homelessness and supportive housing need across New York State in order to better position the State and City governments, and other decision-makers to make informed, data-driven decisions on future supportive housing unit allocations.*

CSH worked with key stakeholders from New York State and local government agencies to collect data, and develop common definitions and methodology on how to assess the need for supportive housing, and then create a systematic approach to analyzing data. The data analyzed for this assessment was to provide a means for the State to make targeted decisions when determining housing funding allocations and allow the State to better match resources to need, both in terms of the number of supportive housing units and in the type of units and populations serviced.

Deliverables of the grants included:

- Informed estimates of individuals and families experiencing homelessness over the course of a year in five targeted regions.[4]
- Estimates of specific homeless subpopulations in each of the targeted categories: Health Home members, individuals with mental illness, individuals with substance use disorders, individuals with HIV/AIDS, adults (55+), veterans, youth aging out of foster care, and individuals living in long term care facilities who prefer to live in the community.
- Estimated unit need for individuals and families that would benefit from supportive housing in targeted communities, based on data gathered and assumptions of need generated in conjunction with community stakeholders.
- Final report detailing estimates of homelessness and subpopulations and supportive housing unit need including input from State agencies and community stakeholders.

[4] Following review of the initial data, the decision was made to increase the number of communities to eight (8) statewide in order to provide a more comprehensive look at homelessness in different areas across the State.

CSH gratefully acknowledges the following individuals and organizations that served as advisory members or in our community Advisory Groups and contributed significantly to the development of the supportive housing needs assessment findings and the completion this report.

Name	Organization	Region
Amy Lacey	*Catholic Charities*	*Capital District*
David Poach	*Capital City Rescue Mission of Albany*	*Capital District*
Joe Sluszka	*Albany Housing Coalition*	*Capital District*
Judith McLaughlin	*The Equinox*	*Capital District*
Liz Hitt	*Homeless and Travelers Aid Society (HATAS)*	*Capital District*
Michelle Sandoz-Dennis	*CARES Inc.*	*Capital District*
William Gettman Jr.	*St. Catherine's Center for Children*	*Capital District*
Carolyn Dodge	*Onondaga Case Management*	*Central NY*
Christopher Warren	*Onondaga Dept. of Children & Family Services (DCFS)*	*Central NY*
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Jan Moag Killam	*Onondaga Dept. of Adult & Long-Term Care – SPOA*	*Central NY*
Jessica Allen	*ACR Health*	*Central NY*
Joe Simko	*Central New York Services*	*Central NY*
Kristian Allen	*Catholic Charities*	*Central NY*
Laura Zocco	*Liberty Resources*	*Central NY*
Liddy Hintz	*Bowman Systems Inc.*	*Central NY*
Liz Perry	*Catholic Charities*	*Central NY*
Melissa Marrone	*COC-NY-505*	*Central NY*
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Patricia Quattrocchi	*Westchester County Department of Social Services*	*Hudson Valley Region*
Paul Stolz	*Veterans Administration*	*Hudson Valley Region*
Stephen Piasecki	*Supportive Housing Network of New York*	*Hudson Valley Region*
Ali Rosen	*Federation of Organizations*	*Long Island*
Ariel Sotelo	*Círculo de la Hispanidad (CDLH)*	*Long Island*
Daniel J Stern	*Concern for Independent Living*	*Long Island*
Donna O'Hearon	*Mercy Haven*	*Long Island*
Greta Guarton	*Long Island Coalition for the Homeless*	*Long Island*
Jennifer Pollina	*Transitional Services of New York for Long Island, Inc. (TSLI) and Haven House/Bridges, Inc. (HHB)*	*Long Island*
Jessica Lopez	*VOA – SSVF*	*Long Island*
Joanne Massimo	*Suffolk County United Veterans (SCUV)*	*Long Island*
Kathy LaSalla	*United Veterans Beacon House (UVBH)*	*Long Island*

Kristin Ohrtman	*Help-Suffolk*	*Long Island*
Lareicha Hunter	*SCO Family of Services*	*Long Island*
Lisa Mosquera	*Catholic Charities*	*Long Island*
Nicole Maggiotta	*The Safe Center LI (TSCLI)*	*Long Island*
Paul Finks	*Community Development Corporation of Long Island (CDCLI)*	*Long Island*
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Tareek Penn	*Melillo Center*	*Long Island*
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Background

Supportive housing combines affordable housing and supportive services to help vulnerable individuals and families with complex challenges live with stability, autonomy and dignity. Supportive housing is appropriate for individuals and families experiencing or at-risk of homelessness that are facing multiple barriers to employment and housing stability, including mental illness, substance use and/or other disabling or chronic health conditions, as well as individuals who are inappropriately institutionalized. To support stability and growth, supportive housing provides the strong platform of a home from which to access a flexible and comprehensive array of voluntary services including: physical and mental healthcare, substance use treatment, employment, and education. Supportive housing does not place limits on length of tenancy[5].

In the following assessment, CSH worked with communities to identify the particular subsets of their homeless population for which supportive housing is the best fit to foster stability and enable them to permanently exit homelessness. This report analyzes the supportive housing need of individuals and families in the communities representing each corner of the State that present the highest need across multiple indicators; makes recommendations on unit production; and provides recommendations on how to better track, analyze and assess need.

For the purposes of this report, people are considered in need of supportive housing if they would not likely obtain and/or maintain housing without long-term wrap-around supports as a result of one or more disabilities that contribute to instability.

Current data collection on homeless populations varies by communities and lack uniform definitions across agencies providing services for the homeless populations. Where data does exist, it is often limited to singular variables that fail to account for the multiple medical and other complexities that contribute to housing instability. Without solid, consistent data, this report applies appropriate proxies and data-informed estimates on assumed need provided by local stakeholders who know the local intricacies and variables well and are best suited to provide this information.

Understanding Need

Supportive housing is designed primarily for people with long histories of homelessness due to persistent obstacles like serious mental illness, substance use disorders, or chronic medical conditions. Compared with other very low-income people, these men and women disproportionately use shelters, emergency health care and public mental health services—often cycling rapidly through various public institutions at great cost to taxpayers. Supportive housing can break this cycle by providing affordable housing and the services that these individuals or families need to remain stably housed. A significant aspect of this assessment included working with the local communities to target that portion of the homeless population with need for these long-term supports and services It is important to note that although supportive housing plays a key role in helping communities address homelessness for its most vulnerable individuals and families, it is just one piece of a larger continuum of housing options available to

[5] For more information on high-quality supportive housing, please refer to CSH's Dimensions of Quality Supportive Housing, available at http://www.csh.org/wp-content/uploads/2013/07/CSH_Dimensions_of_Quality_Supportive_Housing_guidebook.pdf

communities. **Not all individuals experiencing homelessness need the intensive level of long-term supports and services offered by supportive housing**.

Process

CSH engaged in a multi-stage process of data collection, analysis and gathering of community feedback in order to develop the population estimates, assumptions of need for supportive housing and unit need estimates included in this report. The process began with the collection and analysis of 2013 data from the New York State Point-in-Time (PiT) Homeless Assistance Program Reports[6] and data provided by NYS agencies on homeless populations and subpopulations receiving services in communities across New York. CSH worked with 2013 data as it was the most current, consistent and available data across communities.[7] CSH selected the "communities" (Continuums of Care (CoC)) with the highest prevalence and proportion of homelessness in each of seven regions[8] as the target communities, and added an eighth community because the prevalence of homelessness was comparable in two communities in the Western New York region (Erie & Niagara CoC and Monroe CoC).

CSH engaged key stakeholders, primarily leadership from the local CoCs that included HMIS Leads, Collaborative Applicants, and the Point of Contact for Homeless persons, in each of these targeted regions to explain the needs assessment purpose and process, request their input and to obtain additional local community data. Continuum of Care leaders assisted CSH in the identification of other key stakeholders to form their local Advisory Group for the needs assessment. These Advisory Groups participated in a webinar, during which CSH shared the data gathered for their community and identified outstanding data needs with an appeal to participants to help collect that data. Follow-up in-person meetings with each of the advisory groups to review the data[9] apply appropriate local proxies and make reasonable assumptions around the percent of homeless adult and family households in need of supportive housing that would be used to calculate total SH units needed in 2013. **The analysis of supportive housing need among the subpopulations was not used to calculate unit need; rather these individuals should be understood as a subset of the homeless individual and family households CSH examined**

For the purpose of establishing common definitions that can be applied across all the targeted communities, CSH used the United States Department of Housing and Urban Development's (HUD) definitions for the targeted populations (see Appendix A). In doing so, CSH recognizes that some local jurisdictions, (e.g. New York City[10])

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[6] The Point-in-Time (PIT) count is a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night.

[7] 2014 data was utilized for the community chosen in the North Country region of NYS (Hamilton, Saratoga, Warren and Washington Continuum of Care) as 2013 AHAR data was not reliable because less than 50% of providers reported in 2013.

[8] CSH broke the state into 7 geographic regions: Capital District, Central NY, Hudson Valley Region, Long Island, New York City, North Country and Western NY

[9] An in-person meeting was not convened in Erie County

[10] Eligible individuals and families applying for NYNY III supportive housing must meet the chronically homeless definition: ***single adults*** (18+) with a disability and has spent at least 1 (365 days) of the last 2 years in a shelter or living on the street, not necessarily consecutively; ***families*** lived in a homeless shelter for at least 365 days of the last two years, not necessarily consecutively or head of household with a disability has spent at least 1 of the last 2 years in a shelter or living on the street.

have different definitions for homelessness and by utilizing HUD definitions we exclude a proportion of individuals and families who may under certain definitions be deemed "homeless".

Targeted Populations in Need of Supportive Housing

For decades, New York State and local agencies have been combining efforts to develop housing solutions to meet the needs of a range of vulnerable populations, including individuals and families facing chronic homelessness, those with chronic health conditions and populations with disabilities leaving institutional care. With data collected from the HUD Homeless Management Information System (HMIS) and Point-in-Time reports for the eight selected NY CoCs/communities and the local advisory groups, and data obtained from various state and local New York government agencies, the Supportive Housing Needs Assessment targets the following vulnerable populations:

Targeted Populations

- Chronic/ Non Chronic Homeless Adults and Families
- Individuals in Nursing Homes
- Homeless Unaccompanied Youth
- Homeless Adults over the age of 55
- Homeless Veterans
- Homeless Individuals living with serious mental illness (SMI), substance use disorders (SUD), and HIV/AIDS
- Homeless Health Home Enrollees
- Homeless Transition Age Youth

It is important to note that, with the exception of those leaving institutional care (nursing homes), **the homeless subpopulations analyzed for the report (adults over 55, veterans, individuals with SMI, SUD, HIV, Health Home enrollees and transition age youth) are subsets of the total chronic and non-chronic homeless adults and family populations and contain significant overlap. The analysis of supportive housing need among the subpopulations was not used to calculate unit need.**

Without unique, identifiable data, it is impossible to ascertain how many times a single homeless individual is represented in one or more of the above-listed sub-populations. In addition, data attained for each sub-population was derived from a different data source. For example, an individual counted as "homeless over the age of 55" can also be counted as a "homeless veteran" as well as a "homeless individual with a serious mental illness". For this reason, the report must assume significant overlap across sub-populations; however, the assessment of supportive housing need for each sub-population is estimated irrespective of what other category or categories they may also fall into. Please see Appendix A for the definitions and sources for the targeted populations.

Discussions at the Advisory Group meetings acknowledged the need for additional data collection and analysis to estimate other populations' need for supportive housing. These additional target populations, which are not included in this assessment include:

- Re-entry Population (jail, prison, parole, probation)
- Victims of Domestic Violence
- Individuals in institutions that are able to live in the community and would prefer to do so

Estimating Population Need for Supportive Housing

Estimated population in need of supportive housing and proposed need for new supportive housing units were calculated for each of the eight target communities. CSH compiled all of the data collected on the target populations detailed above. The data analysis looked at both the 2013 Point-in-Time (PIT) counts for the communities and at estimates for annualized homelessness counts based on local, extrapolated 2013 Annual Homeless Analysis Report (AHAR)[11] data on individuals engaged in the homeless service systems over the course of a year for each community.

