



Assessing Strengths in Uncertain Times

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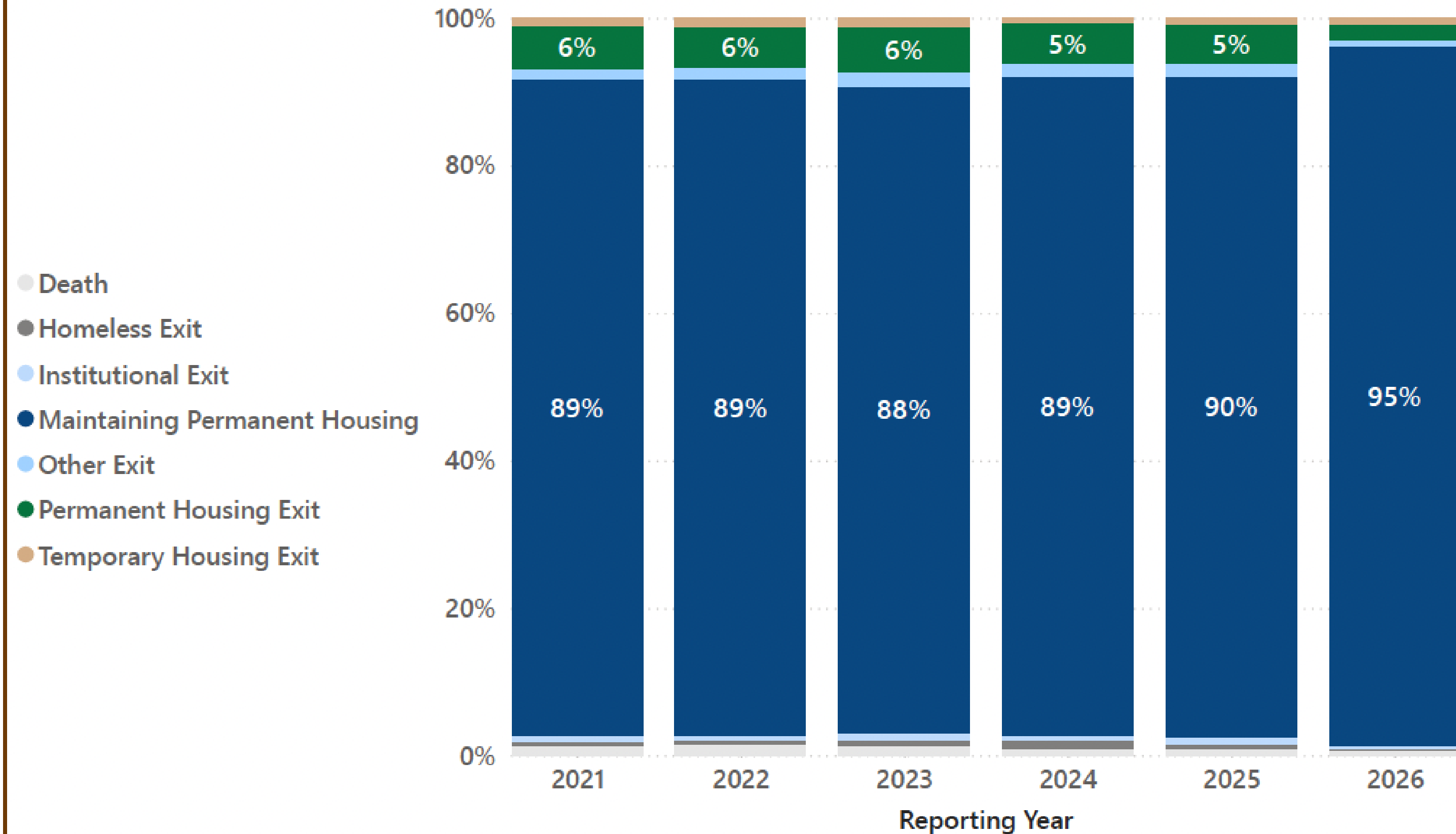
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Housing as a Human Right: Access, Stability, & Production

