



RESEARCH REPORT

Show Me Healthy Housing Final Evaluation Report

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Executive Summary

This is the third and final evaluation report for Missouri Foundation for Health's Show Me Healthy Housing pilot program. Through Show Me Healthy Housing, the foundation provided grants to four supportive housing programs: two that served veterans experiencing homelessness, one that served homeless families, and one that served individuals with a serious mental illness or a disability and households that are homeless. The main findings of the Urban Institute's evaluation are the following:

- The four programs funded by Missouri Foundation for Health provided supportive housing to 101 people from 67 households. Most households were formerly homeless and had one or more members with disabling conditions.
- The sites showed varying levels of fidelity to the Housing First supportive housing model. Some sites followed the model of housing without preconditions, a rental subsidy without time limits, and voluntary services, while others conditioned assistance on "housing readiness," offered time-limited subsidies, or did not offer services.
- Participants reported improvements in most outcomes of interest after entering supportive housing. However, the evaluation's ability to ascribe these outcomes specifically to supportive housing is limited by small sample size, the lack of a true comparison group, high missing rates for some data, and a lack of standardized reporting requirements across grantees.
- Supportive housing tenants expressed high satisfaction with their housing. Many described it as the nicest home they had ever had. Two years after program entry, 78 percent of participants were still in permanent housing.
- Among the 63 households for whom income data were available, average monthly household income increased by more than \$300 while they were in supportive housing as more participants began working or receiving income from benefits.
- Entering supportive housing decreased the likelihood that adults in the evaluation would have a new conviction, parole violation, or open court case. Among the 65 (out of 78) adult supportive housing tenants for whom criminal justice data were available, the share of tenants with criminal justice involvement fell from 29 percent in the two years before entering supportive housing to 8 percent in the two years after entering supportive housing.

- Many tenants reported that their health improved after entering supportive housing, and program data for 11 participants from one site showed modest improvements in the Daily Living Activities Functional Assessment scale.
- Supportive housing tenants in the two nonveterans' sites reported higher rates of physical and behavioral health conditions (e.g., depression, substance use, and diabetes) than a reference group of homeless and unstably housed Medicaid participants. Although tenants generally reported that their health improved after entering supportive housing, our analysis of Medicaid and Veterans Health Administration data showed no major changes in emergency department visits. Among the nonveterans' programs, we found no major changes in hospitalizations or Medicaid costs. These findings are consistent with other research on supportive housing's effects on health care use.
- Transportation was a recurring challenge for supportive housing tenants. Tenants often lacked their own vehicle, and public transportation was generally inconvenient and unreliable. The lack of transportation made it more difficult for tenants to find and keep jobs, attend medical appointments, and receive benefits. It also contributed to feelings of isolation and interpersonal conflict in some sites.

Overall, the evaluation findings confirm and extend previous studies that show the benefits of supportive housing in promoting stability for formerly homeless people with disabilities. They are also a reminder that people's challenges do not end when they enter supportive housing. Health care, access to transportation, and employment and volunteer opportunities are crucial to helping tenants lead productive, fulfilling lives.

Show Me Healthy Housing Final Evaluation Report

In 2014, Missouri Foundation for Health created the Show Me Healthy Housing (SMHH) program to help subsidize the development of new permanent supportive housing projects. Permanent supportive housing projects combine an ongoing rental subsidy with case management and supportive services for formerly homeless people with disabilities. The SMHH program awarded grants (totaling slightly more than \$1 million) to four organizations to help fund supportive housing projects in four Missouri cities: Columbia, Hannibal, Mexico, and Springfield. Table 1 shows the lead organization, location, target population, and size of each site.

TABLE 1
Show Me Healthy Housing Grantees

Organization	Project	Location	Target population	Total apartments	Set-aside apartments
North East Community Action Corporation	Berkshire Estates	Mexico, MO	Seniors, with units set aside for senior homeless veterans	29	5
Columbia Housing Authority	Patriot Place	Columbia, MO	Homeless veterans eligible for HUD-VASH vouchers	25	25
Preferred Family Healthcare	Chloe Place	Hannibal, MO	Low-income households, with units set aside for households that are homeless or individuals with a serious mental illness or disability	25	12
The Kitchen Inc.	Beacon Village II	Springfield, MO	Low-income households, with units set aside for homeless families	32	8
Total				111	50

Sources: Show Me Healthy Housing application materials and stakeholder interviews.

Notes: HUD-VASH = US Department of Housing and Urban Development-Veterans Affairs Supportive Housing.

To measure the impact of its investment, the foundation contracted with the Urban Institute to evaluate SMHH. The evaluation documented the development and implementation process for each project and changes in housing stability, health care, income, and overall well-being of participants after they moved into supportive housing. It also analyzed changes to participants' use of jails and homeless programs, hospitalizations and emergency department (ED) visits, and Medicaid expenditures after moving into supportive housing. Although supportive housing has been the focus of dozens of studies,

this is the first in-depth evaluation of supportive housing in Missouri and one of the first of supportive housing outside of major metropolitan areas.

This is the third and final report of this evaluation. The first report (Leopold et al. 2016) documented the supportive housing development process in each site, including challenges with identifying funding for permanent rental subsidies and ongoing case management. The second report (Leopold et al. 2018) provided information on the characteristics of supportive housing tenants in SMHH projects, housing retention rates, and changes in income, benefits, and health care use in the first 12 months after their move into supportive housing. This final report extends the analysis period and provides data on housing retention rates and changes in household income and benefits and use of health care up to 24 months after entering supportive housing. It also includes data on households' criminal justice involvement and use of homelessness assistance programs before and after entering supportive housing. The report concludes with a discussion of the overall findings from the evaluation and its implications.

Study Data Sources and Methodology

This evaluation draws from the following data sources:

- documents, including interim reports submitted to the foundation, memoranda of understanding and other contractual documents, and written policies and procedures
- annual in-person and telephone interviews with key staff at each site
- annual in-person interviews with supportive housing tenants at each site
- data on supportive housing tenants collected by program staff during regular assessments
- for nonveterans' programs, Medicaid data on health insurance coverage, diagnoses, health care claims, and costs
- for veterans' programs, data on ED visits at Veterans Health Administration hospitals and use of US Department of Veterans Affairs (VA) shelter beds and residential programs
- for nonveterans' programs, homelessness management information systems data on use of homeless shelters, transitional housing, rapid re-housing, and prevention assistance
- data from the Missouri Automated Criminal History System and Missouri Case.net on convictions, arrests, and pending charges

For the most part, this evaluation relies on analysis of changes in participants' housing stability, income and employment, health care use, and criminal justice involvement from the two years before they entered supportive housing to the two years after entry.

For Chloe Place and Beacon Village II (the nonveterans' programs in SMHH), the University of Missouri Center for Health Policy constructed a reference group of homeless Medicaid enrollees in the same counties by matching enrollees' residential addresses with the addresses of homeless programs and mail-forwarding programs for people without a stable residential address. We had hoped that this data could be used to create a comparison group of households with similar characteristics as SMHH tenants, to better understand the effects of supportive housing on health care use. We ultimately decided that the Medicaid enrollees not enrolled in SMHH are more of a reference group than a true comparison group for several reasons. First, the data were available only for Medicaid enrollees; no similar group was available for supportive housing tenants in the veterans' programs. Second, although a medical diagnostic code for homelessness exists, staff rarely entered this information.¹ Because the diagnostic code was not used, the Center for Health Policy identified Medicaid enrollees as homeless or unstably housed if their residential address matched a local shelter, jail, or mail-forwarding service. This is an imperfect proxy and does not provide information on how long a person has been homeless or if or when their homelessness was resolved. Finally, the number of homeless Medicaid enrollees identified through the match was too small for the Center for Health Policy to use propensity score matching or other statistical techniques to create a true comparison group with characteristics similar to SMHH tenants. Despite these limitations, the reference group is useful for understanding how the health conditions of SMHH tenants compared with other homeless or unstably housed Medicaid enrollees in the same counties.