CSH worked with each community during the in-person sessions to identify the portion of homeless adult and family households for which supportive housing is the most appropriate intervention. This resulted in the assumptions for percent in need of supportive housing, which would drive the total number of units needed for homeless single adult and family households. In alignment with assumptions used in other supportive housing needs assessments around the country (including Delaware, Detroit, Michigan, Ohio and Pierce County Washington,)[12], Advisory Group members in all but one of the targeted communities estimated that somewhere between 95% and 100% of individuals and families experiencing chronic homelessness are in need of supportive housing. Nationally there is less agreement on the standard estimated percentage of non-chronic individuals and families that need supportive housing, with recent needs assessments in Delaware, Pierce County Washington, Ohio and Detroit citing between 5% and 35% for these populations. In the target communities in this NYS analysis, estimates ranged between 10% and 40%; based on a variety of factors including the belief in some communities that many homeless individuals and households not specifically defined as "chronically homeless" still face a variety of barriers to housing stability (i.e. mental health issues and disabilities) and therefore need supportive housing in order to stabilize and become successful in permanently exiting homelessness. The population need was drawn only from the total number of homeless adult and family households, not including subpopulations.

With this information in hand, CSH's calculations determined that an estimated 36,164 households (30,311 Adult and Youth, 5,853Family) in are in need of supportive housing.

Estimating Unit Goal

The next step in our assessment for each community was to determine the **Estimated Total Supportive Housing Unit Goal.** This estimate is derived from the calculation of the **Estimated Household in Need of Supportive Housing** less the **Estimated Supportive Housing Units Available in 2013.**

Est. Total Supportive Housing (SH) Unit Goal = Est. Households in Need of SH - Est. SH Units Available

The **Estimated Household in Need of S**upportive Housing is based is based on the assumed households in need of supportive housing recommended by the community Advisory Groups, The **Estimated Existing**

[11] AHAR is based on two primary sources of data: (1) Homeless Management Information Systems (HMIS) data covering one-year reporting period, October 1, 20113 to September 30, 2014 and the communities point-in-time data.
[12] CSH has previously completed similar supportive housing need assessments in these states/localities.

Supportive Housing Units were taken from each community's 2013 HUD Housing Inventory Count (HIC)[13] – reporting current supply of supportive housing units dedicated to homeless individuals and families. **The actual Estimated Supportive Housing Units Available in 2013** is derived from the turnover rates on existing units plus new pipeline of units becoming available in 2013. **Annual Estimated Turnover Rates** were taken from the AHAR, when available, or gathered directly from community stakeholders. The **Estimated Supportive Housing Unit Pipeline** represents the units that became available during 2013 (whether through new construction, additional scattered-site units, and/or allocation of additional housing vouchers). These pipeline numbers were obtained by taking the difference of existing supportive housing stock in the HIC between 2013 and 2014. These "pipeline" units became available for use at some point during 2013. The **Estimated Supportive Housing Units Available in 2013** was calculated by adding the units made available through turnover and the pipeline number and assumes that the current supportive housing stock is fully utilized.

Household Population & Sub-Population Assumptions Used

There were a number of commonalities and emerging trends among the communities in determining supportive housing need for their chronic and non-chronic homeless adult and family households.

From the overall estimated homeless adult and family household numbers, the Advisory Group members identified the portion of each for which supportive housing is the most appropriate housing intervention, keeping in mind that it is one intervention in a continuum of housing options available to help communities address the needs of vulnerable households. Targeting existing and new supportive housing units for those that will benefit most from the supports will prove to be an effective utilization of valuable and limited resources. The following assumptions of the percentage of target populations in need of supportive housing are based on estimates of current placement rates, local or regional conditions and experience, characteristics of the homeless population, and completeness of reporting as identified by the Advisory Groups. Discussions on these variations are presented in the sections that follow:

Assumptions of Need for Homeless Households

- ✓ 75 – 100% of chronically homeless adult and family households
- ✓ 10 – 40% of non-chronically homeless adult and family households
- ✓ 25 – 100% of homeless unaccompanied youth

Assumptions of Need for Homeless Individuals (subset of above)

- ✓ 75 – 100% Homeless Adults 55+
- ✓ 5 – 95% Homeless Veterans
- ✓ 50 – 95% Homeless Individuals with SMI
  - 75 – 100% of Homeless Individuals with a primary SMI diagnosis and co-occurring SUD
- ✓ 50 – 95% Homeless Individuals with SUD
  - 50 – 100% of Homeless Individuals with a primary SUD diagnosis and co-occurring SMI

[13] The Housing Inventory Count (HIC) is a point-in-time inventory of provider programs within a Continuum of Care that provide beds and units dedicated to serve persons who are homeless, categorized by five Program Types: Emergency Shelter; Transitional Housing; Rapid Re-housing; Safe Haven; and Permanent Supportive Housing.

- ✓ 75 – 100% Homeless Individuals with HIV/AIDS
    - 90 – 100% of HIV+ Homeless Individuals with a co-occurring SMI
    - 75 – 100% of HIV+ Homeless Individuals with a co-occurring SUD
- ✓ 75 – 100% Homeless Health Home Enrollees
- ✓ 98 – 100% Homeless Transition Age Youth

Homeless Adults

As it pertained to *chronically homeless* single adults and groups of adults with no minor children, Advisory Group members reasoned that a majority suffered from multiple disabilities - mostly SMI and SUD - and members were liberal with their assumptions of need, generally ranging between 95% - 100%. Recommendations for *non-chronic adult households* did vary among communities as detailed below.

- Monroe County was on the conservative end of that range believing that there is a portion of their chronic adult population (approximately 5%) that does not need supportive housing because they do not to have any behavioral health issues, but rather physical disabilities that are compounded by a loss of income or poverty that serve as their main barrier. The Monroe County Advisory Group believed that this small cohort can be re-housed relatively quickly once they are stabilized in housing, and can obtain steady benefits or employment.
- Onondaga County had the lowest assumed need for supportive housing for its *non-chronic adult households* (10%). According to the Advisory Group members, Onondaga does not have a large population of non-chronic individuals with disabilities or long shelter stays. Many of the adults and families that enter the homeless system are able to take advantage of transitional, vocational and other short-term programs that provide initial support to help them stabilize and exit homelessness without needing the ongoing, permanent services attached to supportive housing. For this reason, an estimate of *10% of non-chronic adults* and *15% of non-chronic families* needing supportive housing seemed reasonable to the community advisory group.
- Westchester County had a relatively high percentage of assumed supportive housing need for their *non-chronic adult homeless household*s. At 35% for *non-chronic adult households*, the County asserted their success in identifying, engaging and getting homeless individuals and families off the street, despite having the highest homeless per capita population in the Hudson Valley region (n=2,054). This includes success with finding and engaging some of the hardest to reach individuals. As a result, they contend, many of the individuals in the homeless system have very high needs and are appropriate candidates for supportive housing, even if they do not meet the HUD chronically homeless definition. In addition, the Advisory Group stated that incomplete reporting from shelters in Westchester, combined with the characteristics of the population in the shelters that did not report into the AHAR, resulted in a significant undercounting of homeless individuals in the community, particularly those in need of supportive housing.
- Advisory Group members in Monroe County believe that between 15-20% of their *non-chronic adult household* need supportive housing because many of these individuals are impacted by multiple systems (i.e., jails, mental health treatment facilities) that start them off in a transitional housing situation and provide them with key life skills (e.g. budgeting, parenting), but once those temporary programs are

ended these services are still needed. Without these supports, they are likely to re-enter a public crisis system. Monroe County does not yet practice Housing First (low-barrier, quick access to permanent housing with a harm reduction service delivery approach), so they witness a significant pipeline of individuals moving from transitional programs into permanent supportive housing. They noted that a vast majority of the non-chronically homeless individuals are utilizing rapid-rehousing, but contend that six months of wrap-around services for some is insufficient. Rapid re-housing is seen by the community as an effective model for individuals who require a "lighter touch".

- Similar to Monroe and Westchester County, Advisory Group members from Long Island and New York City contended that many of their *non-chronic homeless individuals* do not technically meet the chronic definitions because they have not been clinically diagnosed with Axis I conditions or are touching multiple systems (e.g. jails/ treatment programs) and are therefore hard to track. Representatives from Family Services League, a Suffolk County-based homeless shelter serving 60 homeless adults each night, noted that the number of "diagnosed" disabled people is very low compared to undiagnosed people. "Physical disabilities are easier to diagnose, but behavioral health conditions (SUD+ MI) - (Axis I) can be very difficult. They have the homeless history but not the diagnosed disability to define them as 'chronic'."

Homeless Families

While a majority of supportive housing research has focused on outcomes among homeless single adults with disabling conditions, there is a growing body of evidence showing that supportive housing is a promising intervention for many families with long histories of homelessness who face multiple obstacles to stability and self-sufficiency.[14] More often than not, families experience short, episodic periods of homelessness that can be addressed with more affordable housing options and a housing subsidy. For these families, interventions like rapid re-housing have become an effective tool in responding to homelessness. Some families, however, face more serious challenges to housing stability and require more long-term and flexible supports.

Long Island and several other communities noted that family homelessness is often the result of poor economic conditions more so than disabilities, whereas single adults tend to be homeless due to their disabilities. Long Island Advisory Group members noted that a lot of families are not categorically chronic, however the head of household has a significant behavioral health challenge and is unable to stabilize on his or her own.

Homeless Youth

Nearly all selected communities believed that homeless youth under the age of 18 need supportive housing; however, they recognize that the supportive housing for youth is different than the traditional model for adults and families in that it is not necessarily "permanent". Advisory members could not help but think of themselves when they were between the ages of 16 - 18 and their inability to live independently. Members also recognized the significant trauma and other adverse events these youth have experienced including involvement in the child welfare system and overall unstable upbringing.

[14] Ellen L. Bassuk et al., Family Permanent Supportive Housing: Preliminary Research on Family Characteristics, Program Models, and Outcomes, (Corporation for Supportive Housing, February 2006).

Onondaga was the outlier community with the lowest percentage of estimated need for supportive housing for this population. According to Advisory Group members, the number of homeless unaccompanied youth in Onondaga who enter the shelter system but leave quickly to return to families is high, and the number of those that stay in the shelter system for a long period is extremely low. In addition, the community has seen that many youth that are not able to return to families do well with transitional housing. This combination of factors means that the percentage of unaccompanied youth for whom supportive housing is the best intervention is lower in this community than in the others.

Throughout the State, availability of supportive housing units for this population is limited. While family reunification is the goal, if it is not feasible then communities try to place the youth with an adult caregiver. If placement with a caregiver is not feasible, communities contend that supportive housing is the next best intervention. When all ideal options – including supportive housing – are exhausted, as a last resort youth are provided with public assistance to live on their own. Monroe County noted that they try to limit how many youth live alone on public assistance as much as possible but there simply are not enough supportive housing units available.

Nursing Home Population

Several of the communities were hesitant about making assumptions on supportive housing need for the select nursing home population for which data was provided by the State because they did not have sufficient knowledge of group and stated that further analysis of this population's needs is important. CSH obtained data from the NYS Department of Health's Office of Health Systems Management on current nursing home residents deemed as high functioning with "low" Resource Utilization Group (RUG) scores that express interest in living outside of the nursing facility. Many Advisory Group members were unfamiliar with this population; whereas others were awardees of the Nursing Home Transition and Diversion (NHTD)[15] program but were unclear of the relationship between the NHTD program and this selected sub-population. As a result the estimated need for supportive housing for this sub-population varied greatly (0% - 100%). With the exception of New York City, the assumed need percentage applied was often inconsequential because of the very small cohort of individuals being analyzed per community (between 4 – 20 individuals per community outside NYC and 298 in NYC). Advisory Group members in New York City agreed that supportive housing can be an effective alternative to premature placement into nursing homes, but felt that not all those individuals exiting nursing homes who are able to live in community would require the intensive level of supports provided in supportive housing. They noted that medication management was the biggest challenge for this population and that for some individuals, market-rate or affordable housing with routine home health services may be most appropriate option.