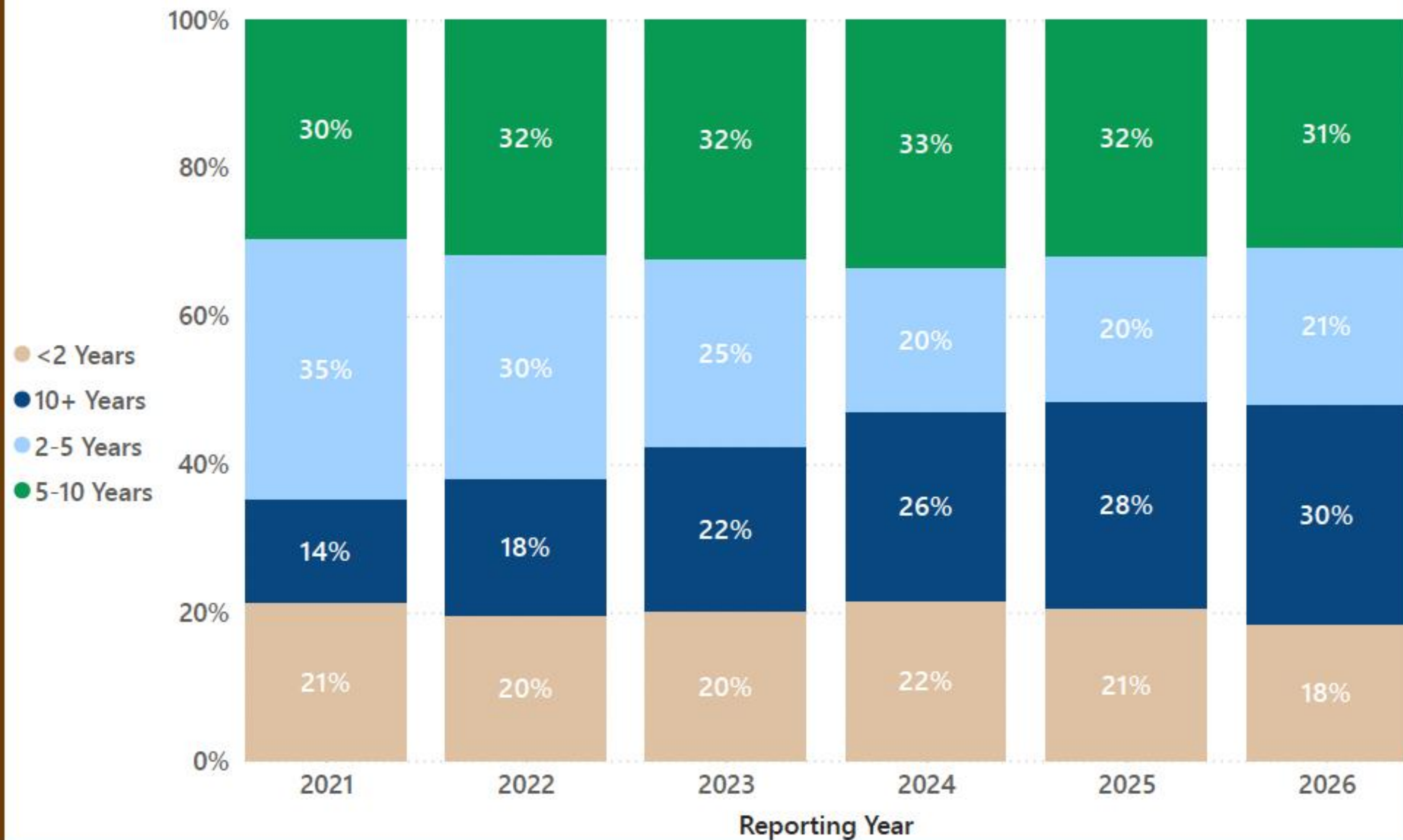
September 23, 2026

PSH Retention Status by Reporting Year



Housing as a Human Right: Access, Stability, & Production

PSH Tenure by Reporting Year



Housing as a Human Right: Access, Stability, & Production



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Housing as a Human Right: Access, Stability, & Production

September 23, 2026

Assessing Readiness to Move On from Supportive Housing

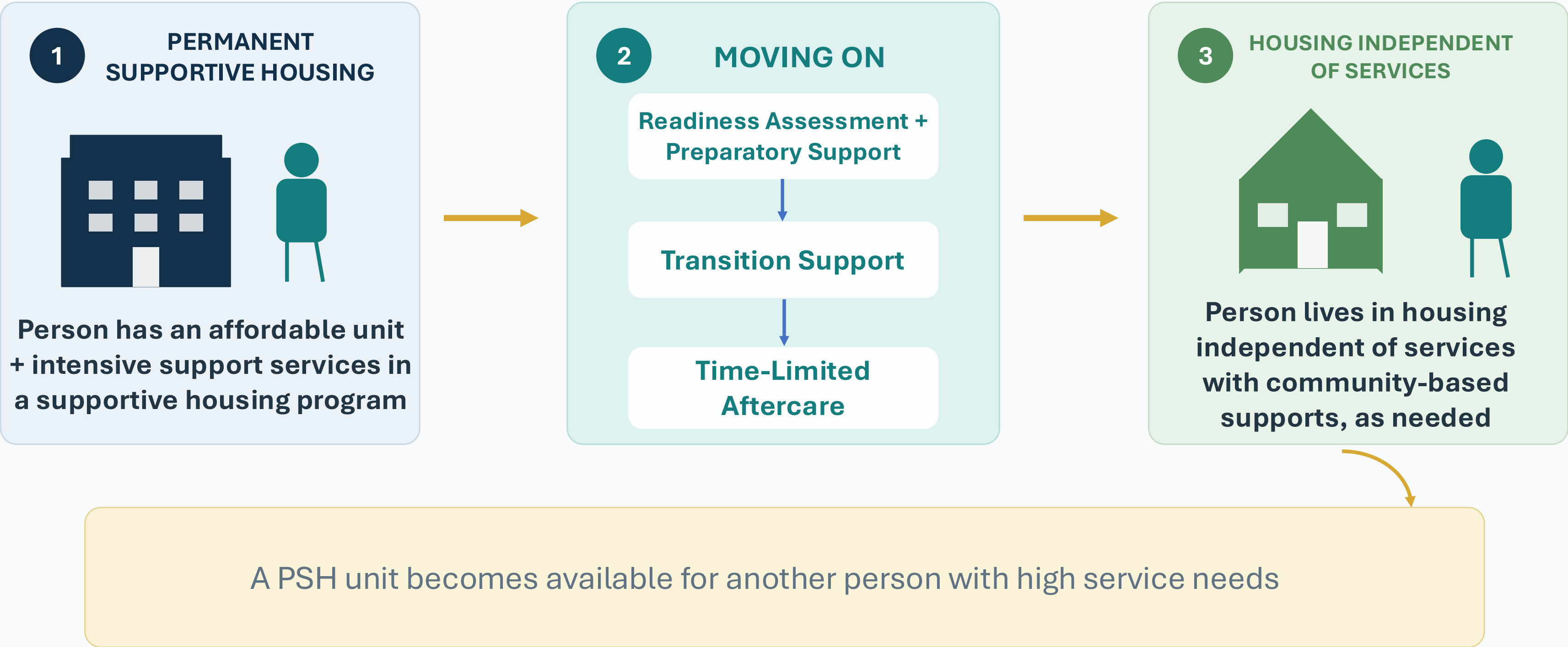
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What is “Moving On” from Permanent Supportive Housing (PSH)?

