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Veterans Support to Self-Reliance Pilot Program

Final Evaluation Report

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Research Report

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About This Report

This report presents findings from the impact evaluation of the California Department of Veterans Affairs (CalVet)'s statewide pilot program Veterans Support to Self-Reliance (VSSR). VSSR is an initiative designed to provide enhanced supportive services to 425 veterans living in permanent supportive housing (PSH). Participating veterans have experienced chronic homelessness and have one or more serious health conditions. The VSSR program operates through four regional service providers across California: Nation's Finest (Northern California), Swords to Plowshares (San Francisco Bay area), People Assisting the Homeless/PATH (San Diego), and U.S.VETS (Inland Empire and Los Angeles regions). The evaluation assesses program effectiveness and impact on veteran resident well-being, with specific focus on housing stability, health-related behaviors, health care utilization, perceived health status and functional limitations, social support and connectedness, and perceived quality of life. This report examines demographic and clinical characteristics for 560 VSSR participants and presents longitudinal findings for 400 participants with at least one year of program enrollment, documenting trends in service utilization and well-being outcomes. The findings are intended to inform CalVet program administrators, grantee service providers, and state and federal policymakers working on supportive service delivery for housing-insecure veterans with complex health needs.

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Summary

Issue

Permanent supportive housing (PSH)—a long-term housing subsidy paired with supportive services—reliably keeps formerly homeless people housed, but the evidence that it improves health and well-being is thinner, particularly for veterans. That gap matters in California, where more than 9,000 veterans experienced homelessness in 2024 and where the veteran population is aging: Roughly 69 percent of California veterans are 55 or older. Veterans who have experienced chronic homelessness often arrive in PSH with the functional limitations of adults decades older, and existing supportive services, including those attached to federal U.S. Department of Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH) vouchers, may not meet the needs of residents with high clinical or social acuity.

In July 2023, the California Department of Veterans Affairs (CalVet) awarded three-year pilot grants to four organizations (Nation’s Finest, People Assisting the Homeless [PATH], Swords to Plowshares, and U.S.VETS) to deliver enhanced supportive services at 13 PSH locations across four grantees in six counties. The Veterans Support to Self-Reliance (VSSR) pilot funds peer specialists, service assistants, transportation specialists, mental health specialists, social workers, nurses, and occupational therapists, with the goal of helping aging and high-acuity veterans age in place rather than move prematurely into institutional care or return to homelessness. CalVet and the grantees sought an independent evaluation of whom the pilot reached, how participants fared, what it cost relative to alternatives, and what a future evaluation would need to establish impact.

Approach

We evaluated the pilot using program data collected from June 2023 through May 2026, together with cost data, interviews, and a structured literature review:

- **Participant characteristics:** descriptive analysis of enrollment records for 560 veterans who enrolled in the pilot, covering demographics, military service, chronic conditions, functional needs, service use, and habitability concerns at baseline
- **Housing stability:** classification of every housing exit through May 2026 into one of three outcomes: positive (another independent living situation), neutral (includes higher level of care or death), and negative exits (includes returns to homelessness), summarized in six-month intervals
- **Changes over time:** comparison of baseline and fourth-quarter outcomes for the 400 participants with a full year of enrollment and complete follow-up data
- **Service use and outcomes:** lagged mixed-effects models relating quarterly use of three VSSR services (assistance with daily living activities, group programs, and other general

assistance) to outcomes in the following quarter, over four quarters and, for 233 longer-tenured residents, eight quarters

- **Quality of life:** mixed-effects models using the annual self-administered resident survey to test how health, housing quality, housing safety, housing worry, and loneliness relate to residents' own ratings of their quality of life, plus paired first-to-last survey comparisons showing how many residents improved, declined, or held steady in each of six domains
- **Cost analysis:** estimation of annual cost per veteran from grantee expenditure data, combined with modeled housing voucher and case management costs, compared with California residential and service-only alternatives
- **Leadership interviews:** semistructured interviews with leadership at each of the four grantee organizations on program planning, implementation, and sustainability
- **Future evaluation design:** a structured review of 16 studies (2007–2026) that used administrative data and comparison groups to evaluate PSH, used to design recommendations for a future causal evaluation.