[15] The NHTD waiver program targets individuals between the age of 18-64 that have a physical disability or who are 65 or older and require nursing home level of care but may be successfully served and included in their surrounding communities. The individual is the primary decision-maker and works in cooperation with care providers to develop a plan of services that promotes personal independence, greater community inclusion, self-reliance and participation in meaningful activities and services. More information available at the MRT Managed Long-term Care page: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

Monroe County Advisory Group members expressed apprehension in terms of supportive housing need for this cohort because they felt there may be some significant challenges to independent living and that perhaps supportive housing is not the right intervention. Advisory Group members participating in the NHTD waiver program noted no current waiting list for this population and some interpreted this as low need, whereas others noted administrative barriers preventing successful transitions into the community. Advisory Group members in Long Island stated that there is likely a sizeable segment of this population with mental illness or developmental disabilities that were likely prematurely placed into nursing homes initially from hospitals as there were no safe alternative options and acknowledge that many do not belong in institutional settings, and can successfully live in community with the appropriate community supports. Another challenge identified by Long Island for this population is the potential infringement of the privacy for those who share housing with this nursing home population. The use of the shared housing model is quite prevalent in Long Island, and some of the formerly institutionalized individuals who transition into the community may require 24-hour at-home supportive services, which could negatively impact the privacy and livelihood of those they share a home with. Based on these challenges and the uncertainty around levels of care needed for this group, the Long Island Advisory Group members were unable to provide an estimated assumed supportive housing need for this group.

Older Homeless Adults

Advisory Group members from communities across the state believe that a significant proportion of homeless adults 55+ need supportive housing (average 83% assumed need). New York City Advisory Group members affirmed the severity of physical and emotional trauma and impact of homelessness for individuals 55+, and noted that their needs are acute when coming out of transient situations. Some will stabilize relatively quickly and after a year or so, may be able to move on to completely independent housing, but initially a majority will need a supportive setting that is more comprehensive than service-enhanced senior housing. They saw this sub-population falling into 3 groups: 1) those who initially need traditional, permanent supportive housing, but who stabilize rather quickly and after a year or two may be able to move on to even more independent housing; 2) those who will do well in permanent supportive housing but will always need this level of support; and 3) those who actually have more intense mental health needs and will require more intensive supports (e.g. OMH level 2 transitional housing).

Onondaga County cited the county's growing aging population trend that is likely to continue. The Advisory Group felt that supportive housing will play an increasingly important role in meeting the needs of this population. Increasingly, the average median age of chronically homeless adults is growing; the average age of chronic individuals is close to 50[16]. Aging in trend in chronically homeless is expected to increase with the last of the "Baby Boomer generation" – those born between 1946 and 1964 – turning 50 in 2014, and as they continue to mature, the demand for aging services will increase. By 2030, at least 1 in 5 individuals in New York City will be over the age of 60.[17] Older homeless adults often have mobility challenges and need accessible housing, which is not always available in the community when people use programs such as rapid rehousing. In addition, supportive housing provides flexibility and autonomy, which are valued by the generation that is currently aging into this group (55+).

[16] Several research studies published between 2004 to 2006 documented the increasing age of chronically homeless individuals and/or homeless individuals in shelters. The average age at that time was mid-to-late 40's and had been steadily increasing over the prior 10-15 years. This research is summarized in a paper by Caton, Wilkins, and Anderson "People Who Experience Long-Term Homelessness: Characteristics and Interventions" which was prepared for the 2007 HUD/HHS National Symposium on Homelessness Research

[17] *U.S. Census Bureau. 2010 Census.*

HIV/AIDS

For people living with HIV/AIDS (PLWHA), many communities cited the limitations in existing housing programs that serve as barriers for individuals accessing housing. For example, Options for Community Living, Long Island's largest HIV provider, noted that for a majority of the housing programs, an individual must be homeless or inappropriately housed to be eligible. The challenge over many decades with this particular sub-population has been the inability of shelters and other homeless systems to capture an individual's status: either the individual is not being asked, not disclosing or unaware of their HIV status. A lot of individuals do not know their status, creating a limitation with current programs that require that they know their status and have sought treatment for it. In order to meet the supportive housing needs of people living with HIV/AIDS (PLWHA), flexibility in admissions criteria is needed in order to effectively respond to their housing needs. In addition, the fact that homeless systems struggle to capture the HIV/AIDS status of individuals leads to significant undercounting of this population. Many Advisory Groups recognized that although there are likely far more people living with HIV/AIDS in their communities than any of the available data sources suggest, the challenges around capturing this information leave them unable to provide an accurate count. CSH initially obtained data on homeless HIV+ individuals captured in NYS DOH AIDS Institute 2013 AIDS Institute Reporting System (AIRS). The data provided included the total number of unique HIV+ clients served by an AIDS Institute contracted service providers by county of residence and, of that number, the number and percent of self-reported homeless HIV+ clients served by county of residence. The AIRS data is limited in that it does not include all HIV service providers in NYS – only service providers that are grant funded through the AIDS Institute who are required to submit data through AIRS. As a result, CSH only included homeless HIV+ data in the sub-population chart when the community was able to provide this data (e.g. Onondaga, New York City). CSH did not include the data provided by AIRS in the sub-population chart as those numbers do not reflect an accurate count of this sub-population by community.

Homeless Health Home Enrollees

CSH analyzed 2013 data from NYS DOH Health Homes that includes the number of Health Home members that were enrolled and completed a FACT –GP[18]/ Health Home Functional Assessment self-reported as homeless. In 2013, the median percentage of homeless Health Home enrolled members was 19.21%, in NYC and 10% rest-of-state (not including NYC). In 2013, through a project funded by NYSHealth, CSH partnered with NYS agencies on a series of statewide trainings targeted to Health Home care coordinators and "downstream providers" on supportive housing and Health Home integration. A pre-test assessing the housing needs and challenges Health Home representative face found that respondents (n=177) noted affordability (63%) and availability (54%) of supportive housing as the greatest challenges for their homeless clients. Given the vulnerability of Health Home enrollees[19], Advisory Group members affirmed that housing continues to be a challenge for their homeless clients and overwhelmingly they noted that supportive housing was the most effective intervention for this vulnerable

[18] The Functional Assessment of Cancer Therapy-General Population (FACT-GP) and Health Home Functional Assessment is the comprehensive assessment administered in an interview format during Health Home enrollment,

[19] To be eligible for Health Home, an individual must be a Medicaid recipient and have two chronic conditions or one single qualifying condition of HIV/AIDS or Serious Mental Illness (SMI)

sub-population. Advisory Group members in Long Island noted that this sub-population, once placed in supportive housing, are maintaining their housing and are participating in services at higher rates.

Transition Age Youth Discharged From Foster Care

CSH examined transition age youth (ages 18-24) who have "aged out" of the foster care system and, specifically, those who were discharged to "self", "shelter" and/or "institution" such as (jail, prison, psychiatric center). Nearly all communities noted that although those aging out of the foster care system should not be discharged to shelter, it does happen. In NYC CSH examined data provided by the Department of Homeless Services of 18-24 year-old individuals who were discharged from the foster care system at any point between 2004 and 2013 and entered shelter in 2013. Of the 451, CSH identified that 10% (n=47) were discharged from foster care and entered shelter in the same year, 2% (n=7) within the same month. Onondaga Advisory Group members acknowledged the instability for this highly vulnerable group – once they are discharged to self at age 18, they try to "go at it on their own", often in very tenuous living situations, such as staying with friends. The Advisory Group added that after they have been on their own for a while, a significant proportion require assistance with housing.

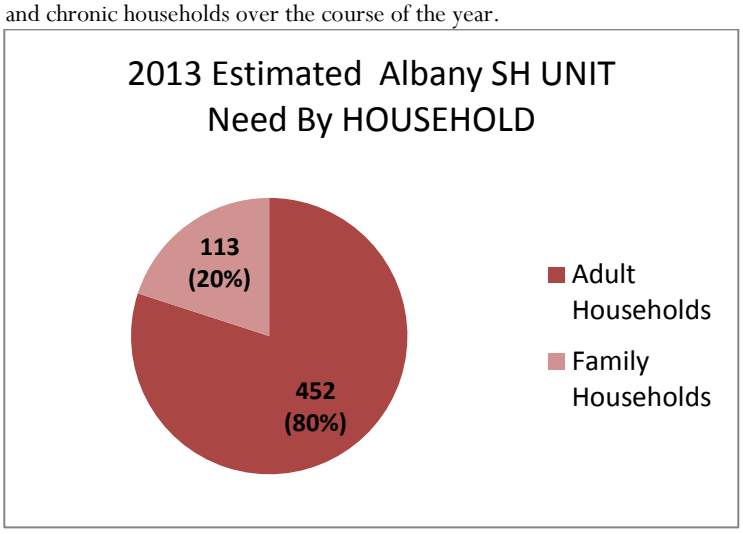
Estimated Population and Unit Needs Charts for Target Communities

The following series of charts highlight the data and assumptions for Estimated Supportive Housing HOUSEHOLD Need and Estimated Supportive Housing UNIT Need for each of the Target Communities:

Capital District

Estimating Population Need for Supportive Housing, Albany (2013)				
County/COC: Albany COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households)*				
Homeless Adult(s)				
Chronic Adults	80	216	100%	216
Non-chronic Adults	345	726	35%	255
Nursing Home Population	N/A	1	40%	1
Homeless Unaccompanied Youth	18	127	75%	96
Total Homeless Adult + Nursing Home Households	**443**	**1,070**	**----**	**472**
Homeless Families w/ Children				
Chronic Families	7	16	100%	16
Non-chronic Families	87	380	30%	114
Total Homeless Family Households	**94**	**396**	**----**	**130**

* Data provided for homeless households were derived from PiT Count and the AHAR and CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year.



Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	Estimated SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	130	123	15	.85%	17	**113**
Adult(s) and Unaccompanied Youth	472	431	14	1.19%	20	**452**
Total SH units needed						**565**

Homeless Sub-Population (subset of Households) Data contains significant overlap across sub-populations**		
County/COC: Albany COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55) [1]	302	80%
Homeless Veterans [2]	233	75%
Homeless Adults with Mental Illness (MI) [3]	130	90%
Adults with co-occurring SUD [4]	54	100%
Homeless Adults with Substance Use Disorder (SUD)[5]	763	55%
Adults with Co-occurring MI [6]	328	75%
Homeless Adults with HIV/AIDS	N/A	100%
Adults with Co-occurring MI	N/A	100%
Adults with Co-occurring SUD	N/A	100%
Homeless Health Home Enrollees [7]	94	100%

** Sub-population data derived from state agencies: mental illness (OMH), substance use disorder (OASAS), Health Home Enrollees (DOH)

[1] 55+ homeless adult data provided by the Capital City Rescue Mission of Albany. This number is an approximation of the total number of clients served in 2013, of which one-third of their clients are 55+. CSH applied this approximation to Albany's total persons in emergency shelter and transitional housing in 2013 (AHAR).

[2.] Veteran data provided by the Capital City Rescue Mission of Albany.

[3] Refers to homeless individuals captured in OMH's 2013 Patient Characteristics Survey. These data include duplicates.

[4] Assumes 41.6% of homeless adults with MI (that have sought treatment for it) have a co-occurring substance use disorder (SUD), based on rates of co-occurrence in OMH-served population.

[5] Refers to homeless individuals captured in OASAS's Client Data System which tracks the frequency of individuals admitted into OASAS treatment facilities. These data include duplicates.