Site Descriptions

SMHH provided predevelopment and gap funding to develop supportive housing for vulnerable populations. In its request for proposals, the foundation defined this broadly to include “individuals with mental illness and/or substance abuse addiction and their families, people living with HIV/AIDS, persons who are homeless (including veterans), individuals experiencing domestic violence, youth aging out of foster care, and single parents living in poverty.”² The funded projects varied greatly by size, location, target population, staffing, and service delivery. Two of the programs, Berkshire Estates and Patriot Place, served veterans without children. Beacon Village II focused on families, while Chloe Place served both single adults and families but typically focused on people with a severe mental illness. Because the

number of supportive housing tenants in each site is relatively small, we often combine the veterans' programs (Berkshire Estates and Patriot Place) and the nonveterans' programs (Beacon Village II and Chloe Place) in our analysis.

Except for Patriot Place, which was entirely supportive housing, all the developments had a mix of formerly homeless households in supportive housing and other low-income households who were typically not receiving a rental subsidy or any form of case management. Our interviews and data collection focused exclusively on the supportive housing tenants in each project.³

Patriot Place

Located in Columbia, Missouri, Patriot Place is a 25-unit supportive housing project. All units are set aside for veterans who have experienced homelessness. Patriot Place is a collaboration between the Columbia Housing Authority and the Harry S. Truman Memorial Veterans' Hospital. The housing authority served as the developer and funded project construction using federal and state low-income housing tax credits, tax-exempt bonds, the SMHH grant, and other funding sources. US Department of Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH) project-based vouchers subsidize the operating costs for all Patriot Place units. Veterans pay 30 percent of their monthly income on rent, and the HUD-VASH voucher covers the rest of the costs. The subsidies are tied to the apartments at Patriot Place, but after one year, tenants can transition to a tenant-based voucher if they want to move.

HUD-VASH is a national “special purpose” voucher program for chronically homeless veterans with disabling conditions, long histories of homelessness, and multiple barriers to housing. HUD-VASH combines a housing voucher from the housing authority with case management and supportive services from the VA. In Columbia, the Truman VA assesses veterans who are homeless or at risk of homelessness using the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). Veterans with the highest VI-SPDAT scores are referred to the housing authority for a HUD-VASH voucher. Veterans can use their voucher to rent an apartment on the private market or to move into Patriot Place. If veterans are interested in living at Patriot Place, they meet with the on-site case manager to determine whether they would be a good fit.

Over time, the Truman VA has modified the Patriot Place screening and referral process to put greater emphasis on the case manager's clinical judgment. It originally saw Patriot Place as a potential home for the most-difficult-to-house chronically homeless veterans. Because the housing authority owned the building and by law could screen out only veterans on the national sex offender registry,

Patriot Place could house veterans who have poor credit, evictions, and criminal histories and are usually rejected by private property owners. These veterans could also benefit from having a full-time case manager on site and a community of veterans who could support them. Although the Truman VA still targets Patriot Place referrals to veterans with the highest needs, it now does more to balance this with concerns about the community dynamic at Patriot Place. The Truman VA has learned that having too many veterans with personality disorders living next to one another can create problems. Similarly, after some early issues, the Truman VA was sensitive to having former sergeants, who were used to giving commands, living with other veterans.

Patriot Place was one of the first SMHH projects to complete construction. The building, a converted motel that had fallen into disrepair, is across from the relatively new Welcome Home emergency and transitional shelter for homeless veterans. Although Patriot Place is adjacent to Interstate 70 and within 2 miles of downtown Columbia, it is not along a major bus line. The Columbia Housing Authority was in talks with the city to create a new bus stop to serve Patriot Place tenants, but that has not occurred. Some tenants and staff felt that Patriot Place's proximity to liquor stores and nightlife created challenges for veterans in recovery, while others felt that those temptations would be available regardless of location.

The housing authority is responsible for property management and maintenance, and the VA is responsible for case management and supportive services. The housing authority property manager and the VA case manager share office space in converted motel rooms at Patriot Place.

Chloe Place

Chloe Place is a 25-unit building in Hannibal, Missouri, for households with low incomes; 12 units are set aside as supportive housing for households that are homeless or individuals with a serious mental illness or other disability. Preferred Family Healthcare (PFH), a community-based health care organization with a dedicated supportive housing division, handled each phase of the project, serving as the developer (with support from consultants), property manager, and service provider. In addition to the SMHH grant, PFH funded the project's construction with low-income housing tax credits and HOME Investment Partnerships Program funds. To subsidize the operating costs, PFH received Shelter Plus Care vouchers from the Missouri Department of Mental Health.⁴ Shelter Plus Care combines an ongoing voucher with supportive services for people with a serious mental illness. The Shelter Plus Care allocation was not enough to support 12 supportive housing units, but PFH also received an allocation of project-based vouchers from the Missouri Department of Mental Health's Rental Assistance

Program (RAP). As with Shelter Plus Care, the RAP subsidies that PFH received are not time-limited: participants recertify annually and can continue receiving assistance for as long as they remain eligible.

Chloe Place's supportive housing tenants came from multiple sources. Some were Shelter Plus Care tenants who used their tenant-based vouchers to move to Chloe Place to live in a nicer apartment in a safer neighborhood. Others were new supportive housing households identified through the local homeless coordinated entry system. Finally, some Chloe Place tenants went through the standard rental application process and did not meet the development's minimum income requirements but were able to rent a set-aside unit because they qualified for a subsidy through the RAP program. As of fall 2018, Chloe Place had 13 households in supportive housing, one more than PFH had originally set aside. Eight households were in the RAP program, four were in the Shelter Plus Care program, and one received a subsidy funded by PFH's operating reserves.

Chloe Place completed construction in 2017, later than other SMHH projects, because of environmental challenges with the original planned site. The final site is accessible to amenities such as medical centers and Walmart that residents use frequently. Tenants generally liked the location of the property, and some moved there specifically to live in the neighborhood. PFH hopes to build a federally qualified health center adjacent to Chloe Place, but that is dependent on federal funding.

Chloe Place was the only SMHH site where the same organization handled property management and case management. The property manager's office is located within Chloe Place, while the case managers are off-site but do home visits with tenants. PFH's supportive housing team includes several Shelter Plus Care case managers who help supportive housing tenants find and maintain housing. Most supportive housing tenants at Chloe Place also received behavioral health services through Clarity Healthcare, a PFH-operated federally qualified health center in Hannibal. These tenants also had a community support specialist who helped them with medical appointments, medication, treatment plans, transportation, and other health care needs.

Beacon Village II

Beacon Village II is a 32-unit affordable housing development in Springfield, Missouri. The Beacon Village II project is a partnership between The Kitchen Inc., the grantee, and Housing Plus LLC, its developer subsidiary. Beacon Village II was primarily funded through low-income housing tax credits, the SMHH grant, HOME funds, and Missouri Housing Development Commission loans.

The Kitchen chose the location for Beacon Village II because of its proximity to shopping, jobs, and services and because it is in a good school district. It is not, however, close to downtown Springfield, where most of Springfield's public services and employment assistance programs are. The Kitchen and Housing Plus LLC tried unsuccessfully to persuade the city facilities board to add a bus stop closer to the development. The closest bus stop is several blocks away and requires crossing a busy street, creating challenges for residents who are elderly or have limited mobility. Bus service is also limited during the week and does not run on the weekend. The developer is currently working with the city to improve access to transportation.

The Kitchen set aside eight units in Beacon Village II for families who have experienced homelessness. Beacon II families are referred through One Door, the local coordinated entry system, to The Kitchen's programs from emergency shelters, domestic violence safe houses, or the homes of family or friends. All Beacon Village II applicants must meet income limits and pass a background check. Applicants are ineligible if they have a prior eviction, bankruptcies, unpaid rent or utility bills, a history of property damage, and certain criminal convictions, including violent crimes or felonies.

Unlike Patriot Place and Chloe Place, Beacon Village II does not have any rental subsidies attached to it. Instead, The Kitchen refers families receiving subsidies through other programs to the development. Most families in Beacon Village II's set-aside units come from the rapid re-housing program. They receive rental assistance for up to 18 months, although case managers can extend assistance up to 24 months in some cases. Families can remain in their apartments when their subsidies end if they can pay the full rent. The Kitchen has transferred some families exiting rapid re-housing to its other rental assistance programs, such as Shelter Plus Care, provided that assistance is available and that they meet the eligibility requirements. In fall 2018, three of the eight set-aside units were housing families with Shelter Plus Care.