Moving On is a **voluntary** pathway from supportive housing services to housing independent of supportive services for tenants who want to move on and are ready to do so.



Why Moving On Can Be a Good Thing

1

Tenant Autonomy

Some tenants want more privacy, an opportunity to live with friends/family, or greater independence (Livingstone & Herman, 2017; Tiderington, 2021.)

2

Right-Sized Supports

Prevents low-need tenants from becoming “stuck” in PSH services that they don’t need.

3

System Capacity

Successful transitions can open scarce PSH resources for people who need that level of support now.

Why Accurately Assessing Move On Readiness is *Critically* Important

1

Recovery is Non-Linear

Mental health/substance use recovery is not always a smooth path. There may be bumps in the road.

2

No “Right of Return”

Most service systems do not allow people who leave PSH to automatically reenter the unit/program they left behind.

3

Autonomy vs. Risk

PSH programs want to protect tenants (but should also provide “the dignity of risk and the right to fail”??)

2023-2025 Study Funded by the *National Alliance to End Homelessness* (PI: Tiderington)

Investigating Predictors of Successful Exits from Permanent Supportive Housing

Authors: Emmy Tiderington, John S. Palatucci, Evan Cole & Joel Cantor
Additional Contributors: Eric Seymour, Tanika Moss, Susan Kirkland,
Mojdeh Nasiriahmadabadi, Taiisa Kelly, Jose Nova, Monique Tardif
2026

Permanent supportive housing (PSH), an evidence-based intervention that combines housing assistance and supportive services, is a critical resource for unhoused individuals. PSH has been shown to improve housing stability and health service use outcomes for high-need populations.¹ Yet, demand for PSH far outstrips supply.² As a result, many individuals are left waiting for safe and secure permanent housing, which can have life-threatening consequences.

PSH supply is driven, not only by the construction, development, and funding of new PSH units, but also by unit turnover when stable participants exit these programs. Once stable, PSH

¹ National Academies of Sciences, Engineering, and Medicine. *Permanent supportive housing: evaluating the evidence for improving health outcomes among people experiencing chronic homelessness*. Washington (DC): National Academies Press; 2018.

² Culhane D, Fowle M, Moses J. How Much Would It Cost to Provide Housing First to All Households Staying in Homeless Shelters? National Alliance to End Homelessness. 11 Mar 2025.
<https://endhomelessness.org/resources/research-and-analysis/how-much-would-it-cost-to-provide-housing-first-to-all-households-staying-in-homeless-shelters/>

- A quantitative study identifying predictors of successful PSH exit
- A systematic scoping review of existing move on readiness assessment tools and practices
- A qualitative study of former/current PSH tenant views on move on readiness assessment tools and practices

GOOD NEWS:

9 out of 10 individuals who left PSH for permanent housing without paired support did NOT return to homelessness within the first two years after the move!

Predictors of Successful PSH Exits

- Younger age
- Female gender
- Black, non-Hispanic, and Hispanic/Latine race
- Not having a substance use disorder
- Residing in a PSH program with low tenant turnover
- Living in an area with a more affordable rental market

Existing Readiness Assessment Tools/Practices (Tiderington et al., 2026)

Types of Assessment (N=28) • Likert scoring tools (n=11) • Toolkits or program guidelines (n=10) • Hybrid tools (n=4) • Threshold (yes/no) tools (n=3)	Administration of Assessment (N=28) • Collaboration between tenant and provider (n=12) • Provider-driven (n=8) • Tenant-driven (n=1) • Unknown (n=7)
Purposes of Assessment • Determining eligibility • Gauging capacity • Informing service planning • Assisting tenants in move on decision-making • Standardizing assessment processes	Primary Domains of Assessment • Housing stability (n=28) • Income and benefits (n=26) • Connection to community/social supports (n=25) • Dependence on services (n=23) • Health and health service use (n=21)