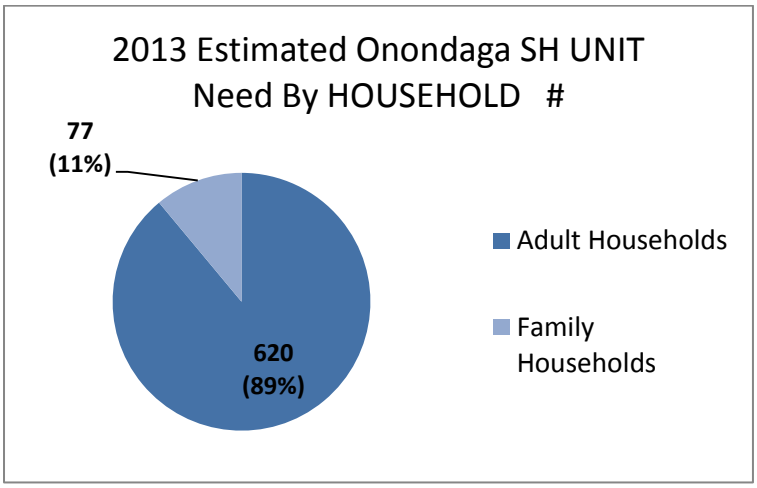
[6] Assumes 43% of homeless adults with SUD (that have sought treatment for it) have a co-occurring MI (based on national averages cited by SAMHSA).

[7] Includes total # of enrolled homeless Health Home members from the one Health Home (Capital Region Health Connections) serving both Albany and Rensselaer Counties.

Central NY

Estimating Population Need for Supportive Housing, Onondaga (2013)				
County/COC: Onondaga COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households) *				
Homeless Adult(s)				
Chronic Adults	68	423	95%	402
Non-chronic Adults	548	2,775	10%	278
Nursing Home Population	N/A	5	100%	5
Homeless Unaccompanied Youth	32	262	35%	92
Total Homeless Adult + Nursing Home Households	**648**	**3,465**	**----**	**777**
Homeless Families				
Chronic Families	1	12	100%	12
Non-chronic Families	66	650	15%	98
Total Homeless Family Households	**67**	**662**	**----**	**110**

* Data provided for homeless households were derived from the 2013 PiT and AHAR reports. CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year.



Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	110	140	26	5%	33	**77**
Adult(s) and Unaccompanied Youth	777	870	0	18%	157	**620**
Total SH units needed						**697**

Homeless Sub-Population (subset of Households) Data contains significant overlap across sub-populations		
County/COC: Onondaga COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55) [1]	418	80%
Homeless Veterans [2]	234	5%
Homeless Adults with Mental Illness (MI)	1,139	90%
Adults with co-occurring SUD [3]	854	95%
Homeless Adults with Substance Use Disorder (SUD)	1,221	50%
Adults with Co-occurring MI [4]	525	95%
Homeless Adults with HIV/AIDS[5]	92	90%
Adults with Co-occurring MI[6]	50	100%
Adults with Co-occurring SUD[7]	64	100%
Homeless Health Home Enrollees[8]	96	95%
Homeless Youth Discharged from Foster Care[9]	30	98%

[1]Data provided by community's HMIS lead

[2] Data provided by community's HMIS lead

[3] Assumes 75% of homeless adults with MI (that have sought treatment for it) have a co-occurring SUD, based on report of co-occurrence seen from Single Point of Access (SPOA) Coordinator.

[4]Assumes 43% of homeless adults with SUD (that have sought treatment for it) have a co-occurring MI (based on national averages cited by SAMHSA).

[5]Number taken from service records of the two service providers in the community that provide HIV/AIDS services; because of confidentiality concerns the organizations could not share data to determine if there were shared clients, so this figure may include some duplication

[6]Assumes 55% of individuals with HIV/AIDS had a co-occurring mental illness, based on 2014 prevalence rates given by a local provider

[7]Assumes 69% of individuals with HIV/AIDS had a co-occurring substance use disorder, based on 2014 prevalence rates given by a local provider

[8]Data for Onondaga-specific homeless enrolled Health Home members (St. Joseph's Care Coordination Network) provided by the Advisory Board

[9]Data provided by the Onondaga County Department of Children & Family Services

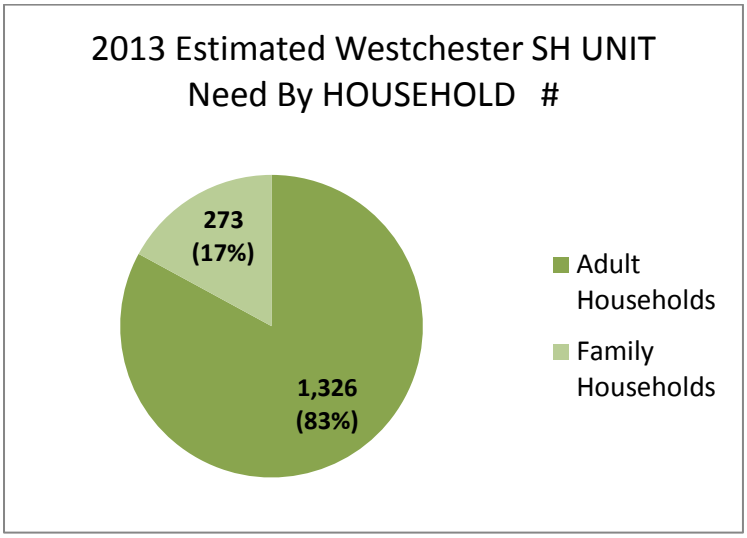
Hudson Valley Region

Estimating Population Need for Supportive Housing, Westchester (2013)

County/COC: Westchester COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households)*				
Homeless Adult(s)				
Chronic Adults	225	930	100%	930
Non-chronic Adults	473	1,491	35%	522
Nursing Home Population	N/A	13	100%	13
Homeless Unaccompanied Youth[1]	10	20	100%	20
Total Homeless Adult + Nursing Home Households	**708**	**2,454**	----	**1,465**
Homeless Families				
Chronic Families	69	117	100%	117
Non-chronic Families	370	614	30%	184
Total Homeless Family Households	**439**	**731**	----	**301**

* Data provided for homeless households were derived from PiT Count and the AHAR and CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year. AHAR data for Emergency Shelter was unavailable for 2013 because providers were not reporting into the HMIS system at that point, so the Households over Course of a Year numbers for this community use AHAR data for Emergency Shelter from 10/1/2014 – 5/31/2015 (8 months) multiplied by 1.5 to account for the missing 4 months of data, AHAR data for Transitional Housing from 2013 and an annualized estimate of unsheltered numbers based on the Point in Time count.

[1]Homeless Unaccompanied Youth households over the course of a year calculated by adding unaccompanied number from 8 mos. ES AHAR multiplied by 1.5 to account for the extra 4 months, the unaccompanied youth # in TH number from the AHAR plus the annualized unsheltered PIT count.



Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	301	257	1	10.50%	28	**273**
Adult(s) and Unaccompanied Youth	1,465	882	41	11.00%	139	**1,326**
Total SH units needed						**1,599**

Homeless Sub-Population (subset of Households)** Data contains significant overlap across sub-populations		
County/COC: Westchester COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55) [1]	290	90%
Homeless Veterans [2]	271	95%
Homeless Adults with Mental Illness (MI) [3]	611	90%
Adults with co-occurring SUD [4]	254	100%
Homeless Adults with Substance Use Disorder (SUD) [5]	1113	85%
Adults with Co-occurring MI [6]	467	100%
Homeless Adults with HIV/AIDS	N/A	90%
Adults with Co-occurring MI	N/A	90%
Adults with Co-occurring SUD	N/A	90%

Homeless Health Home Enrollees [7]	291	95%
Homeless Youth Discharged from Foster Care [8]	59	100%

[1] Homeless Adults 55+ data was provided by Westchester Dept. of Social Services (DSS) and includes a unique count of all people aged 55+ who were sent to county-funded 24-hour shelters in 2013.
[2] Homeless Veterans taken from AHAR data set.
[3] Refers to homeless individuals captured in OMH's 2013 Patient Characteristics Survey. These data include duplicates.
[4] Assumes 41.6% of homeless adults with MI (that have sought treatment for it) have a co-occurring SUD, based on rates of co-occurrence in OMH-served population.
[5] Refers to homeless individuals captured in OASAS's Client Data System which tracks the frequency of individuals admitted into OASAS treatment facilities. These data include duplicates.
[6] Assumes 43% of homeless adults with SUD (that have sought treatment for it) have a co-occurring MI (based on national averages cited by SAMHSA).
[7] Includes total # of enrolled homeless Health Home members from Columbia, Dutchess, Green, Orange, Putnam, Rockland, Suffolk, Sullivan and Westchester .
[8] Westchester had 59 youth aged 17-21 who were discharged from foster care in 2013 with a placement category of "aged out" or "discharged to self".

Long Island

Estimating Population Need for Supportive Housing, Long Island (2013)				
County/COC: Long Island COC	**Number in Point-in-Time**	**Households over Course of a Year**	**Assumptions for Households Needing SH**	
			%	**#**
Homeless Population (Households)				
Homeless Adult(s)				
Chronic Adults	131	303	100%	303
Non-chronic Adults	878	2,113	25%	529
Nursing Home Population	N/A	19	N/A	N/A
Homeless Unaccompanied Youth	3	108	100%	108
Total Homeless Adult + Nursing Home Households	**1,012**	**2,543**	**----**	**940**
Homeless Families				
Chronic Families	106	195	100%	195
Non-chronic Families	550	1,239	35%	434
Total Homeless Family Households	**656**	**1,434**	**----**	**629**

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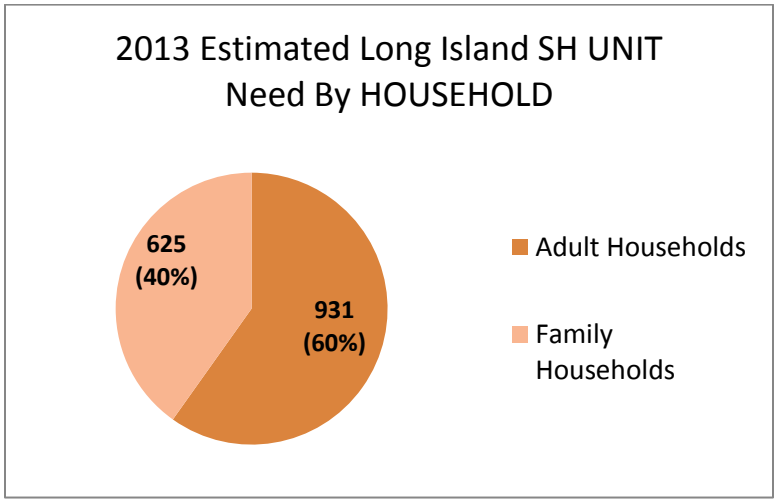


Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families	629	361	0	1.00%	4	**625**
Adult(s) and Unaccompanied Youth	940	899	0	1.00%	9	**931**
Total SH units needed						**1,556**

Homeless Sub-Population (subset of Households) Data contains significant overlap across sub-populations		
County/COC: Long Island COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55)[1]	397	75%
Homeless Veterans[2]	402	95%
Homeless Adults with Mental Illness (MI)[3]	721	95%
Adults with co-occurring SUD[4]	300	100%
Homeless Adults with Substance Use Disorder (SUD)[5]	2,649	95%
Adults with Co-occurring MI[6]	1,139	100%
Homeless Adults with HIV/AIDS	N/A	100%
Adults with Co-occurring MI	N/A	100%
Adults with Co-occurring SUD	N/A	100%

Homeless Health Home Enrollees [7]	397	75%

[1] 55+ data obtained by LI Coalition for the Homeless
[2] 2013 AHAR (Islip & Nassau & Suffolk reports).
[3] Refers to homeless individuals captured in OMH's 2013 Patient Characteristics Survey. These data include duplicates.
[4]Assumes 41.6% of homeless adults with MI (that have sought treatment for it) have a co-occurring SUD, based on rates of co-occurrence in OMH-served population.
[5] Refers to homeless individuals captured in OASAS's Client Data System which tracks the frequency of individuals admitted into OASAS treatment facilities. These data include duplicates.
[6] Assumes 43% of homeless adults with SUD (that have sought treatment for it) have a co-occurring MI (based on national averages cited by SAMHSA).
[7] Includes all homeless Health Home members enrolled in the FEGS Health and North Shore University Hospital (n=397).