The Kitchen handles case management at Beacon Village II and contracts out property management services. Beacon Village II has a full-time service coordinator position, staffed by Catholic Charities. The coordinator works to get local service providers, such as food pantries and mobile dental clinics, on site and helps all tenants, not just those in set-aside units, access services in the community. The Kitchen also employs a full-time nurse. The nurse works with all of The Kitchen's programs but prioritizes tenants with the most serious health conditions, like cancer and heart disease. She assists with medication management, scheduling medical appointments, arranging transportation, and providing support during and after these appointments.

Berkshire Estates

Located in Mexico, Missouri, Berkshire Estates is a 29-unit apartment complex for seniors that has 5 units set aside for formerly homeless veterans. North East Community Action Corporation (NECAC) built the complex on the site of a property it already owned, renovated the existing 11 units, and added 18 units. In addition to the SMHH grant, NECAC funded the development through low-income housing tax credits and HOME grants.

Finding eligible veterans for the set-aside units has been a challenge. Early on in the project, NECAC established a memorandum of understanding with Welcome Home, which administers multiple programs for homeless and at-risk veterans, to identify and refer interested veterans to Berkshire Estates. The relationship struggled because of staff turnover at Welcome Home and a lack of clarity on roles. Welcome Home staff reported that many veterans in Columbia were not interested in moving to Mexico, which is 40 miles away from the Truman VA hospital. Additionally, NECAC staff reported that they screened out many of Welcome Home's referrals because the applicants were not "housing ready," meaning that they were not sober or had poor rental histories or other barriers to housing. Ultimately, the Truman VA filled the referral agency role and promoted the property to veterans on its HUD-VASH waiting list. Four of the five veterans who have moved into Berkshire Estates came from referrals from the Truman VA.

NECAC has informal partnerships with local agencies to provide services to Berkshire Estates residents. For example, because the Berkshire Estates apartments are not furnished, staff worked with the Veterans of Foreign Wars of the United States to provide household furnishings (e.g., beds, sofas, coffee tables, and televisions) to veterans as they moved in. Representatives from Central Missouri Community Action's office on aging have come on site to educate tenants on available services and benefits eligibility. Finally, although Mexico does not have public transportation, veterans can schedule rides to the VA hospital in Columbia or try to get rides from neighbors, family, or friends.

NECAC does not receive any rental subsidies for the set-aside units at Berkshire Estates, nor does it provide case management. It employs an on-site property manager one day a week who helps to coordinate activities, provide referrals to community services, address maintenance needs, and resolve conflicts between tenants. Veterans referred to Berkshire Estates through the HUD-VASH program receive a voucher and case management from the Truman VA. Berkshire Estates has also hosted veterans who do not receive a subsidy or case management or who have a regular voucher but no case management.

Adherence to the Housing First Supportive Housing Model

The descriptions above make clear the various housing and service models adopted by SMHH sites. Supportive housing projects require capital subsidies to help pay for construction costs, operating subsidies to help tenants with little or no income afford the rent on an ongoing basis, and supportive services funding to help tenants successfully find and maintain housing and get connected to essential services (CSH 2013). Of the four SMHH sites, only Chloe Place and Patriot Place satisfied all three criteria. Beacon Village II had supportive services but did not have a dedicated source of funding for ongoing rental subsidies, and Berkshire Estates had neither a dedicated rental subsidy nor dedicated services.

Sites also showed varying levels of adherence to Housing First practices. Although Housing First is not an essential feature of supportive housing, it is a best practice, as it is much more effective than other approaches in helping people exit homelessness (Gulcur et al. 2003). Housing First is the philosophy that the best way to resolve homelessness is to help people get into housing as soon as possible rather than conditioning housing on sobriety, treatment, employment, or other milestones. Once people are housed, providers should offer services on a voluntary basis and should make every effort to keep tenants in permanent housing even if they engage in risky behaviors like substance use.

Part of the Housing First approach is minimizing barriers to entry for people with poor credit, poor rental histories, criminal backgrounds, or other factors that make finding housing difficult. Patriot Place went the furthest of the SMHH sites in adopting this low-barrier approach, prioritizing veterans with the most acute needs. Although the Truman VA remained committed to this low-barrier approach, it also began giving greater weight to having a harmonious mix of tenants. NECAC was on the opposite end of the spectrum, explicitly adopting a “housing readiness” approach that screened out Berkshire Estates applicants who drank or used drugs or had untreated mental health conditions. At Beacon Village II, there were “competing interests” between the developer’s interest in managing the property as an asset and program staff members’ desire to use the property to house families whom other property owners would screen out. One staff member noted a frustration that “we own these beautiful properties” but because some families cannot meet the eligibility requirements, they have to be placed in housing in the community that is of much lower quality than the units The Kitchen owns. Although Chloe Place had less strict eligibility requirements than Beacon Village II did, PFH included other factors beyond acuity of need in its selection process. PFH staff members noted that in their first supportive

housing project, they initially selected only tenants with the highest needs but later decided that this approach created too many conflicts and that they needed to consider other factors beyond acuity.

Another aspect of Housing First is giving tenants as much independence and control over their lives as possible while trying to resolve conflicts and avoid evictions whenever possible. Case management staff tended to embrace this approach more than property managers and property owners. One case manager reported embracing the supportive housing site as an “apartment complex” while the property owner treated it like a “program” with strict rules around visitors, alcohol, and congregating in public spaces. While case managers stressed the importance of Housing First, property managers were either unfamiliar with the concept or actively disagreed with it. One property manager told us, “You think someone would say, ‘You can’t keep throwing money at the same person who is not making progress’—they don’t even try to make them get off the wagon.”

Tenant Characteristics

During the evaluation period, from March 2015 to July 2019, SMHH sites provided supportive housing to 101 people in 67 households (table 2). At the two veterans’ programs, Patriot Place and Berkshire Estates, supportive housing tenants were predominantly white males older than 30. Adult supportive housing tenants in the nonveterans’ programs tended to be younger and were more likely to be female. In both the veterans’ and nonveterans’ programs, 85 percent of tenants were white.

The nonveterans’ programs, Chloe Place and Beacon Village II, had a lower share of supportive housing tenants who reported being homeless upon entering supportive housing (53 percent) than the veterans’ programs (92 percent). This is likely driven by Chloe Place for two reasons. First, many early supportive housing tenants at Chloe Place were formerly homeless individuals with Shelter Plus Care vouchers who had heard about Chloe Place, often through their case managers, and transferred their vouchers there because they were unhappy with the condition or location of their apartments. Second, most supportive housing tenants at Chloe Place were subsidized through RAP, and to be eligible for RAP, households had to be in a housing crisis but not necessarily homeless.

Most supportive housing households reported receiving health insurance, but not food stamps or cash assistance. All veterans in supportive housing reported having health insurance, as did 76 percent of supportive housing tenants at Beacon Village II.⁵ Aside from health insurance, benefit receipt was very low. Just 28 percent of supportive housing tenants in veterans’ programs and 21 percent of families in Beacon Village II reported receiving food stamps. Thirty-six percent of all supportive housing

households reported receiving some form of cash assistance, such as Temporary Assistance for Needy Families, VA benefits, or Supplemental Security Income.

TABLE 2
Characteristics of Show Me Healthy Housing Supportive Housing Tenants and Households

Characteristics	Total		Veterans' Programs		Nonveterans' Programs	
	#	%	#	%	#	%
Age of tenants						
Younger than 18	23	23	0	0	23	37
18–30	11	11	0	0	11	18
31–50	21	21	4	10	17	27
51 or older	38	38	31	79	7	11
Missing	8	8	4	10	4	6
Total	101		39		62	
Gender of household head						
Male	37	55	32	82	5	18
Female	30	45	7	18	23	82
Missing	0	0	0	0	0	0
Total	67		39		28	
Race of tenants						
White, non-Hispanic	85	85	33	85	52	85
African American	15	15	6	15	9	15
Total ^a	100		39		61	
Benefits coverage^b						
Health insurance (tenants)	68	88	39	100	29	76
SNAP/food stamps (households)	19	25	11	28	8	21
Cash assistance (households)	24	36	8	21	16	57
Homelessness history						
Homeless at admission	69	68	36	92	33	53
Criminal history (adults only)						
	25	37	16	41	9	26

Source: Program data provided by each Show Me Healthy Housing site.