Tiderington, E. (2026, February 12). *Developing the Life After Supportive Housing (LASH) Readiness Self-Assessment Tool to promote successful exits from permanent supportive housing*. Final Report. Washington (DC): National Alliance to End Homelessness. <https://endhomelessness.org/wp-content/uploads/2026/02/Successful-PSH-Exits-1.pdf>

Existing Readiness Assessment Tools/Practices (Tiderington et al., 2026)

Acuity Index								
Housing	Levels				Tenant Level		Service Plan Goal for Level 0 or 1	
	0	1	2	3	New	Last	Active	Deferred
Rent Payment	Rep Payee/Tenant has not paid rent for last 6 months or has only paid on-time 1-3 times in last 12 months	Rep Payee/Tenant has paid rent on-time 4-6 times in last 12 months	Rep Payee/Tenant has paid rent on-time 7-9 times in last 12 months	Rep Payee/Tenant has paid rent on-time every month for the last 12 months				
Utility Bill Payment	Tenant has paid utility bills on-time for 1-3 months in last 12 months	Tenant has paid utility bills on-time for 4-6 months in last 12 months	Tenant has paid utility bills on-time for 7-9 months in the last 12 months	Tenant has paid utility bills on-time for 10-12 months in last 12 months OR utilities are included in rent.				
Rent Arrears	Tenant has outstanding rent arrears and is not willing to set up payment plan	Tenant has more than 6 months of rent arrears and has set up a payment plan	Tenant has less than 3 months of rent arrears and is current on payment plan	Tenant has no rent arrears				
Utility Arrears	Tenant has outstanding utility arrears and is not willing to set up payment plan	Tenant has less than \$1000 in utility arrears and has set up a payment plan	Tenant has less than \$500 in utility arrears and is current on payment plan	Tenant has no utility arrears				
Safe Living Environment	Tenant had over 5 contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months	Tenant had 3-5 contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months	Tenant had 1-2 contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months	Tenant had no contacts with police and/or landlord regarding disruptive activities or unsafe conditions in the unit in last 12 months				
Lease (include all leases if tenant moved)	Tenant has been in supportive housing less than 12 months OR has held a lease less than 12 months	Tenant has been in a supportive housing program and has held lease for 12-23 consecutive months	Tenant has been in a supportive housing program and has held lease for 24-36 consecutive months	Tenant has been in a supportive housing program and has held lease for over 36 consecutive months				
Housing Subtotal								

Based on the Connecticut Supportive Housing Assessment & Acuity Index

Acuity Index Interpretation

Area	Maximum Level	Minimum Level	Ideal Range	Current Level on this Assessment
Housing	18	12	16-18	
Income and Benefits; Health; and Supportive Services and Resources	39	26	35-39	
Parenting and Child Services	15	10	13-15	

Interpretation:

- All applicable levels fall within the ideal range: Other housing options with community supports should be considered as a short term goal.
- Applicable levels are at or above minimum but not all fall within the ideal range: Other housing options with community-based supports should be considered as a long term goal.
- One or more levels are below the minimum: Tenant should remain in supportive housing.

Benefits	0	1	2	3
Stable/Consistent Source of Cash Income	Tenant has no stable/consistent source of cash income	Tenant has cash income but it is not stable/consistent	Tenant has had stable/consistent cash income for the last 1 – 6 months	Tenant has had stable/consistent cash income for the last 7 or more months
Benefits	Tenant has no benefits and has not yet applied for benefits	Tenant has applied for benefits but has not yet received them	Tenant has received all benefits entitled to for the last 1-6 months	Tenant has received all benefits entitled to for the last 7 or more months OR is not eligible for benefits
Employment	Tenant is not employed, is able to work but not seeking employment OR tenant is not able to work and has not received disability benefits	Tenant is not employed, is able to work and is seeking employment/participating in employment services	Tenant is able to work and has been employed for less than 6 months	Tenant is able to work and has been employed for more than 6 months OR tenant is not able to work and receiving disability benefits
Debt	Tenant debt greater than 50 percent of income and tenant is unable to meet these obligations	Tenant debt is greater than 50 percent of income and tenant is able to meet these obligations	Tenant debt is less than 50 percent of income and tenant is able to meet these obligations	Tenant debt is between 0 and 10 percent of income and tenant is able to meet these obligations
Health				
Mental Health Care Use	Tenant has not had contact with a mental health provider in the past 12 months	Tenant has contact with a mental health provider and has kept less than 50 percent of appointments in the last 12 months	Tenant has contact with a mental health provider and has kept more than 50 percent of appointments in the last 12 months	Tenant has contact with a mental health provider and has kept more than 90 percent of appointments in the last 12 months OR Tenant has no need for mental health services
Primary/Specialty Health Care Use	Tenant has not had contact with a primary and/or specialty health care provider in the past 12 months	Tenant has contact with a primary and/or specialty health care provider and follows preventive screening and treatment recommendations less than 50 percent of the time	Tenant has contact with a primary and/or specialty health care provider and follows preventive screening and treatment recommendations 50 to 90 percent of the time	Tenant has contact with a primary and/or specialty health care provider and follows preventive screening and treatment recommendations more than 90 percent of the time
Medication Adherence	Tenant self-reports never taking prescribed medications	Tenant self-reports rarely taking prescribed medications	Tenant self-reports sporadically taking prescribed medications	Tenant self-reports regularly taking prescribed medications OR has no prescribed medications

Based on the Connecticut Supportive Housing Assessment & Acuity Index

“Tenants are the best judges [sic] of whether they’re capable of doing this [moving on] or not.”