North Country

Estimating Population Need for Supportive Housing, Saratoga (2013- 2014)

County/COC: Saratoga COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households) *				
Homeless Adult(s)	167	793		
Chronic Adults	37	137	100%	137
Non-chronic Adults	130	656	40%	263
Nursing Home Population	N/A	4	100%	4
Homeless Unaccompanied Youth	18	185	80%	148
Total Homeless Adult + Nursing Home Households	167	**797**	**----**	**400**
Homeless Families**	33	N/A	N/A	N/A
Chronic Families	9	N/A	N/A	N/A
Non-chronic Families	24	N/A	N/A	N/A
Total Homeless Family Households	**33**	**N/A**	**----**	**N/A**

* Data provided for homeless households were derived from the 2014 PiT and the AHAR reports. CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year.
Per the communities request, CSH utilized 2014 data because less than 50% of the providers reported into the HMIS in 2013 for the AHAR (as required by HUD).
** According to the community Advisory Group, there are no family shelters in this 4-county CoC.

Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	No shelters to estimate need	21	5	1.00%	6	**N/A**
Adult(s) and Unaccompanied Youth	400	83	4	1.00%	5	**395**
Total SH units needed						**395**

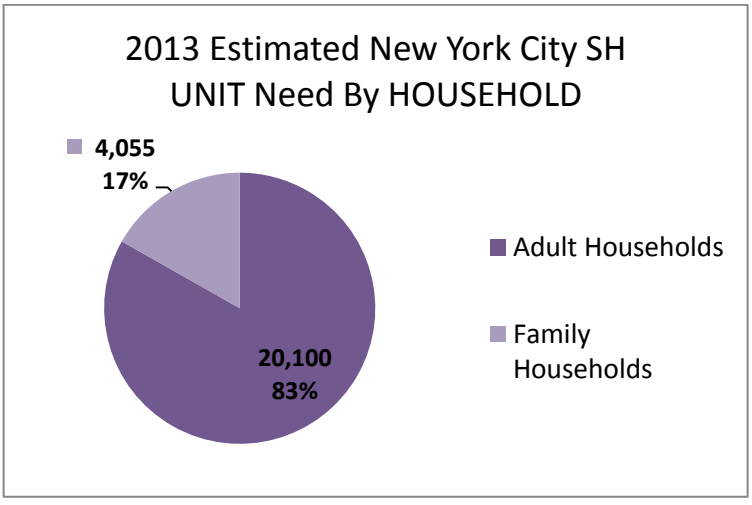
Homeless Sub-Population (subset of Households) Data contains significant overlap across sub-populations		
County/COC: Saratoga COC	**Individuals in 2014**	**Assumptions for % Needing SH**
Homeless Older Adults (>51) [1]	196	100%

[1] 51+ data derived from extrapolated AHAR. According to the 2014 AHAR 16% (143) of individuals in ES (899) were between the ages of 51-61, 2% (18) were 62 and older. Of those single individuals in transitional programs (60), 50% (30) were between the ages of 51 - 61 and 8% (5) were 62 and older for a total of 196 that were 51 and older.

New York City

Estimating Population Need for Supportive Housing, NYC (2013)				
County/COC: NYC COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households)*				
Homeless Adult(s)				
Chronic Adults	2,839	6,230	98%	6,106
Non-chronic Adults	19,454	50,116	30%	15,035
Nursing Home Population	N/A	298	98%	293
Homeless Unaccompanied Youth	12	2,056	100%	2,056
Total Homeless Adult + Nursing Home Households	**22,305**	**58,700**	-----	**23,490**
Homeless Families				
Chronic Families	438	1,070	98%	1,049
Non-chronic Families	11,078	20,811	16%	3,328
Total Homeless Family Households	**11,516**	**21,881**	-----	**4,377**

* Data provided for homeless households were derived from PiT Count and the AHAR (via DHS) and CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year.



Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	4,377	1,519	246	5.00%	322	**4,055**
Adult(s) and Unaccompanied Youth	23,490	15,117	1,878	10.00%	3,390	**20,100**
Total SH units needed						**24,155**

Homeless Sub-Population (subset of Households)** Data contains significant overlap across sub-populations		
County/COC: NYC COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55)	5,904	80%
Homeless Veterans	2,566	18%
Homeless Adults with Mental Illness (MI)[1]	5,990	90%
Adults with co-occurring SUD[2]	2,492	100%
Homeless Adults with Substance Use Disorder (SUD)[3]	32,755	75%
Adults with Co-occurring MI[4]	14,085	100%
Homeless Adults with HIV/AIDS[5]	4,597	75%
Adults with Co-occurring MI	657	100%
Adults with Co-occurring SUD	1,218	75%
Homeless Health Home Enrollees[6]	4,550	100%
Homeless Youth Discharged from Foster Care[7]	451	100%

** Sub-population data derived from DHS, HRA (HASA), and DOH.

[1] Refers to homeless individuals captured in OMH's 2013 Patient Characteristics Survey. These data include duplicates.

[2] Assumes 41.6% of homeless adults with MI (that have sought treatment for it) have a co-occurring SUD, based on rates of co-occurrence in OMH-served population.

[3] Refers to homeless individuals captured in OASAS's Client Data System which tracks the frequency of individuals admitted into OASAS treatment facilities. These data include duplicates.

[4] Assumes 43% of homeless adults with SUD (that have sought treatment for it) have a co-occurring MI (based on national averages cited by SAMHSA).

[5] HASA provided the total unique cases placed in Emergency Housing (Commercial SRO and Transitional Housing) in CY 2013 as well as the total unique cases that were considered ""SA treatment needed"" and answered yes to the question ""Do you suspect, observe or know of any mental health issues?"".

[6] Includes total # of enrolled homeless Health Home members from all 10 Health Homes serving all of NYC (all 5 boroughs).

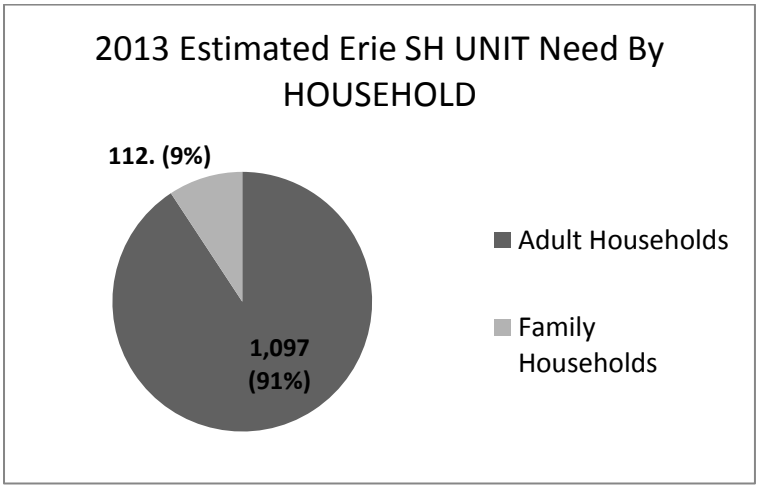
[7] Data provided by DHS that includes by borough, the number of young adults 18-24 who were discharged from the foster care system at any point between 2004 – 2013and entered shelter in 2013 by borough of previous residence.

Western NY

Erie County

Estimating Population Need for Supportive Housing, Erie (2013)				
County/COC: Erie COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households)*				
Homeless Adult(s)				
Chronic Adults	139	493	98%	484
Non-chronic Adults	590	1,913	30%	574
Nursing Home Population	N/A	2	0%	0
Homeless Unaccompanied Youth	18	199	25%	50
Total Homeless Adult + Nursing Home Households	**747**	**2,607**	**----**	**1,108**
Homeless Families				
Chronic Families	2	11	95%	11
Non-chronic Families	95	411	25%	103
Total Homeless Family Households	**97**	**422**	**----**	**114**

* Data provided for homeless households were derived from PiT Count and the AHAR and CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year.
While Niagara County CoC merged with Erie CoC in July 2013, Niagara County data was only available from July – September 2013. PiT data used is for only Erie but some data from Niagara is included in the AHAR reported numbers.



Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	114	82	0	1.3%	2	**112**
Adult(s) and Unaccompanied Youth	1,108	872	0	1.2%	11	**1,097**
Total SH units needed						**1.209**

Homeless Sub-Population (subset of Households) ** Data contains significant overlap across sub-populations		
County/COC: Erie COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55) [1]	403	75%
Homeless Veterans [2]	257	50%
Homeless Adults with Mental Illness (MI) [3]	1,127	50%
Adults with co-occurring SUD [4]	340	75%
Homeless Adults with Substance Use Disorder (SUD) [5]	943	50%
Adults with Co-occurring MI [6]	340	75%
Homeless Adults with HIV/AIDS [7]	11	100%
Adults with Co-occurring MI [8]	7	100%
Adults with Co-occurring SUD	0	100%
Homeless Health Home Enrollees [9]	274	95%
Homeless Youth Discharged from Foster Care [10]	0	0%

** Sub-population data derived from the following sources: mental illness (OMH), substance use disorder (OASAS), Health Home Enrollees (DOH) .

[1] Homeless adults 55+ data provided by the Homeless Alliance of WNY.

[2] Ibid.

[3] Data source OMH admissions data in 2013.

[4] Co-occurring data provided by the Homeless Alliance of WNY.

[5] Data provided by the Homeless Alliance of WNY.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Includes total # of enrolled Health Home members from the 2 Health Homes (Greater Buffalo United IPA and HHUNY Western ADDS) serving exclusively Erie County in 2013.

10 Data provided by the Homeless Alliance of WNY.

Monroe County

Estimating Population Need for Supportive Housing, Monroe (2013)				
County/COC: Monroe COC	Number in Point-in-Time	Households over Course of a Year	Assumptions for Households Needing SH	
			%	#
Homeless Population (Households)*				
Homeless Adult(s)				
Chronic Adults	63	487	95%	463
Non-chronic Adults	322	2,891	18%	521
Nursing Home Population	N/A	6	96%	6
Homeless Unaccompanied Youth	28	401	100%	401
Total Homeless Adult + Nursing Home Households	**413**	**3,785**	**----**	**1,391**
Homeless Families				
Chronic Families	28	53	75%	40
Non-chronic Families	141	944	16%	152
Total Homeless Family Households	**169**	**997**	**----**	**192**

* Data provided for homeless households were derived from PiT Count and the AHAR and CSH used its multiplier/ratio tool to annualize both the unsheltered and chronic households over the course of the year.