Notes: SNAP = Supplemental Nutrition Assistance Program.

^a Excludes individuals of other races.

^b We did not receive data on health insurance coverage or SNAP participation for Chloe Place tenants.

Outcomes

In this section, we describe the effects of supportive housing on households' housing stability, use of homeless assistance programs, criminal justice involvement, income and benefits, use of health care, and overall functioning. Although the small sample size and lack of a comparison group limit our ability to determine the impact of the program, we do find that the vast majority of households remain stably housed for up to two years after entering supportive housing. We also observe reductions in the use of homeless programs, reduced criminal justice involvement, and increased earned and benefits income after households enter supportive housing. We find no change in health care use or health care costs.

Housing

The primary benefit that supportive housing residents identified in interviews was access to safe and stable housing. Our interviewees identified many difficult situations that supportive housing tenants transitioned out of, including living in homeless shelters, dilapidated and dangerous housing, or housing without heat, running water or electricity; living with abusive partners; and sleeping in cars or outside.

Tenants' pathways into SMHH projects varied, but most involved a case manager who identified the opportunity for a person or household to obtain a supportive housing unit. As one participant told us,

I started sleeping in my car with my kids near the school. One of my kid's friends saw us and told the social worker. Then I got connected to...One Door, and it was like God had came down himself and said, "You're not going to be in this position anymore."

At Chloe Place, some tenants had applied for a regular apartment and during the application process discovered that they were eligible for a RAP rental subsidy.

Supportive housing tenants interviewed for this evaluation largely had positive feelings about their apartments. They often reported that their SMHH unit was the nicest home they'd ever had and were thankful to live in affordable, high-quality housing.

Tenants expressed mixed feelings about their neighborhoods. Some tenants discussed transportation challenges. The lack of a vehicle or reliable public transportation made working, attending school, visiting doctors, or shopping for groceries difficult. However, many tenants described their neighborhoods as "serene" or "peaceful" and said they felt safer there than they had in their previous neighborhoods.

Like residents of all communities, residents of the SMHH properties recounted positive experiences with neighbors as well as conflict. Geographic isolation may have contributed to the conflicts because tenants often "didn't have a lot to do...so you have to be in everybody's business," according to one case manager. A few case managers told us that some families avoided common areas out of fear that other families would "hotline" them, meaning report them to social services, although whether that ever happened is unclear. In some properties, conflicts arose from public drinking, drug dealing, or drug use. These problems often arose from tenants who were not part of the supportive housing programs. In interviews, several supportive housing tenants reported that they were the victims of racial harassment and that they felt the staff did not properly address it. In some cases, staff reported frustration with the lack of training and resources for addressing the unique tensions that may arise in supportive housing. Some of the more difficult situations were when racial conflicts arose between tenants, when some

tenants were concerned that others had special privileges, and when tenants were not taking their medications or were drinking to excess.

In a few sites, tensions arose between supportive housing tenants and property managers. Both Patriot Place and Beacon Village II had property manager turnover. At Patriot Place, a property manager was brought in who had more experience working with high-needs populations, including formerly homeless veterans. Beacon Village II saw multiple turnovers of property managers, with residents expressing some frustration with responsiveness regarding issues with their units and confusion about changing policies.

Despite these challenges, housing retention rates—the percentage of tenants who remained stably housed after program entry—were high. Information on housing retention was available for 78 of the 101 supportive housing tenants. Some tenants declined to share data for the evaluation, reliable exit data were not available for some tenants, and others entered supportive housing too close to the end of the evaluation period to measure retention. Housing retention was measured by dividing the number of supportive housing tenants who were still in permanent housing at a certain point in time by the total number of people who had entered supportive housing long enough ago to meet that mark. For example, for the 12-month housing retention rate, we calculated the number of tenants still housed 12 months after entering supportive housing and compared that with the number of people who had entered supportive housing at least 12 months before the end of the analysis period. Thus, if the analysis period ends on December 31, 2019, 50 people had entered supportive housing as of January 1, 2019, and 40 of them were still housed, the 12-month housing retention rate is 80 percent (40/50).

Table 3 shows the housing retention rates at 6, 12, 18, and 24 months after program entry for the program overall and by site. Eighty-six percent of all SMHH supportive housing tenants were still stably housed 12 months after program entry (65 of the 76 people who entered more than 12 months from the end of the analysis period), and 78 percent were stably housed 24 months after program entry (38 of 49 people who entered more than 24 months from the end of the analysis period). These retention rates are similar to those found in other evaluations of Housing First supportive housing (Pearson, Montgomery, and Locke 2009).

We combined Patriot Place and Berkshire Estates in our analysis of housing retention rates by site because they are both veterans' programs and the number of tenants in Berkshire Estates is too small to include on its own. Patriot Place/Berkshire Estates experienced some turnover, in part because of conflict between residents, the deaths of some tenants, and moves by a few tenants to higher levels of care. Some tenants exited Patriot Place and used their vouchers to rent apartments elsewhere in

Columbia. Staff members indicated that they were starting to see “a turnaround where folks are quitting drinking together or joining programs.” Chloe Place similarly had some program terminations for residents after significant violations, such as safety issues or illegal activity. Beacon Village II had a lower 24-month housing retention rate than Patriot Place and Berkshire Estates primarily because many families received only 18 months of rental assistance and those who did not qualify for a permanent voucher often could not afford to stay in their apartments without a subsidy.⁶

TABLE 3
Housing Retention Rates for Show Me Healthy Housing Supportive Housing Tenants

	All Tenants			Beacon Village II		Patriot Place/ Berkshire Estates		Chloe Place	
	# in cohort	# still housed	% still housed	# still housed	% still housed	# still housed	% still housed	# still housed	% still housed
6 months	78	73	94	23	85	27	100	23	96
12 months	76	65	86	23	85	24	89	18	82
18 months	54	45	83	23	85	22	81	—	—
24 months	49	38	78	19	70	19	86	—	—

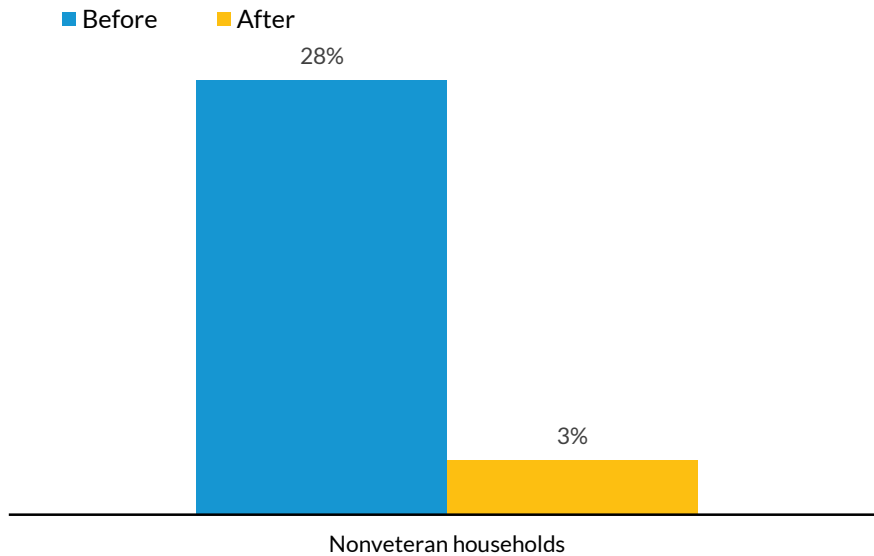
Source: Program data from Show Me Healthy Housing programs.