LIFE AFTER SUPPORTIVE HOUSING (LASH) READINESS SELF-ASSESSMENT TOOL & ACTION PLAN

Is living in a home *without* supportive housing services a goal for you, now or sometime in the future? **YES** **NO**

If **YES**, when would you ideally like to move to a home without supportive housing services? _____

People are typically successful when leaving supportive housing services if they score high in the areas below. If moving on from services is a goal for you now or sometime in the future, complete the **LIFE AFTER SUPPORTIVE HOUSING READINESS SELF-ASSESSMENT** below and self-assess your “readiness for life after supportive housing”. Then, work with your provider to create your own personal action plan for improving your readiness score.

If an area does not apply to you or you want to provide a reason for your score, you can note this information in the *Comments* section. You can also add other areas that you would like to work on before leaving supportive housing in the *Other* section at the end of the tool. And remember – any progress toward life after supportive housing counts as progress, whether it’s a big or small step, taken at a fast or slow pace. It’s up to you!

	1	2	3	SCORE
Rent Payment	I have paid rent on time less than 6 times in the last 12 months	I have paid rent on time 6-11 times in the last 12 months	I have paid rent on time every month in the last 12 months (or my portion of the rent is \$0)	

Comments: _____

	1	2	3	SCORE
Utility Bills	I have paid my utility bills on time less than 6 times in the last 12 months	I have paid my utility bills on time 6-11 times in the last 12 months	I have paid all of my utility bills on time every month in the last 12 months (or utilities are included in my rent)	

Comments: _____

	1	2	3	SCORE
Income	I have not had any income through employment or benefits for the past 12 months	I have had unstable income through employment or benefits for the past 12 months	I have had stable income through employment or benefits for the past 12 months	

Comments: _____

	1	2	3	SCORE
Community Living	I have had more than 2 police visits or landlord complaints in the past 12 months	I have had 1-2 police visits or landlord complaints in the past 12 months	I have not had any police visits or landlord complaints in the past 12 months	

Comments: _____

	1	2	3	SCORE
Community Services/Support	I am not connected with any community services (primary care, mental health, addiction services) or natural supports (friends, family, other supports), and I still need PSH services	I am connected with some community services (primary care, mental health, addiction services) or natural supports (friends, family, other supports), but I still need to connect with others, and I still need PSH services	I am connected with all of the services (primary care, mental health, addiction services) and natural supports (friends, family, other supports), that I need in the community, and I no longer need PSH services	

Comments: _____

	1	2	3	SCORE
Housing Stability	I am not confident that I can maintain stable housing	I am somewhat confident that I can maintain stable housing	I am very confident that I can maintain stable housing	

Comments: _____

	1	2	3	SCORE
OTHER:				

Comments: _____

TOTAL SCORE

PERSONAL ACTION PLAN

WHAT would help me to improve my total score? [EXAMPLES: I need a monthly reminder to pay rent. I need additional income to be able to make rent. I need a savings account and budgeting assistance to help me save money for rent every month.]

WHO can help me to improve my score? [EXAMPLES: friend, supportive housing staff, family, doctor, myself]

HOW can these individuals or organizations help me to improve my score?

WHEN would I like to receive this help?

Using the information above, work with your provider to develop **one or more action(s)** that you can take **before the next self-assessment** to improve your score.

[EXAMPLES: I will ask my case manager to help me look for a job this month so I can make additional income. I will ask my friend to remind me when the rent is due every month, so I remember to pay rent on time. I will ask the bank teller to help me open a savings account, so I can save money for utilities. I will connect myself to a primary health care provider by calling this week to make an appointment for an annual physical.]

ACTION 1: _____

ACTION 2: _____

ACTION 3: _____

If any of the actions involve supportive housing staff, review the action(s) with that staff member to enlist their help. If they agree to help you, ask them to initial next to the action to indicate their commitment to help you.

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The LASH tool is adapted from the *Orange County HMIS Moving On Assessment* (January 2024), available at <https://ochmis.org/wp-content/uploads/2024/01/Moving-On-Assessment.pdf>. Adapted and used with permission from Orange County.

You can use this tool...

- To facilitate service planning conversations
- To assess eligibility for Moving On resources
- To track program- and system-wide Moving On progress by integrating the tool into HMIS or program-level data collection
- To demonstrate progress in meeting HUD's expectation that programs will "advance recovery and self-sufficiency"

If you're interested in using this tool...

You can obtain a FREE license to use it at the link below or using this QR code:

<https://express-licensing.rutgers.edu/product/life-after-supportive-housing-lash-readiness-self-assessment-tool-and-action-plan>



Thank You!

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TRENTON/MERCER COC PROGRAM CLIENT ACUITY INDEX

A TOOL TO HELP MOVING- ON STRATEGIES



How Did it Come About



- HUD Debriefing Call
- HUD Annual CoC Program Competition



What Did We Do

More than 10 years ago, the Trenton/Mercer CoC researched, identified and adopted the Acuity Index based on the Connecticut Supportive Housing Assessment Tool.