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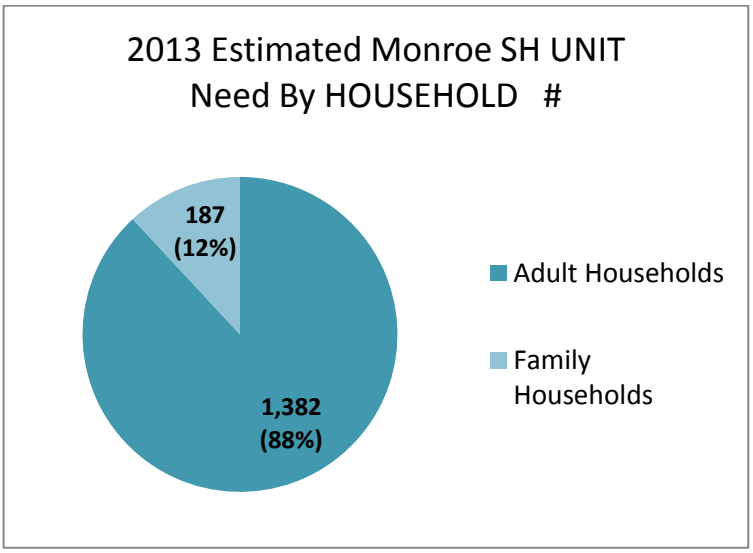


Household Unit Type	Estimating Supportive Housing (SH) Units Needed in the Community					
	Estimated Households Benefiting from SH	Estimated Existing SH Units	Estimated SH Unit Pipeline	Annual Estimated Turnover Rate	SH Units Available in 2013	Estimated SH Units Needed
Families w/ Children	192	467	0	1.06%	5	**187**
Adult(s) and Unaccompanied Youth	1,391	762	0	1.11%	9	**1,382**
Total SH units needed						**1,569**

Homeless Sub-Population (subset of Households)** Data contains significant overlap across sub-populations		
County/COC: Monroe COC	**Individuals in 2013**	**Assumptions for % Needing SH**
Homeless Older Adults (>55) [1]	225	85%
Homeless Veterans	342	85%
Homeless Adults with Mental Illness (MI)[2]	513	95%
Adults with co-occurring SUD[3]	213	100%
Homeless Adults with Substance Use Disorder (SUD)[4]	1,099	80%
Adults with Co-occurring MI[5]	473	100%
Homeless Adults with HIV/AIDS	N/A	N/A
Homeless Health Home Enrollees[6]	40	100%
Homeless Youth Discharged from Foster Care[7]	19	100%

** Sub-population data derived from the following sources: mental illness (OMH), substance use disorder (OASAS), Health Home Enrollees (DOH).

[1] 55+ data provided by HMIS Lead of the CoC.

[2] Refers to homeless individuals captured in OMH's 2013 Patient Characteristics Survey. These data include duplicates.

[3]Assumes 41.6% of homeless adults with MI (that have sought treatment for it) have a co-occurring SUD, based on rates of co-occurrence in OMH-served population.

[4]Refers to homeless individuals captured in OASAS's Client Data System which tracks the frequency of individuals admitted into OASAS treatment facilities. These data include duplicates

[5]Assumes 43% of homeless adults with SUD (that have sought treatment for it) have a co-occurring MI (based on national averages cited by SAMHSA).

[6]Includes all homeless Health Home members enrolled in the Greater Rochester Health Home Network Monroe (n=40).

[7]Data provided by the Center for Youth Services Inc. demonstrating that 18 transition age youth (16-21) with previous child welfare involvement entered the Center for Youth transitional program in 2013. Of this number, 9 had a history of Foster Care, 7 had a history of out of home OCFS placement and 2 had a history of failed adoptions. Data provided by the Department of Human Services indicated that 1 transition age youth (18-24) entered jail in 2013.

Limitations

This needs assessment provides the best estimates of supportive housing need in target communities within New York State possible given the disparity of data sources and definitions, and the parameters of the project. To ensure continuity, CSH utilized data from the same year – 2013- across all data sources, with minor exception[20]. Of note was that Advisory Group members from nearly all of the communities have made significant progress in addressing veteran homelessness since 2013. Future needs assessments should capture the impact of the intense local and national focus on ending veteran homelessness, community-wide coordination and an influx of veteran-specific housing resources has had on the need for supportive housing for this population since 2013.

The lack of a common definition for homelessness among different State agencies presented a substantial challenge. Another significant challenge was trying to find a way to conduct a meaningful analysis of homelessness and homeless subpopulations throughout the state using more than 30 different data sources. CSH acknowledges that supportive housing is not just for those experiencing homelessness, but is a successful, permanent intervention for those who are at imminent risk of homelessness, including those exiting institutions, or those who suffer from multiple co-morbid conditions; however, there is no comprehensive system to track unduplicated counts of precariously or unstably individuals in need of supportive housing. The task of quantifying the number of households that fall into a particular homeless subpopulation, such as those with co-occurring mental health and substance use issues, was complicated by the fact that although individuals may touch multiple systems (e.g. OMH and OASAS), unique identifiers of these individuals with co-occurrences are not in place, making an unduplicated count impossible. Currently, agencies collect data on the treatment for which they are billing, and as a result individuals show up in each data set separately. Most significantly, this results in missed opportunities for communities to realize cost-savings that would come from data-matching across systems and targeting of high-cost individuals for supportive housing.

Existing supportive housing units may be dedicated to populations not uniformly characterized under a common homeless definition. Due to the inconsistent definitions discussed above, CSH was limited to assessing supportive housing need and the existing inventory based on HUD-defined homeless individuals and families. In order to complete a true "apples-to-apples" comparison of supply and demand, CSH utilized supportive housing data from the Housing Inventory Count (HIC) to establish existing stock and what units came online (became available) in 2013. Although available in some cases, we could not consistently use other data sources that captured the existing stock of all supportive housing units in 2013, as they included units designated for individuals and families broader than the "homeless" criteria, conflicting with our homeless needs-based analysis. These sources included units dedicated for individuals exiting hospitals; high-utilizers of Medicaid (e.g. MRT units) or OMH supported housing (over 9,000 units in NYC alone). Using data sources other than the HIC would inaccurately demonstrate a greater supply than demand. As a result, the count for existing supportive housing stock and pipeline unit data are limited in that they do not capture the full depth of supportive housing units available. In addition to the HIC unit count, CSH also examined the complete list of supportive housing inventory stock in 2013 (units operating as of end of calendar year 2012) and new units that opened in 2013 through new construction or vouchers in both scatter-site

[20] An exception to the use of 2013 data was 2014 data were used to annualize homeless households in North Country (Saratoga).

and congregate buildings as provided by the Supportive Housing Network of New York (see Appendix C); however, for the reasons outlined above, these data were not used in calculating the total estimated unit need.

CSH Recommendations

This Statewide Supportive Housing Needs Assessment is intended to help position State and local agencies and other decision-makers to make informed, data-driven decisions on future supportive housing allocations. Based on the findings of the needs assessment and lessons learned in the process of completing it, CSH recommends the following:

The State of New York efficiently identify & target resources to address needs of the most vulnerable populations. Given the limited amount of existing and projected supportive housing within communities and growing demand outpacing supply, supportive housing resources should be deployed in a way that targets the most vulnerable populations such as chronically homeless and those who are high-cost utilizers of multiple public systems. Recent studies have shown cost savings and housing stability associated with supportive housing when targeted to the top 10% highest cost homeless adults with mental illness[21]. In order to produce unduplicated counts of homeless individuals utilizing multiple public systems, there needs to be the ability to data-match across systems to identify homeless "frequent flyers" of multiple systems (e.g. emergency departments, hospitals, inpatient detox, psychiatric inpatient stays, shelters etc.) and apply the most appropriate housing intervention. Currently, agencies collect diagnosis-specific data for which they are billing. This piecemeal approach to data collection complicates attempts to identify and target resources to those with the greatest need and serves as a missed opportunity to capture the scope of service need for vulnerable populations as well as the cost-savings associated with a targeted supportive housing intervention. It is essential to work with local communities to identify and prioritize the allocation of available supportive housing units for that portion of the homeless population with need for these long-term supports and services.

The State of New York standardize definitions and data collection. Currently, not all agencies use the same definition of homeless. For example, the data obtained from OMH defines "Homeless persons" as those who are shelter and street homeless, marginally housed (i.e. in adult home) or staying with friends and family and hospitalized in inpatient units. OASAS, an agency that serves a population that has significant overlap with OMH's, defines "Homelessness" as individuals or families who are street or shelter homeless. This difference in definition means that a person served by both agencies may be considered homeless by one but not homeless by the other. To address this issue and provide comprehensive and accurate estimates of need in the future, state and local agencies must work to adopt, at a minimum, a standard definition of homelessness.

The State of New York comprehensively assess to better capture need. Because of the data limitations, CSH recommends that additional target populations for supportive housing be included in future needs assessments and discussions around targeting of supportive housing. Additional populations identified by Advisory Group members as needing supportive housing include:

- The reentry population – individuals with criminal justice histories including juvenile justice

[21] Paula N. Goering, PhD et al. Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness. JAMA, March 2015 DOI: 10.1001/jama.2015.1163

- Survivors of domestic violence
- Individuals in institutions that are able to live in the community and would prefer to do so, including individuals with intellectual and/or developmental disabilities

The State of New York should issue an annual comprehensive assessment of supportive housing need that relies on a whole-person and person-centered approach, encompassing a holistic understanding of the multiple complexities individuals and families face, versus an over-reliance on diagnosis-specific categories of need. To address this issue, CSH recommends the establishment of a New York State clearinghouse agency or unit where uniform and complete data encompassing all populations served by supportive housing are reported and collected to effectively assess supportive housing need on an ongoing basis and make appropriate, data-driven decisions on resource allocation.

It is important that decision-makers consider the findings from this assessment to make appropriate allocations for not only unit household size (family vs. individuals), but realize opportunities for investment to potentially eliminate chronic homelessness in targeted geographic regions. It is clear that even the current stock and pipeline of supportive housing does not come close to meeting the units needed. A long-term plan and commitment to create supportive housing is needed from all levels of government to begin to address this large gap in supply as compared to the supportive housing market demand.

State government and local communities should use this report as a tool for such thoughtful, long-term housing planning. It can help them determine how state and local resources, through better targeting of efforts and services, can work together to end homelessness for New Yorkers across the state.

A. SUMMARY OF TARGETED POPULATIONS

Summary of Targeted Populations	
Sheltered Homeless Adults	Refers to single adults, adult couples with no children, and groups of adults). This category includes individuals in emergency shelter, transitional housing including Safe Havens.
Sheltered Homeless Families	Refers to households with one adult and at least one child under age 18. This category includes individuals in emergency shelter, transitional housing including Safe Havens.
Unsheltered Homeless Individuals/ Families	Refers to individuals and families whose primary nighttime residence is a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for people, such as the streets, vehicles, or parks.
Chronically Homeless Individuals/ Adults & Families	Refers to an individual with a disability, or people in families in which the head of household has a disability, who have been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years.
Individuals in Nursing Homes	Refers to nursing home residents deemed as high functioning with "low" Resource Utilization Group (RUG) scores that express interest in living outside of the nursing facility.
Homeless Unaccompanied Children	Refers to unaccompanied youth under the age of 18 staying in emergency shelters or transitional housing facilities.
Homeless Adults over 55	Refers to single adults, adult couples with no children, and groups of adults in emergency shelter or transitional housing that are 55 years of age and older.
Homeless Veterans	Refers to any person who served on active duty in the armed forces of the United States. This also includes military reserves and National Guard who were called up to active duty.
Homeless Individuals living with Serious Mental Illness	Refers to self-reported homeless individuals who reported being homeless within the last 6 months by county of residence received mental health services in NYS Office of Mental Health (OMH) treatment facilities (both inpatient and outpatient).
Homeless Individuals living with Substance Use Disorder	Refers to self-reported homeless (street or shelter homeless) individuals admitted into a NYS Office of Alcohol and Substance Abuse Services (OASAS) treatment facility (including crisis programs).
Homeless Individuals living with HIV/AIDS	Refers to HIV+ self-reported homeless clients served by an AIDS Institute contracted service providers by county of residence.
Homeless Health Home Enrollees	Refers to self-reported enrolled Health Home members in 2013 that completed a FACT –GP comprehensive assessment.
Homeless Transition Age Youth discharged from Foster Care	Refers to individuals, ages 18 to 24 years, previously discharged from foster care to either "self", "shelter" or "jail/institution".