Notes: Sample is 78 tenants. Excludes tenants who entered supportive housing less than six months from the end of the analysis period. Housing retention data for Chloe Place were available for only the first 12 months.

Previous studies have found that supportive housing can reduce demand for emergency shelter and other homeless assistance programs. We analyzed local homelessness management information systems data to see whether this was the case for tenants in the SMHH nonveterans’ programs (Chloe Place and Beacon Village II). We found that supportive housing reduced the use of homeless programs: 28 percent of households had a homeless stay recorded in the local homelessness management information system before entering supportive housing, and just 3 percent had a homeless stay after entering supportive housing (figure 1). The reductions would have been greater if more families had used shelter before entering supportive housing, but families were much more likely to be on the streets, in their cars, in a home without running water or electricity, or in a double-up situation than in a homeless program.

FIGURE 1

Share of Nonveteran Households with Homeless Stays before and after Entering Supportive Housing



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Sources: Homelessness management information systems data pulled by the Institute for Community Alliances.

Notes: Sample is 28 households housed at Chloe Place or Beacon Village II. The “before” period is from April 1, 2014, to program entry. The “after” period is from program entry to February 2019.

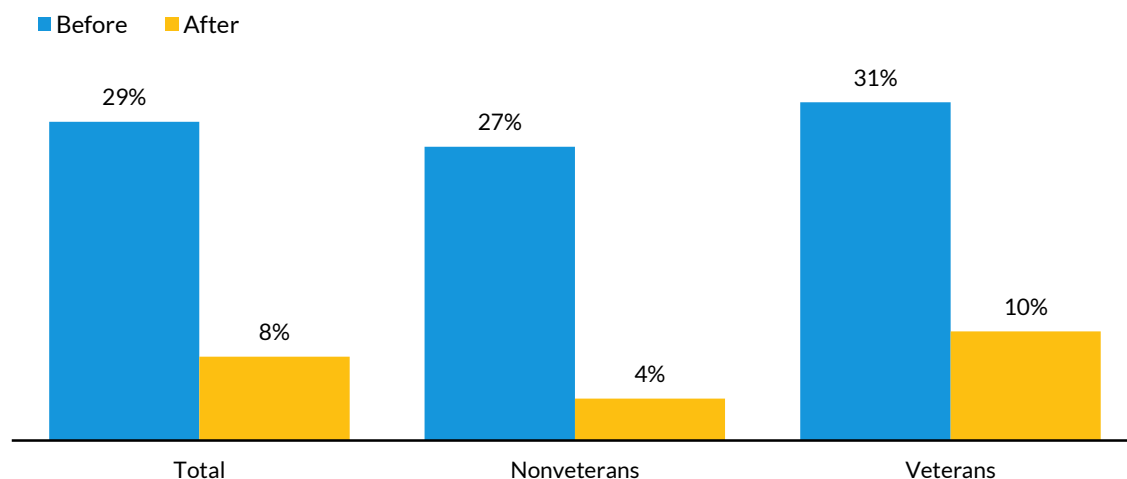
Our evaluation also used VA records to analyze the use of VA-contracted shelter beds and residential programs among SMHH tenants in the veterans’ programs. Unlike for the nonveterans’ programs, however, these data are only for the period after veterans entered supportive housing. The data show that of the 27 veterans for whom data were available, five (19 percent) used a VA residential treatment program and three (11 percent) used a VA-contracted shelter bed. For the most part, veterans who used a treatment or shelter program exited these programs quickly and returned to supportive housing. None of these stays lasted more than two months, and most lasted less than two weeks. All but one of the veterans who used these programs were still in supportive housing at the end of our analysis period.

Criminal Justice

To address whether supportive housing affected tenants’ involvement in the criminal justice system, we analyzed data from the Missouri Automated Criminal History System, maintained by the Missouri State Highway Patrol, for Chloe Place and Beacon Village II and data from Case.net, Missouri’s state courts case management system, for Patriot Place and Berkshire Estates. These data were available for 65 of the 78 adult SMHH supportive housing tenants. As shown in figure 2, although 29 percent of adults in

our evaluation had a conviction, parole violation, or pending criminal case in the two years before entering supportive housing, only 8 percent had one after entering supportive housing. Tenants in both the veterans' and nonveterans' programs experienced sharp drops in criminal justice involvement after entering supportive housing. Criminal justice involvement before entering supportive housing was slightly lower among adults in the nonveterans' programs because none of the adults at Beacon Village II had a criminal history in the two years before program entry. This may be because the property's background checks screened out applicants with a recent criminal history.

FIGURE 2
Share of Adult Show Me Healthy Housing Tenants with Convictions, Parole Violation, or Pending Criminal Cases before and after Entering Supportive Housing



URBAN INSTITUTE

Sources: Missouri Automated Criminal History System and Missouri Case.net.

Notes: Analysis is based on records from 65 out of 78 adult supportive housing tenants. The “before” period is two years before program entry. The “after” period is from program entry through July 2019.

In interviews, some tenants credited supportive housing with helping them turn away from criminal activity. Stable housing reduced the financial pressures that had caused some tenants to engage in illegal activities. Some tenants also credited the services they received through supportive housing, like anger management and behavioral therapy, with helping them address behaviors that had previously led to problems with the police. As one tenant explained,

If [the program] couldn't have helped financially, then it would have set me with a lot more interactions with the cops. I wouldn't jeopardize a place to live to get money. If they would have just gave me a place to stay. The things that I was out here doing I was doing because I had to live.

Income, Earnings, and Benefits

The average monthly income for the 63 SMHH supportive housing households for whom data were available increased by more than \$300 after they entered supportive housing (table 4). The percentage of households with income from benefits increased from 42 to 75, while the percentage of households with earned income increased from 12 to 19. Many supportive housing tenants were either disabled or retired, which helps explain the low percentage of working households.

TABLE 4

Income for Show Me Healthy Housing Households before and after Entering Supportive Housing

	Before	After
Percentage of households with earned income	12	19
Percentage of households with benefits income	42	75
Average monthly income	\$601.75	\$928.60

Sources: Program assessment data from Beacon Village II and Chloe Place and administrative data from the Columbia Housing Authority for Patriot Place tenants.

Notes: Sample is 63 households. This analysis does not include data from Berkshire Estates. “Before” data were captured when households entered supportive housing, and “after” data were captured when households had been in supportive housing for at least 12 months.

Each SMHH location provided assistance to help tenants find employment and increase their income. Patriot Place had an on-site community employment specialist to connect tenants with employment opportunities, including referrals to the VA’s Compensated Work Therapy program. PFH hired several Chloe Place tenants as peer specialists to help other members with their recovery from mental illness, substance abuse, or trauma. This provided a therapeutic benefit as well as a source of income for many tenants. One said, “I had never been in a place where people give you the opportunity to help people.”

However, while some supportive housing tenants worked or received cash assistance, many lacked any stable source of income. In interviews, tenants reported experiencing difficulty paying for groceries, copays for doctor visits and prescriptions, household cleaning supplies, lightbulbs, and other basic goods.

The barrier to finding steady work that supportive housing tenants cited most often was the lack of reliable transportation. Most available jobs were in the services industry (e.g., fast food) and required working shifts that started or ended outside of the service hours for public transportation. This gave tenants few options because they did not have regular access to a car and the jobs were not accessible by walking or biking. One participant described the challenges of trying to work in the service industry without a car:

The bus stops running at 6:00. I was working at Hardee's for a while, and I had to be there 4:30 in the morning, and I would walk, and it was good until I almost got hit by a car and I broke my ankle, so I was out for six months.

In addition to jobs in the service industry, several participants reported working as peer advocates or as care members for family members with a disability. Other participants reported receiving income from donating plasma, babysitting, or providing other services.

Most supportive housing households reported benefit programs (e.g., Supplemental Security Income, Social Security, and Temporary Assistance for Needy Families) as their primary source of income. Case managers at all sites helped tenants secure benefits and manage their income. Many of the veterans we interviewed had spent years trying to get or increase their VA compensation for service-related disabilities. Transportation challenges also made receiving benefits difficult because getting to social service agencies by bus often took more than an hour and involved multiple transfers.