What is an Acuity Index

An Acuity Index is an evaluation tool used to measure an individual's severity of need, vulnerability and level of independence.

Low Acuity

Indicates strong stability or growth; the individual may be a candidate to transition to independent housing with minimal community-based support.

Medium Acuity

Indicates ongoing needs where long-term community-based support would be beneficial

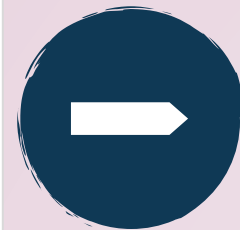
High Acuity

Reflects severe, complex needs requiring intensive, continuous permanent supportive housing

Acuity Index Help Support the Trenton/Mercer CoC

Assessment

Helps the case manager to evaluate and assess the CoC Permanent Supportive Housing (PSH) tenant's Moving-On readiness



Incorporating

The acuity index measures are incorporated in the Continuum of Care planning efforts to promote client-centered engagement towards long-term housing independence

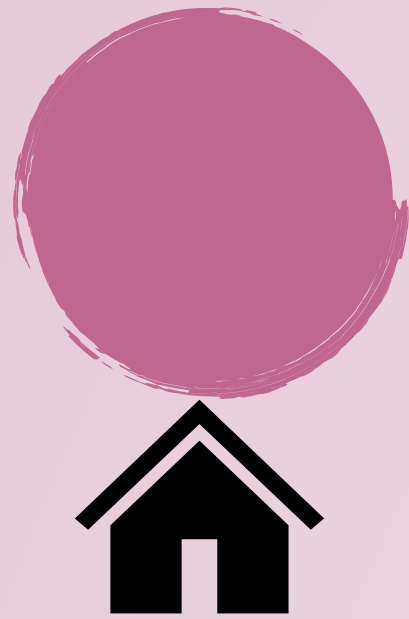


Integration

Acuity Index is integrated into the overall Housing Stability Plan and Moving-On strategy to strengthen program fiscal and system performance outcomes

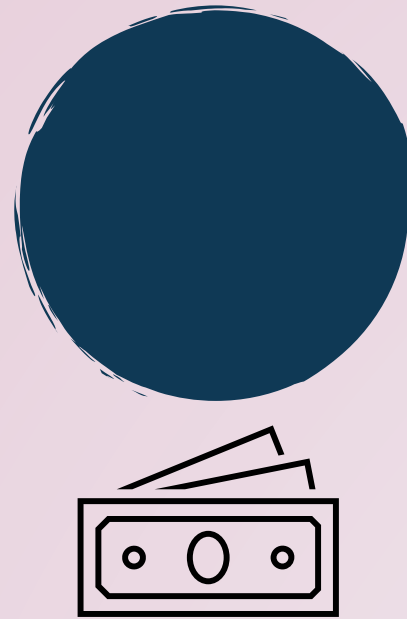
Acuity Index Categories

Each domain provide score levels from 0-3. For example, under Rent Payment, if the tenant has paid rent on-time every month for the last 12 months, it would receive the highest score of 3.



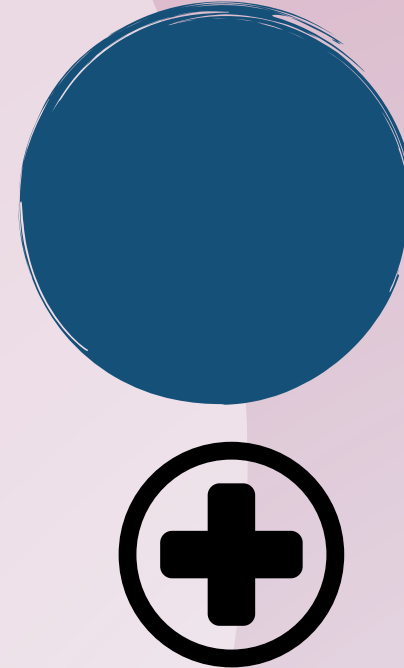
Housing

Rent Payment, Utility
Bill Payment, Rent
Arrears, Utility
Arrears, Safe Living
Environment, Lease