B. DEFINITIONS AND SOURCES FOR TARGETED POPULATIONS

Sub-Population	Defined	Limitation
Sheltered Homeless Individuals	Refers to single adults, adult couples with no children, and groups of adults. This category includes individuals in emergency shelter, transitional housing including Safe Havens.	
Sheltered Homeless Families	Refers to households with one adult and at least one child under age 18. This category includes individuals in emergency shelter, transitional housing including Safe Havens.	
Unsheltered Homeless Individuals/ Families	Refers to individuals and families whose primary nighttime residence is a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for people, such as the streets, vehicles, or parks.	
Chronically Homeless Individuals/ Adults	Refers to an individual with a disability who has been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years.	
Chronically Homeless Families	Refers to people in families in which the head of household has a disability, and that has either been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years.	
Homeless Unaccompanied Youth	Homeless unaccompanied youth (also known as unaccompanied children) refers to a homeless person who is under age 18.	
Homeless Adults over 55	Refers to single adults, adult couples with no children, and groups of adults in emergency shelter or transitional housing that are 55 years of age and older.	
Homeless Veterans	Refers to any person who served on active duty in the armed forces of the United States. This also includes military reserves and National Guard who were called up to active duty.	
Housing Inventory Count (HIC)	The HIC collects information about all of the beds and units in each Continuum of Care homeless system, categorized by program types that includes emergency shelter, transitional housing, and permanent supportive housing	Only counts units designated for homeless individuals and families. May have instances of under/over-reporting due to multiple funding streams; units may be counted more than once.
Homeless Individuals w/ Serious Mental Illness	Refers to homeless individuals captured in OMH's 2013 Patient Characteristics Survey which supplies the counts of patients who received mental health services in OMH treatment facilities (both inpatient and outpatient) and self-reported as "currently homeless" and "homeless in the past 6 months" by the county of an individual's residence. "Homeless persons" are those who are shelter and street homeless, marginally housed (i.e. in adult home) or staying with friends and family and hospitalized in inpatient units.	The admissions data may include duplication from homeless individuals. While we analyzed the data for individuals who experienced homelessness within the last 6 month, it is unclear how long and the severity of their crisis.
Homeless Individuals w/ Substance Use Disorder	Refers to homeless individuals captured in OASAS's Client Data System which tracks the frequency of individuals admitted into OASAS treatment facilities (including crisis programs). The data provided to CSH from OASAS was the frequency of admissions by homeless individuals during the period October 2013 – September 2014 broken down by county of residence. "Homelessness" is defined as individuals who are street or shelter homeless.	The admissions data may include duplication from homeless individuals. Only 61 of 62 counties were included. One county (Hamilton) does not have any OASAS treatment programs.

		The overall frequency admissions data includes multiple service admissions from homeless individuals; however OASAS was able to identify 26,850 unique homeless individuals who utilized OASAS treatment facilities statewide.
Homeless Individuals w/ HIV/AIDS	Refers to individuals captured in NYS DOH AIDS Institute 2013 AIDS Institute Reporting System (AIRS). The data provided included the total number of unique HIV+ clients served by an AIDS Institute contracted service providers by county of residence and, of that number, the number and percent of self-reported homeless HIV+ clients served by county of residence.	The AIRS data does not include all HIV service providers in NYS – only service providers that are grant funded through the AIDS Institute who are required to submit data through AIRS. Services provided through Medicaid and other insurances are not included in AIRS. The total number of HIV service providers in NYS is unknown. Based on the insufficient available data, coupled with the fact that HIV status is often not collected by or disclosed to the homeless shelter staff in most COCs, CSH will not include HIV/AIDS sub-population data if derived only from the AIDS Institute as those numbers are significantly under-reported in several of the COCs. The National Center for Health Statistics report that in 2013, there were 132, 174 known individuals living with HIV/AIDS in New York State. Of that number, AIRS reported serving 62, 020 of those individuals, about 50%.
Homeless Health Home Enrollees	Refers to the number of enrolled Health Home members in 2013 that completed a FACT –GP, (comprehensive assessment administered in an interview format during Health Home enrollment,) and self-reported as homeless. The FACT GP defines "'having a home' as having one's own residence that one has access to at any time. Being in a shelter or 'couch surfing' would be considered homeless."	Data regarding homelessness is self-reported. This definition of homeless is more inclusive then the traditional definition of being in a shelter or street homeless and could also include those who are at-risk of homelessness or unstably housed. Data provided is for enrolled members only and does not include assigned members in outreach. Health Homes have reported a higher prevalence of homeless individuals in outreach then enrolled. The data provided for each Health Home is grouped by the counties they serve; and does not provide a breakdown of homeless enrollees for each county. Individuals can only enroll into one Health Home; however it is not uncommon for an individual to be enrolled into more than one Health Home. The data provided is by the county(s) the Health Home serves and not necessarily the county of residence of that Health Home

		member.
Homeless Transition Age Youth	Refers to homeless youth who have "aged out" of the foster care system and are between the ages of 18-21.	
Individuals in Nursing Homes who prefer to live in the community	The New York State Department of Health's Office of Health Systems Management (OHSM) provided CY 2013 data on all nursing home residents with "Low" Resource Utilization Group (RUG) scores who answered "Yes" to Section Q on the MDS (Long-term Care Minimum Data Sets), part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities regardless of their payer source. Section Q allows individuals to express interest in living outside of the nursing facility. RUGs assigned to individuals reflect levels of resource need in long-term care settings to facilitate Medicare and Medicaid payment, and are derived from data elements in the MDS. The scoring is hierarchal and weighted.	The MDS data provided is not inclusive and was derived only from residents with low RUG scores (needing low/limited rehabilitation) that were targeted and answered this question. The county specified is where the nursing home is located, not necessarily where the nursing home resident would like to live.

C. COMPLETE SUPPORTIVE HOUSING INVENTORY STOCK AND PIPELINE IN 2013

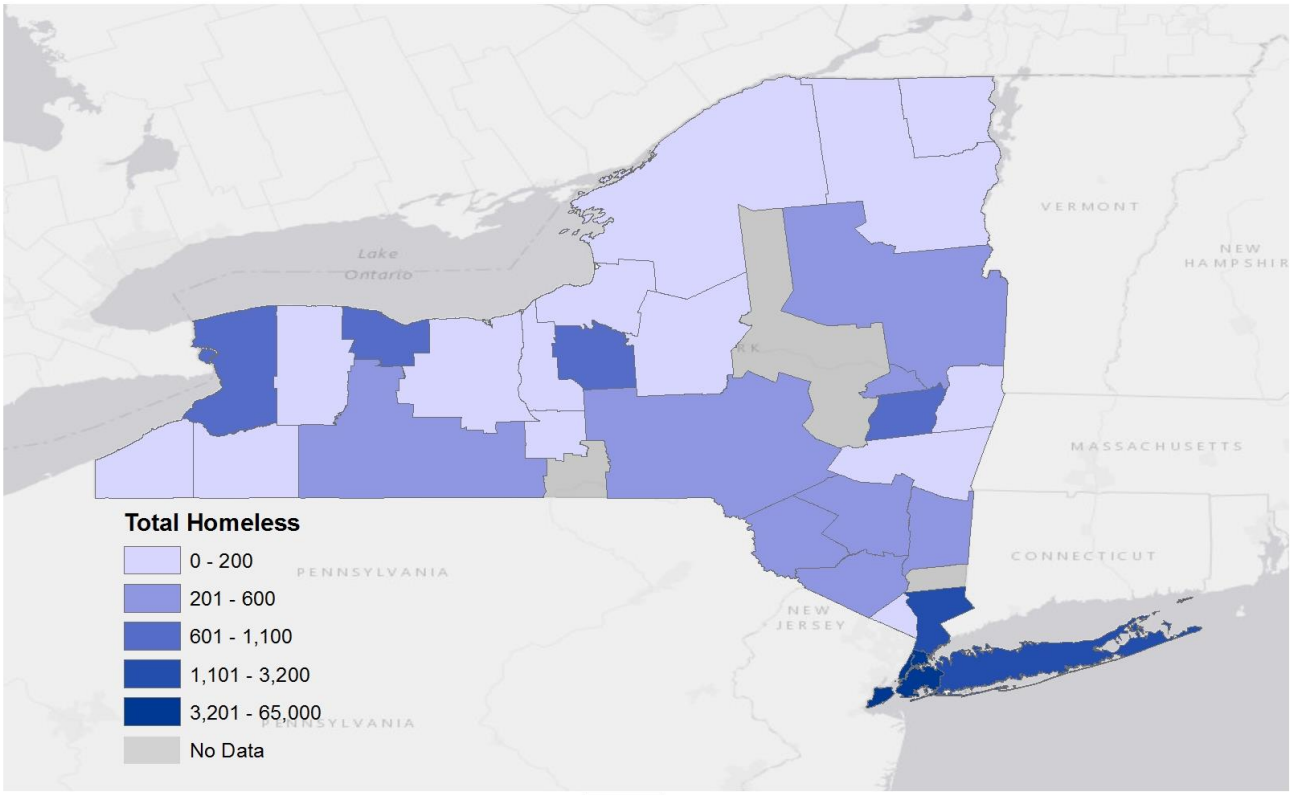
The Supportive Housing Network of New York provided the following data showing their inventory of supportive housing units in the targeted communities in both congregate (single-site) and scatter-site settings, including units targeting populations beyond homelessness. This data inventory was not used in the calculation of unit need for the CoC communities because it includes units not explicitly targeted to homeless.

County	Existing Single Units2013	Existing Family Units 2013	New Pipeline Single Units 2013	New Pipeline Family Units 2013	Total SH Units 2013
Albany	374	57	27	4	462
Suffolk	1153	76	85	5	1319
Nassau	673	50	144	0	867
Monroe	946	105	316	13	1380
Niagara	248	0	12	0	260
Erie	1210	36	0	0	1246
Warren	53	0	-6	0	47
Washington	18	0	5	0	23
Saratoga	68	10	-2	0	76
Hamilton	4	0	0	0	4
Onondaga	629	263	155	19	1066
Westchester	1336	124	82	32	1574
TOTALS	**6712**	**721**	**818**	**73**	**8324**
Borough	**Single Units 2012**	**Family Units 2012**	**Single Units 2013**	**Family Units 2013**	**Total Units2013**
Bronx	6790	569	514	25	7898
Brooklyn	6231	243	763	34	7271
Manhattan	9725	274	76	15	10090
Queens	2044	31	226	16	2317
Staten Island	208	0	21	0	229
Totals	**24998**	**1117**	**1600**	**90**	**27805**

D. MAPS

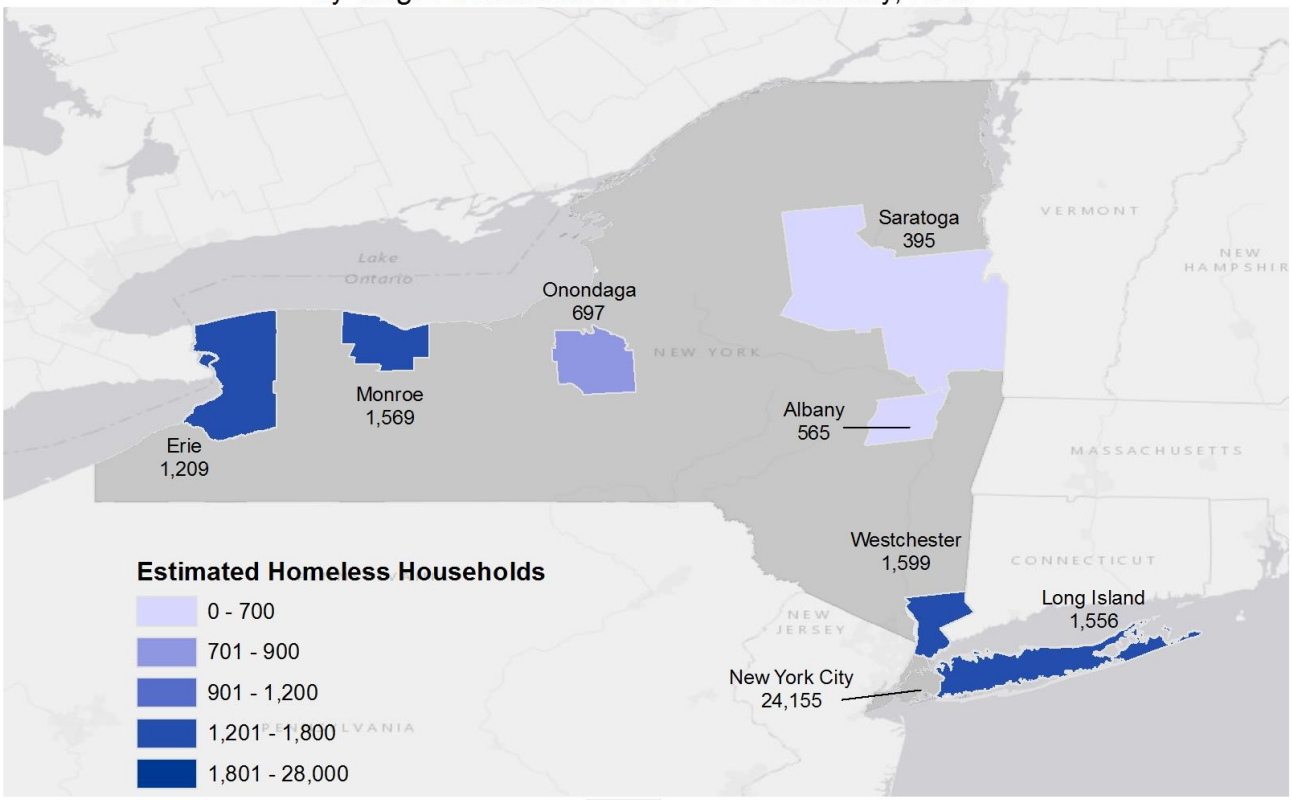
a. By disability- all 62 counties, highlight target communities, table at the bottom of 8 communities snapshot.
b. Map of communities estimated population need
    i. Adults
    ii. Families
c. Map of communities estimated unit need