Health

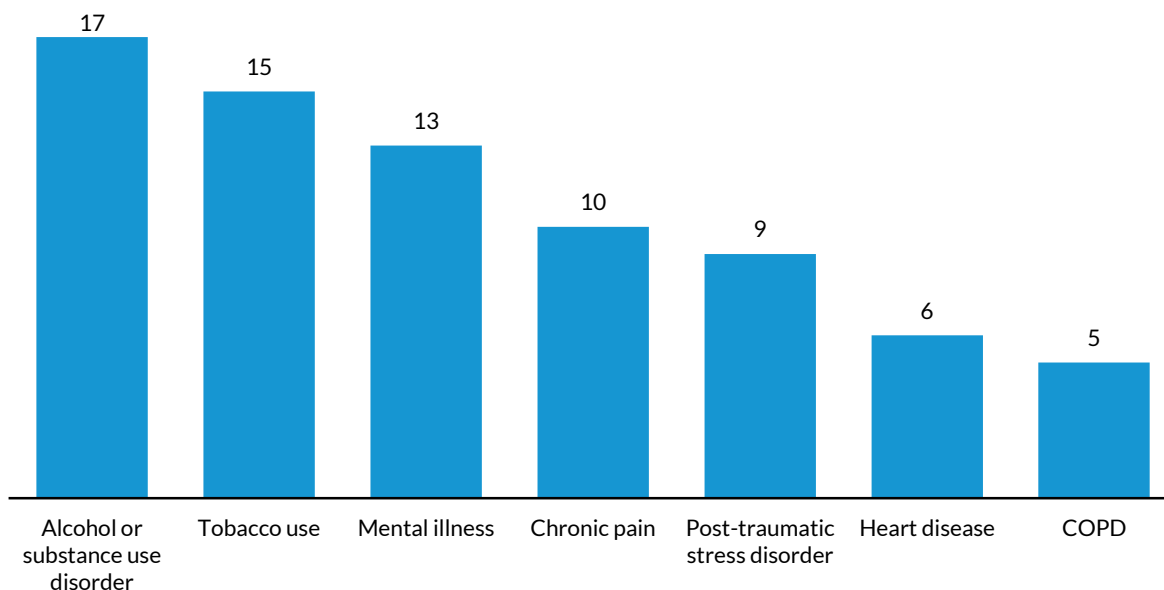
By the time they entered supportive housing, many tenants were already in poor health. One interview respondent told us that “when you are homeless, you can’t always treat your body the way you want.” These health conditions, in turn, jeopardized people’s ability to work, making it more difficult to find or maintain housing. Figure 3 shows the most commonly reported physical and behavioral health conditions for supportive housing tenants in the two veterans’ programs. These data are based on assessments that VA staff conducted at program intake. Health information was available for 26 of the 39 supportive housing tenants in veterans’ programs. Sixty-five percent of these veterans reported having an alcohol or substance use disorder, 58 percent reported a tobacco or nicotine dependence, and 38 percent reported that a doctor or nurse had diagnosed them with chronic pain. Half of the 26 veterans had some form of mental illness, such as schizophrenia, bipolar disorder, or a personality or anxiety disorder, and 35 percent had post-traumatic stress disorder. Heart and lung conditions were also prevalent.

In their baseline assessment before entering supportive housing, veterans were asked to assess their overall health and the health of their teeth. Of the 21 veterans for whom data were available, 62 percent of veterans reported their physical health as “poor” or “fair,” and 69 percent reported that their teeth were in “poor” or “fair” condition.

FIGURE 3

Most Common Health Conditions among Supportive Housing Tenants in Veterans' Programs

Number of veterans who reported having each condition



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Source: Veterans Affairs' Homeless Operations Management and Evaluation System data.

Notes: Sample size is 26; health condition information was missing for 13 veterans. COPD = chronic obstructive pulmonary disease.

Our evaluation also analyzed the health care diagnoses of supportive housing tenants at Chloe Place and Beacon Village II. That information comes from MO HealthNet, Missouri's Medicaid program. Analysts at the University of Missouri Center for Health Policy analyzed the Medicaid claims for the people in our study from January 1, 2014, to December 31, 2018, along with those from a reference group of Medicaid enrollees whose residential addresses matched to known homeless shelters or mail-forwarding services for people without a stable address. Because of the analysis timeframe, we do not know whether individuals received their first diagnosis for these conditions before or after entering supportive housing.

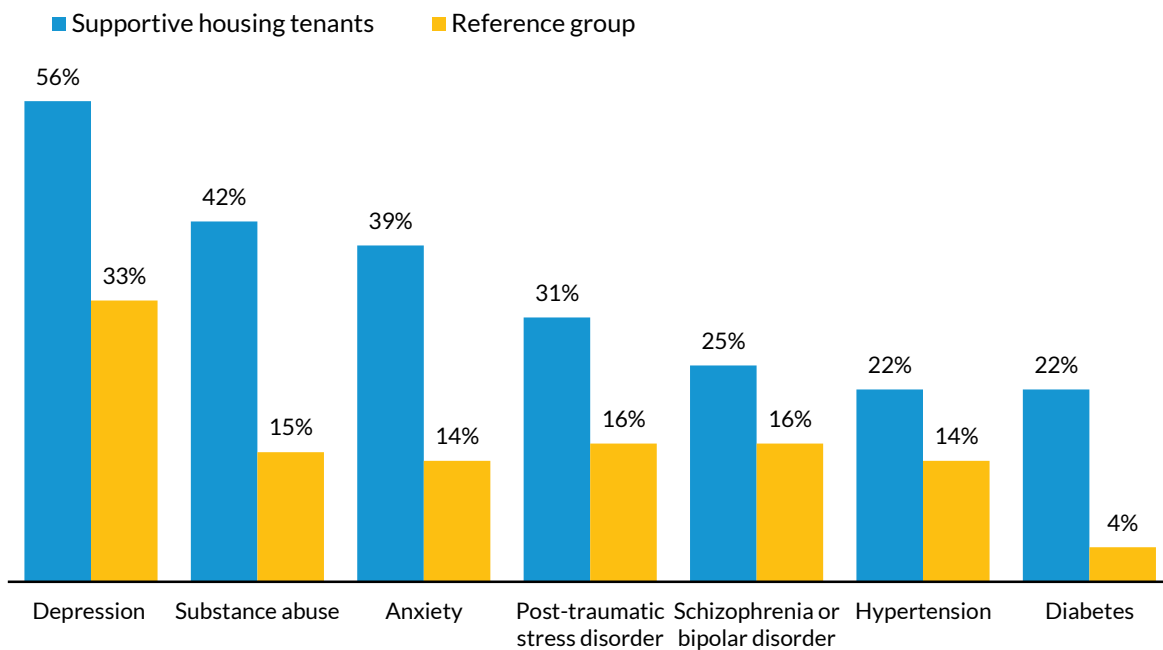
As figure 4 shows, the most common diagnoses for supportive housing tenants in the nonveterans' programs were depression (56 percent), substance use disorders (42 percent), anxiety (39 percent), post-traumatic stress disorder (31 percent), and schizophrenia or bipolar disorder (25 percent). Supportive housing tenants were far more likely to experience these conditions, as well as hypertension and diabetes, than members of the reference group were. Although these are large differences, we did not test whether they were statistically significant. The higher rate of diagnoses for the supportive housing group indicates that they have higher levels of need, not that receiving supportive housing is

associated with worse health care outcomes. This indicates that SMHH programs prioritized assistance to more vulnerable populations.

Among children in supportive housing, acute upper respiratory infections were the only commonly reported condition, affecting 68 percent of tenants younger than 18, compared with 28 percent of adult supportive housing tenants.

FIGURE 4
Most Common Health Conditions among Nonveteran Supportive Housing Tenants and Reference Group

Share of each group that was diagnosed with each condition



URBAN INSTITUTE

Source: MO HealthNet data.

Notes: Sample of supportive housing tenants is 56 people who lived at Chloe Place or Beacon Village II and were enrolled in MO HealthNet during the analysis period. The reference group is 491 MO HealthNet enrollees in the same counties who used a mail-forwarding service or whose residential address matched a known homeless shelter from 2014 to 2018.