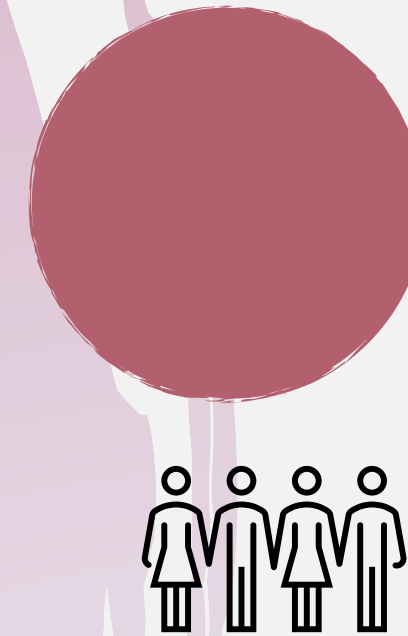
Income & Benefits

Stable/Consistent
Source of Cash
Income, Benefits,
Employment, Debt



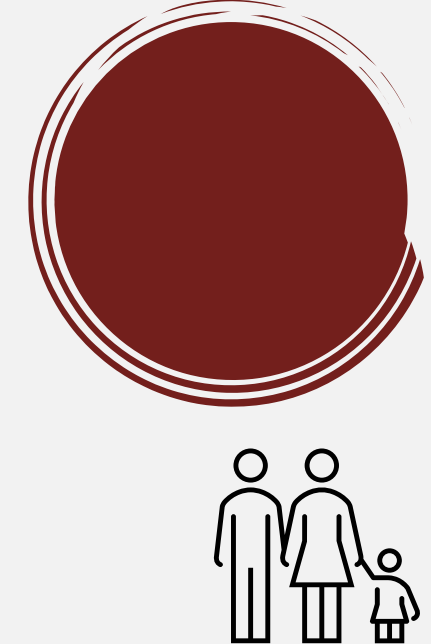
Health

Mental Health,
Primary/Specialty
Health Care, Medication
Adherence, Harm
reduction behaviors



Supportive Services and Resources

Connection to
community supports,
Crisis Intervention, Life
Skills, Legal, Mobility &
Transportation



Parenting & Child Care

Childcare, Children
Education, Parenting,
Child Welfare
Involvement, Children
with Special Needs

How Is it Used

The tool is used in three primary areas

During the annual participant recertification

Identify lower acuity clients that may no longer need supportive services to maintain their housing and can potentially move on to non CoC housing opportunities of their choice

Monitoring & Evaluation

Use of the acuity Index is a contract requirement and is incorporated in the annual project monitoring and evaluation process

Empower

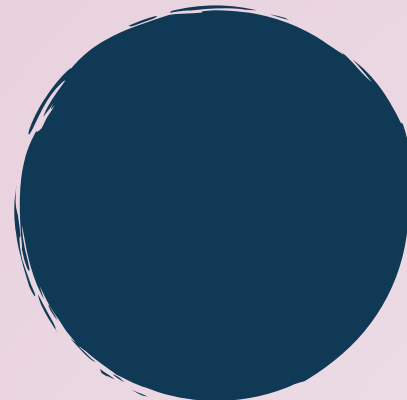
Housing Providers are able to serve more clients with higher service needs in PSH projects

Five Key Areas At-a-Glance



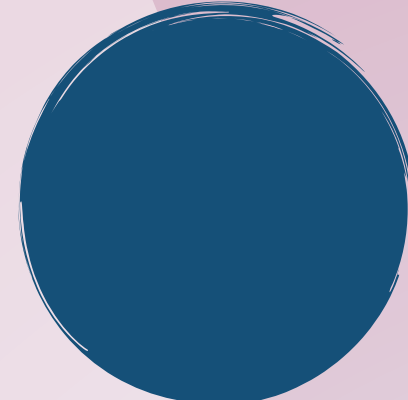
Funding Risk readiness

Potential housing impacts and strengthen NOFO decision making



Moving On readiness

Embeds readiness conversations into housing and transition planning



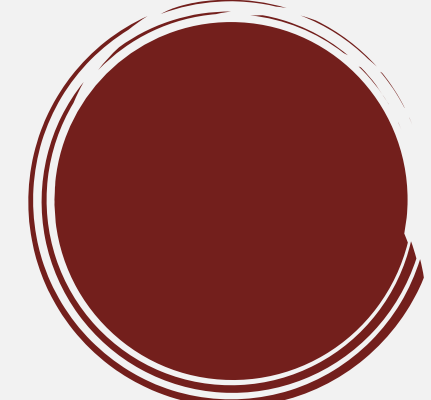
System capacity

Coordinate transition planning with voucher availability and provider capacity



Resident choice and stability

Connects readiness planning to participant preferences, service needs, family and community supports



Performance and accountability

Creates a common framework for reviewing progress, performance reviews and ongoing CoC planning discussions

How the CoC used the Acuity Index During the FY25-FY 26 NOFO Process

The Acuity Index gave the Trenton/Mercer CoC a timely way to understand participants needs, assess funding risk, and coordinate a community response during the FY25-FY26 NOFO process

RESPONDING TO HUD'S NEW POLICY AND FUNDING SHIFTS

Understanding Individual Client Needs

- Called for an immediate completion of the Acuity index for all CoC participants.
- Expanded the index to include age, disability status, employment history, education, rent cost, income source and amount and length of time in the CoC programs.
- Developed a comprehensive assessment report using actual participant data, not estimates, to evaluate the potential impact of the federal policy shifts and significant housing funding reductions.

Identifying Resources and Opportunities

- On behalf of the Trenton/Mercer CoC, the City of Trenton convened and hosted a community-wide Landlord Engagement meeting.
- Over 30 housing providers, developers, landlords, housing complexes, healthcare providers, and other housing related community providers attended.
- The CoC shared an aggregate report showing the potential lost of rental assistance funding and the anticipated impact to the housing system, then discussed collective solutions and next steps, including commitments to Coordinated Entry referrals and possibly housing set-asides.