Statewide Total Homeless Individuals by Continuum of Care (PiT 2013)



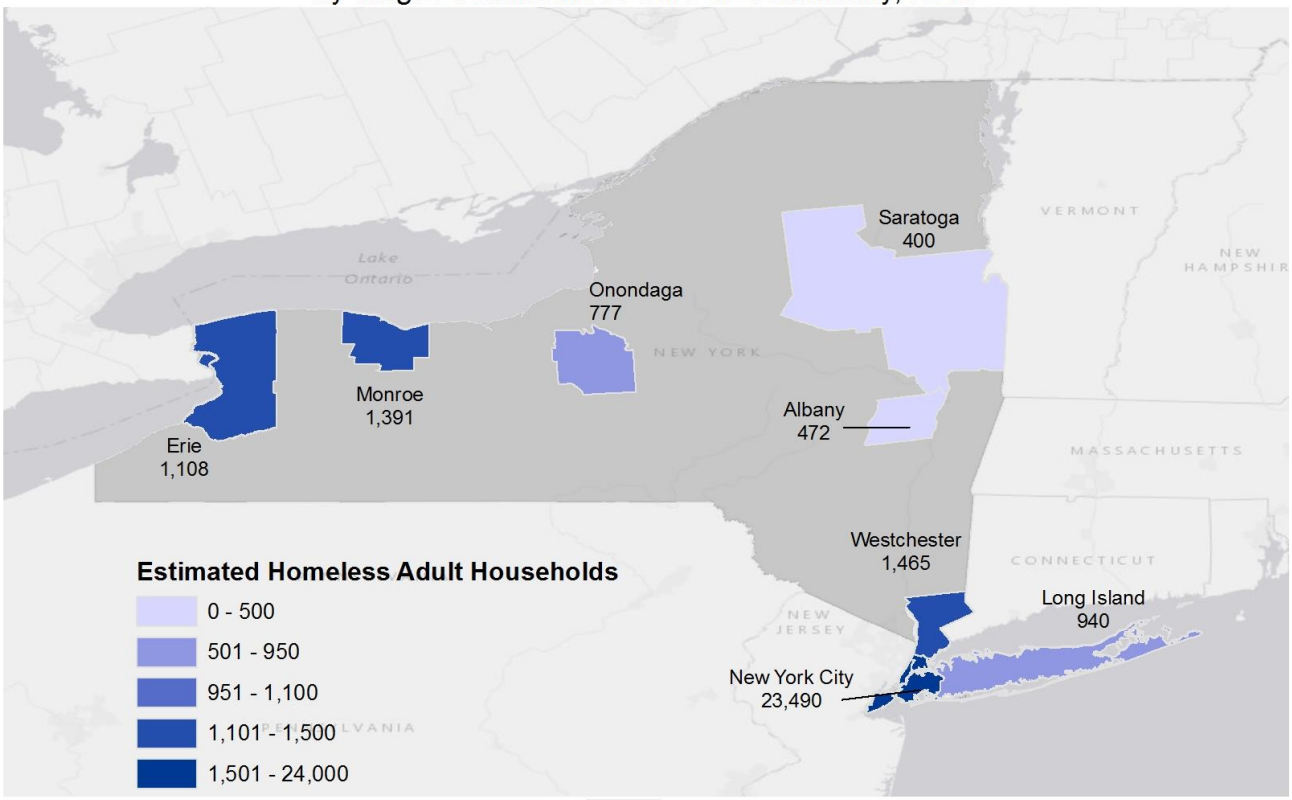
CSH

Estimated Homeless Households in Need of Supportive Housing,
by Target Continuum of Care or Community, 2013



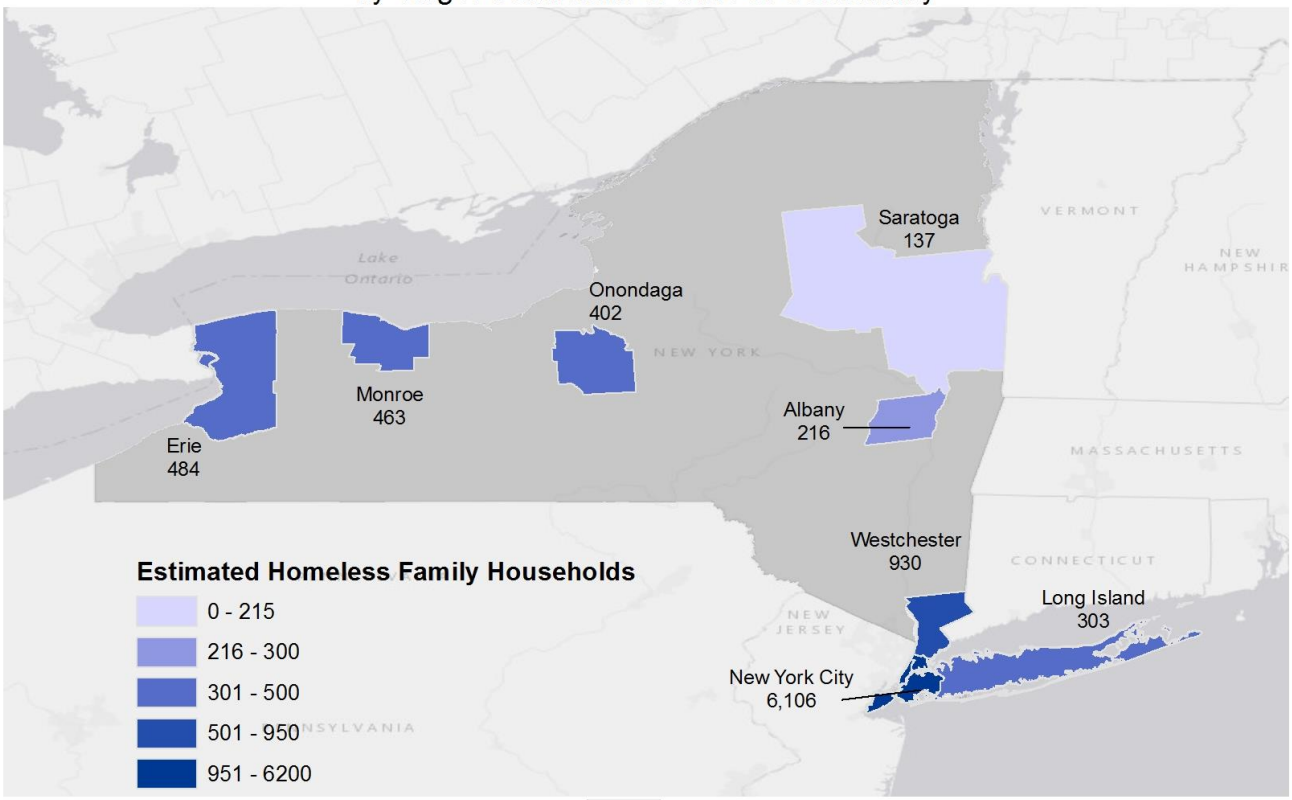
CSH

Estimated Homeless Adult Households in Need of Supportive Housing,
by Target Continuum of Care or Community, 2013



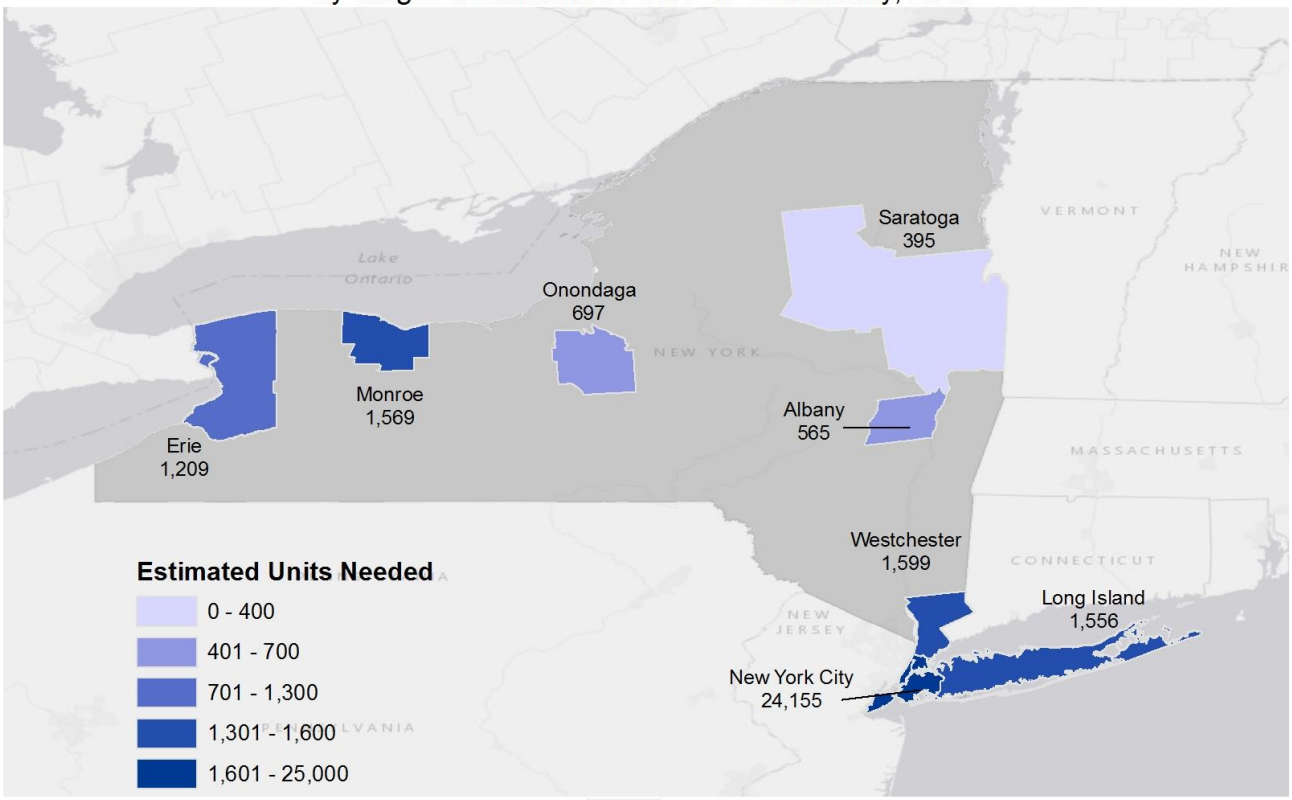
CSH

Estimated Homeless Family Households in Need of Supportive Housing in 2013,
by Target Continuum of Care or Community



CSH

Estimated Supportive Housing Units Needed
by Target Continuum of Care or Community, 2013



CSH