Each SMHH provider took a different approach to addressing health care within supportive housing.

In the veterans' programs, supportive housing tenants were served by the Veterans Health Administration, the country's largest integrated health care system. HUD-VASH case managers frequently referred to the VA as "the land of milk and honey" because of the wide range of specialty programs it offered. The Veterans Health Administration, however, is a huge bureaucracy, and HUD-

VASH case managers sometimes felt removed from other parts of the system, such as primary care. Case managers felt it was important to “respect veterans’ autonomy” and not get involved in health care issues unless their clients asked them to. Similarly, some veterans saw their HUD-VASH case managers as removed from their primary care team. As one veteran put it: “Your case worker can only do so much. They can’t tell the doctors what not to do.” Although these concerns are valid, new research has shown that homeless and formerly homeless veterans have an easier time navigating the Veterans Health Administration bureaucracy and report higher health-care satisfaction if they are part of an integrated care team that includes their case manager and behavioral health and primary health providers (Jones et al. 2018).

Chloe Place provided an integrated service model. The housing developer was also the property manager, case manager, and for many supportive housing tenants the health care provider. PFH is unusual among community health centers in having its own supportive housing division, which sits within its behavioral health department. The property manager works with supportive housing case managers who help formerly homeless households find and maintain housing and increase their income. In addition, PFH clients are assigned community support specialists. Community support specialists tended to take a more active role than traditional supportive housing case managers in helping tenants schedule and attend medical appointments, manage medications, and inform their treatment plan.

By contrast, The Kitchen, the service provider for Beacon Village II, was not a health care provider. The Kitchen does employ a part-time nurse who helps clients whose health problems are too complex for the organization’s case managers. The nurse meets regularly with patients, including some at Beacon Village II. She accompanies them to their medical appointments, helps them understand their treatment plans, calls and refills prescriptions, and prepares end-of-life directives. She also helps pay patients’ Medicaid copays and negotiate lower costs for prescription drugs.

In interviews, many tenants reported improvements to their health after moving into supportive housing. They reported being more attentive to their health needs and more capable of regularly taking their medications. Several reported gaining weight because of reduced stress and better diet. One tenant said, “The stress level has gone down, I take my medication on time, and I feel my health improving.” Another said: “Before my health was very poor. I would say it is 10 times better. I used to be on seven different medicines. Since I moved, I’m only on two medicines. I’ve gained 47 pounds.”

Some also reported that their case managers and other tenants supported them in their recovery from addiction and helped prevent them from relapsing. One Chloe Place tenant said of the PFH support staff, “If you get sick or if they don’t see you, they get concerned; there’s someone out here all

the time.” Another recounted a time that they were feeling “down in the dumps” and credited a PFH case manager’s visit with preventing them from relapsing. Other tenants, however, reported no change in their health after moving into supportive housing, and some reported deterioration because of either geographic isolation or stress from interpersonal conflict. One reported that the stress of their problems with other tenants had exacerbated their PTSD symptoms and increased their blood pressure. Another tenant said her family exercised less because they were living in a less-walkable neighborhood. Several tenants spoke of difficulty navigating the stairs to get in and out of their apartments and concerns about slipping on walkways.

For the most part, SMHH programs did not collect detailed information on changes in the health of their supportive housing tenants. The veterans’ programs switched their assessment scale during the evaluation period, so we did not have sufficient data points to measure changes in tenants’ health. Chloe Place measured changes in functioning every 12 months using the Daily Living Activities Functional Assessment tool. The assessment has 20 items, with each item representing a different component of independent living. For each item, individuals are rated on a seven-point scale, with 1 being the lowest functioning level and 7 the highest. As shown in table 5, Chloe Place supportive housing tenants showed some overall improvement in functioning from entry to 12-month follow-up. Average total scores increased by almost 3 points, with the greatest improvements shown in money management, productivity, housing stability, dress, and community resources.

TABLE 5

Daily Living Activities Assessment Scores for Chloe Place Supportive Housing Tenants

	Average score at program entry	Average score 12 months after entry
Health practices	3.64	3.45
Housing stability	3.36	4.27
Communication	3.82	3.91
Safety	4.00	4.45
Time management	4.00	4.00
Money management	2.82	3.82
Nutrition	3.18	3.64
Problem solving	3.82	3.82
Family relationships	4.64	4.18
Alcohol and drug use	3.64	3.55
Leisure	3.91	4.27
Community resources	3.73	4.27
Social network	4.00	4.45
Sexual health	5.27	5.18
Productivity	2.82	3.82
Coping skills	3.55	3.36
Behavior norms	4.27	4.00
Personal hygiene	4.45	4.73
Grooming	4.64	5.00
Dress	4.18	5.00
Daily Living Activities score	38.86	41.59

Source: Daily Living Activities Functional Assessment scores as collected by program staff.

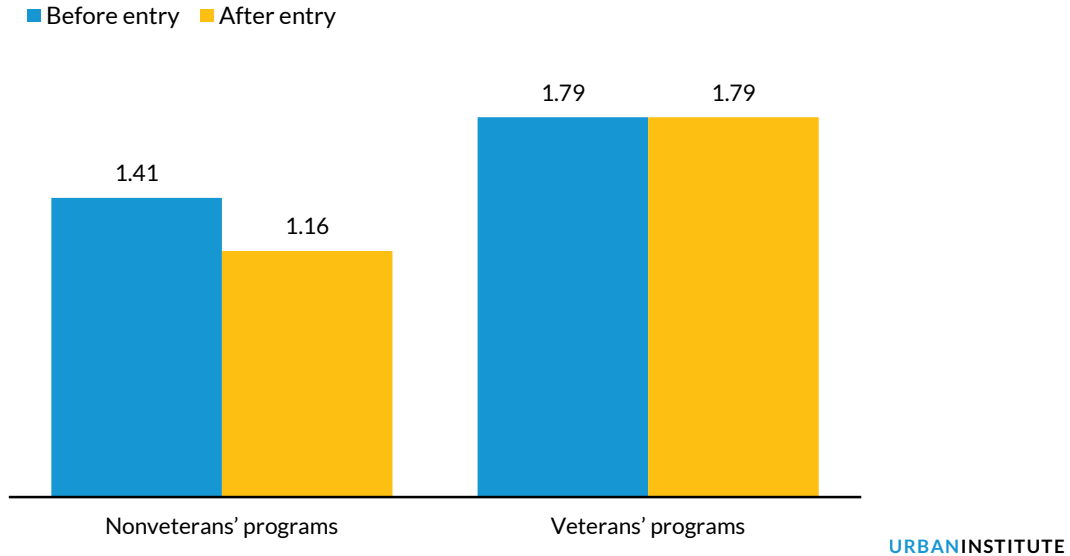
Notes: Sample is 11 tenants; only includes respondents with nonmissing values for both the first and second assessments. Total Daily Living Activities score is calculated by summing the values for all items and dividing by 2.

Some supportive housing evaluations have found reductions in ED visits among tenants, who stopped using EDs as a shelter of last resort and were more likely to go to a health clinic or a doctors' office for routine care. Many of these studies, however, lack a comparison group, so the reduction in ED use could be a "regression to the mean"—people commonly enter supportive housing after an acute health care crisis (National Academies of Sciences, Engineering, and Medicine 2018). In its review of the evidence, however, the National Academy of Sciences reported that it found "no substantial evidence" that supportive housing contributes to improved health outcomes. Our study's findings on the effects of supportive housing on ED visits were mixed. As shown in figure 5, the average annual number of ED visits in VA hospitals did not change for veterans after entering supportive housing.⁷ However, for participants in the nonveterans' programs, the average number of annual ED visits decreased slightly after tenants entered supportive housing.

Data on hospitalizations and health care costs were available only for nonveterans' programs. Our analysis found slight increases in the average annual number of hospitalizations and average annual MO

HealthNet costs after tenants entered supportive housing (table 6). One VA case manager speculated that some veterans may have increased their health care use as they became more engaged in services while others may have used fewer services as their needs became less severe.