THANK YOU

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Middlesex County's Moving On Continuum of Care Program

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2026 Monarch Housing Conference

September 23, 2026



What is a Continuum of Care

- ▶ The US Dept. of Housing & Urban Development (HUD) is the largest provider of funds to address homelessness.
- ▶ HUD awards much of its homeless funding through the Continuum of Care (CoC) competitive process.
- ▶ CoC is both the name of the funding program and also the name of the local collaborative that is in charge of ending homelessness in that community, which can be a City, a county, or a group of cities/counties.
- ▶ In Middlesex County, the whole county is a CoC.
- ▶ CoCs usually consist of shelter providers; mental health/addiction providers; supportive housing providers; special populations like veterans & domestic violence; institutions that aren't primarily about homeless, but encounter homeless clients such as schools, criminal justice, legal services, community organizations serving low/mod clients; workforce development; prevention programs; and **persons with lived experience**.
- ▶ CoCs have a Lead Entity, usually either a unit of government or a non-profit organization, that is in charge of the homeless system and coordinating efforts among providers, with the ultimate goal of ending homelessness. **The Middlesex County Office of Human Services is the county's CoC's lead entity.**

HUD's CoC Funding - Through 2025

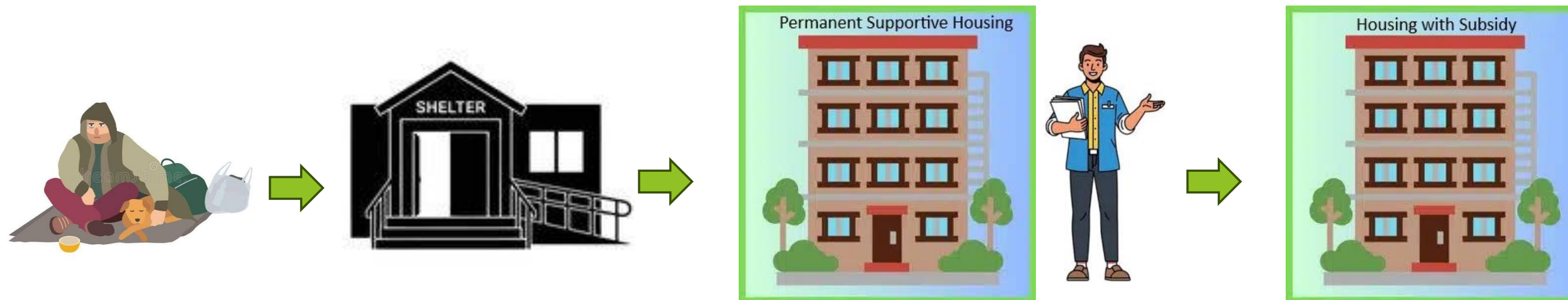
- ▶ Primarily focused on Housing First and the provision of Permanent Supportive Housing, plus some Rapid Re-Housing
- ▶ Permanent Supportive Housing (PSH) was usually for households that were chronically homeless
 - ▶ Homeless for 1 year or had four episodes of homelessness in the past 3 years that total at least 12 months (Place not meant for human habitation or emergency shelter)
 - ▶ Adult member has a long-term disabling condition (physical, behavioral health including substance abuse, or developmental) that limits ability to live independently (Can be evidenced by receipt of SSI or SSDI)
- ▶ This population was prioritized because their homelessness was more costly to other systems (emergency rooms, jails/prisons, etc.) and they were most in need
- ▶ Agencies worked on housing placement and then offered wrap-around services under Housing First. IT WAS NEVER HOUSING ONLY!!!!

Why Moving On Was Created

- ▶ HUD Continuum of Care funding was not growing enough to create or expand programs without re-allocating from other programs
- ▶ Many early PSH clients had been stably housed for years
 - ▶ Didn't need or use many supportive services
 - ▶ Still needed to have housing subsidy
- ▶ Current homeless clients were stuck in emergency shelter because of lack of PSH for them

Moving On Philosophy

- ▶ Permanent Supportive Housing is not the “end game” but a progress step for most clients
- ▶ Change in philosophy for all PSH providers & case managers
 - ▶ Encouraged PSH case managers to have clients apply for other subsidized housing opportunities as they came available
 - ▶ Housing Choice Voucher program
 - ▶ State of NJ SRAP (State Rental Assistance Program)
 - ▶ Affordable Housing



Moving On - Multiple Components

- ▶ Identified standards for current PSH clients (whether or not CoC funded) to be eligible for Moving On program
- ▶ Applied for Mainstream Voucher program from HUD to target both currently homeless and Moving On clients (Mainstream requires disability and to be between ages of 18-61)
- ▶ Amended Middlesex County PHA Administrative Plan to allow homeless preference and to add Mainstream Voucher section, which also prioritized homeless and Moving On clients
- ▶ Used Moving On for participants in CoC programs that were ending or re-allocated
- ▶ Encourage other PHA's to adopt homeless preferences or expand existing ones

Moving On - Next Steps

- Currently working on updated Moving On program criteria through our Permanent Housing Subcommittee
- Plans to use additional HOME funding and HOME-ARP funding for Tenant Based Rental Assistance (TBRA)
 - Band-aid approach to potential HUD CoC cuts for Permanent Supportive Housing
 - Increase Moving On spots to free up PSH for new clients
- Continue outreach to other PHA's for homeless preferences

Thank you!

Question and Answers

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Thank you to our Speakers!

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