FIGURE 5
Average Annual Emergency Department Visits among Show Me Healthy Housing Tenants before and after Entering Supportive Housing



Sources: Analysis of MO HealthNet claims by the University of Missouri Center for Health Policy (nonveterans' programs); Harry S. Truman Memorial Veterans' Hospital (veterans' programs).

Notes: Sample is 56 supportive housing tenants in nonveterans' programs who were also MO HealthNet enrollees and 27 tenants in veterans' programs. For nonveterans' programs, "before entry" is the annualized period between January 1, 2014, and program entry, and "after entry" is the annualized period between program entry and December 31, 2018. For veterans' programs, "before entry" is the annual average for the two years before program entry, and "after entry" is the annualized period from program entry to June 10, 2019.

TABLE 6
Change in Average Annual Hospitalizations and Annual Medicaid Costs among Nonveterans' Program Tenants before and after Entering Supportive Housing

	Before program entry	After program entry
Average annual hospitalizations	0.9	1.1
Average annual Medicaid costs	\$7,083	\$8,975

Source: University of Missouri Center for Health Policy analysis of MO HealthNet data from January 1, 2014, to December 31, 2018.

Notes: Sample is 56 supportive housing tenants in nonveterans' programs who were enrolled in MO HealthNet during the analysis period. "Before program entry" is the annualized period between program entry and January 1, 2014, and "after program entry" is the annualized period between program entry and December 31, 2018.

Limitations

This evaluation has several important limitations. The sample is relatively small and heterogeneous. Each program had its own eligibility criteria, creating a diverse study population of single adults and families with different homeless histories and health conditions. Sites also varied in the type of rental subsidy and services they offered households and the program outcomes they tracked. Because each program had different data collection requirements, other than housing stability, we lack standard outcome measures for the whole study population. Like most supportive housing evaluations, this one lacked an experimental control group. This makes it difficult to determine whether any observed changes in housing stability, criminal justice involvement, or health were the result of SMHH or would have happened without it. Although our analysis of the Medicaid data of tenants in the nonveterans' programs does include a reference group of homeless or unstably housed Medicaid enrollees, no similar reference group was available for tenants in the veterans' programs. Also, for the reasons discussed in the methods sections, the reference group can only be used to understand differences in health care diagnoses, rather than changes in health status or health care costs.

Another limitation is high missing rates for certain program data, such as the self-reported health status of tenants in the veterans' programs. Respondent bias might have occurred if the tenants who did not provide data were less likely to engage in services or were otherwise different in unobserved ways from tenants who did share data.

Conclusion and Recommendations

Despite the limitations detailed earlier, this study was an opportunity to take a close look at supportive housing in a place (Missouri) where it has not been extensively evaluated. And it provided new insights into how supportive housing is developed, how it is operated, and how it affects tenants' lives.

The SMHH grants were the foundation's entry into supportive housing. Although the grant amounts—ranging from \$24,000 to \$500,000—were small relative to the full costs of the projects, they were instrumental to successful financing. Grantee staff members report that the grants covered the “soft costs” for essential early activities like site selection, design, and legal fees that can be the most difficult to fund. In addition, by providing funding early in the development process, the SMHH grants functioned as a “seal of approval” that helped the projects receive other funding, including competitively awarded 9 percent low-income housing tax credits. This could be a template for other philanthropies interested in better leveraging their investments.

By investing early, the foundation provided capital at a critical time to developers, but it increased the risk that the projects it funded would not ultimately become supportive housing. Although all the projects it funded completed construction and began serving tenants, only two projects (Chloe Place and Patriot Place) included all three necessary components of supportive housing. Beacon Village II lacked a rental subsidy without time limits, and Berkshire Estates lacked both a rental subsidy without time limits and supportive services. The lack of fidelity to the supportive housing model across the four sites raises questions about the thousands of other supportive housing projects across the country. Research has shown a relatively modest association between increases in supportive housing and decreases in chronic homelessness (Byrne et al. 2014). A lack of fidelity to the model may be one reason the association is not stronger; another could be that a lack of affordable housing and behavioral health services is causing more people to become chronically homeless.

More research to assess adherence to the Housing First supportive housing model by programs across the country would be helpful. In the meantime, funders can partner with experienced technical assistance providers to ensure that the organizations they fund have the expertise and mission-focus to produce high-quality supportive housing for people experiencing chronic homelessness and other high-needs populations. They should also put mechanisms in place to monitor the projects they fund and hold organizations accountable if they fail to deliver on promises related to producing supportive housing.

Our evaluation showed the challenges that local providers face in implementing federal guidelines to adopt Housing First principles in supportive housing. Although case managers were generally supportive of Housing First and tried to follow its principles, developers and property owners often gave greater weight to the desire to protect their investments by screening out high-barrier individuals and strictly enforcing program rules. Even staff members who believed in Housing First generally felt that the desire to prioritize supportive housing for those with the greatest need had to be balanced with concerns for the harmony of the development and the need for all tenants to feel safe.

Our evaluation was consistent with prior research showing that supportive housing allows people experiencing homelessness to find and maintain housing. Seventy-eight percent of SMHH supportive housing tenants remained stably housed 24 months after program entry, and that percentage would likely be higher if all the sites had provided rental subsidies without time limits. Our interviews found that tenants attached great value to having their own home and were motivated to maintain it. The stability of having a home and the support provided by case managers contributed to a notable decline in criminal justice involvement after tenants entered supportive housing. Although many tenants reported improvements in their health, our analysis found no evidence that supportive housing reduced tenants' emergency department visits, hospitalizations, or health care costs. This is consistent with

other research on the relationship between supportive housing and health care (National Academies of Sciences, Engineering, and Medicine 2018). Our interviews found that many tenants had chronic health conditions that would not be expected to improve with housing and that case managers were often reluctant to get involved with tenants' health care problems.

Finally, our evaluation found that supportive housing relieved a major source of tenants' stress and helped them regain a feeling of normalcy and control over their lives. However, it is not a panacea. Many supportive housing tenants experienced interpersonal conflict and feelings of isolation and depression that were often fueled by limited transportation options. To address these challenges, funders should prioritize supportive housing projects that provide easy access to employment and educational opportunities, groceries, health care providers, and other crucial amenities. In making these considerations, they should give priority to projects that are in walkable neighborhoods or on existing public transportation routes over projects that pledge to change bus routes or make other enhancements if funded. In addition, supportive housing tenants benefit from integrated teams that can help them find and maintain their housing, access health care, and understand and follow their treatment plans. Our evaluation shows that supportive housing is effective at helping vulnerable Missourians resolve their homelessness and reduce the use of homeless shelters and the criminal justice system. Further evaluation may show more long-term benefits if supportive housing tenants are supported in accessing vital services and opportunities to work and connect to social networks.

Notes

- ¹ Homelessness is a diagnostic code in the ICD-10, the 10th revision of the International Statistical Classification of Diseases and Related Health Problems.
- ² This language is from the Missouri Foundation for Health's request for proposals to provide predevelopment and gap financing to nonprofit organizations developing affordable, supportive, and healthy housing for vulnerable populations.
- ³ For the purposes of this evaluation, we treated all the occupants of the set-aside units as supportive housing tenants even if they did not receive a rental subsidy without time limits or supportive services.
- ⁴ From the Missouri Department of Mental Health (DMH) housing manual, August 2015: As of July 2012, under the HEARTH Act and its regulations, Shelter Plus Care ceased to exist by that name and became part of a larger single source of funds called the Continuum of Care (CoC) Program. "Shelter Plus Care" continues to be DMH's name for its 43 permanent housing programs funded under the US Department of Housing and Urban Development's CoC Program.
- ⁵ Data on health insurance coverage and receipt of food stamps were not available for households at Chloe Place.
- ⁶ In some cases, Kitchen staff extended rapid re-housing assistance to 24 months, but that is the maximum allowable length of assistance for US Department of Housing and Urban Development-funded rapid re-housing programs.
- ⁷ The data include all emergency department visits within the Veterans Integrated Service Network 15 area, which includes the vast majority of Missouri, eastern Kansas, and western Indiana.

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STATEMENT OF INDEPENDENCE

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