Key Findings

- **The pilot reached its intended population and exceeded its enrollment target.** The pilot enrolled 560 veterans against a target of 425. Seventy-nine percent were 56 or older, 31 percent had four or more chronic conditions, and depression (38 percent), anxiety (33 percent), and posttraumatic stress disorder (PTSD; 31 percent) were the most common diagnoses. Staff identified substantial unmet need for daily living assistance at enrollment, led by housekeeping (32 percent) and companionship or emotional support (25 percent).
- **Housing stability was the program's strongest result.** Only 20 of 560 participants exited to an unstable situation over three years, an adverse exit rate of 3.6 percent that showed no upward drift as the cohort aged and expanded. Most exits reflected health trajectories rather than housing failure: 62 percent of all exits were transitions to a higher level of care or occurred because a veteran died. A study of Los Angeles HUD-VASH residents reported that 15 percent experienced a negative housing exit over an average of about three years (using a broader definition that included program disengagement and noncompliance alongside eviction and returns to homelessness).
- **Acute health events and emergency care declined over the first year.** Falls fell by 59 percent (22 to 9 percent) and emergency medical visits by 75 percent (15 to 4 percent). Inpatient medical visits fell 36 percent and outpatient mental health visits by 44 percent. The share of residents with no acute events rose from 74 to 90 percent.
- **Daily living needs were met and health behaviors improved.** Few residents were receiving assistance with daily living activities prior to the pilot; by the fourth quarter, 37 percent received companionship or emotional support and 26 percent received housekeeping help. Unmet need fell sharply in most categories, although 13 percent still reported unmet housekeeping need. Missed medical appointments fell 54 percent, the share eating three meals daily rose from 37 to 53 percent, and alcohol, stimulant, and opioid use each fell 40 percent or more.

- **Social engagement rose and habitability complaints fell.** Participation in three or more group programs tripled, from 12 to 37 percent, and cleanliness complaints fell by 53 percent.
- **Service use did not track outcomes in a simple benefit pattern.** Residents receiving daily living assistance or other general assistance showed poorer subsequent health and higher acute care use, most plausibly because staff direct services toward residents with the greatest needs. Group program participation was associated with fewer habitability complaints and, over eight quarters, more frequent time outside the unit.
- **Residents' own perceptions predicted quality of life; measured service use did not.** Self-rated health, housing quality, housing safety, freedom from housing worry, and absence of loneliness each independently predicted better quality of life. By contrast, none of the 24 tested associations between measured service use and quality of life or loneliness reached conventional significance.
- **Residents' self-rated quality of life, general health, and housing quality improved between their first and most recent survey.** Net shifts were +13.6, +12.8, and +10.0 percentage points, all statistically significant, although the housing quality estimate rests on a much smaller sample. Housing worry, housing safety, and loneliness showed substantial movement in both directions with no significant net change.
- **VSSR costs less than every residential alternative with current California figures.** Enhanced services cost \$17,437 per veteran per year; adding voucher-linked case management and the housing subsidy brings total public investment to roughly \$42,800 to \$66,200. That range runs 23 to 50 percent below the private assisted living median of \$85,471 and between one-quarter and just under one-half the cost of semi-private nursing facility care. Many alternatives are also rationed in ways VSSR is not: Medi-Cal's Assisted Living Waiver operates in 15 of 58 counties with more people waitlisted than enrolled, and no Veterans Home campus sits in four of the six VSSR counties.
- **Grantee leaders converged on which roles mattered most, and on the funding cliff.** All four named peer support specialists and service assistants as the highest-value roles and the ones they most hope to sustain. All four made continuation contingent on securing new funding.

Key Limitations

The evaluation was designed to document how participants fared during the pilot, not to compare them with veterans who did not receive VSSR services. With no comparison group, the findings cannot establish what the program caused. Analyses of change over time are restricted to participants with a full year of enrollment, a subgroup with significantly lower baseline rates of depression, anxiety, PTSD, and substance use disorder than other enrollees, so results may not generalize to everyone the pilot served. Most outcome data were entered by pilot staff on residents' behalf, and staff familiarity with residents grew over the observation period, which may itself shift what gets recorded. The service-use analyses involve roughly 30 statistical tests and modest samples and should be treated as exploratory. Cost figures rest on different pricing bases (market rates, net public costs, contract rates, grant expenditures, and published research estimates) and indicate relative magnitude rather than precise equivalents. The leadership

interviews reflect one interview per grantee, from organizations with an interest in the program's continuation.

Recommendations

We recommend that CalVet and the grantee organizations take the following actions:

- **Prioritize peer support specialist and service assistant roles** in any continuation or successor program. All four grantees identified them as the highest-value roles, and the group programming these roles make possible is the one service associated with fewer habitability complaints and more frequent time outside the unit.
- **Close the remaining unmet need in housekeeping**, which 13 percent of residents still reported at the end of their first year, along with meal preparation and laundry, each near 7 percent.
- **Establish a data linkage with the U.S. Department of Veterans Affairs** and regional Homeless Management Information Systems and construct a propensity-matched comparison group of veterans with similar health profiles and housing instability who did not receive VSSR services. No other step would do as much to change what a future evaluation can claim.
- **Report VSSR's negative exit rate against published Continuum of Care benchmarks**, keeping in mind that exit destination data in the Homeless Management Information System can be unreliable.

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Chapter 1. Project Description

This is the final impact evaluation report of the California Department of Veterans Affairs' (CalVet's) California statewide pilot program, entitled Veterans Support to Self-Reliance (VSSR). VSSR is a three-and-a-half-year initiative¹ to provide enhanced services to 425 veterans² who reside in permanent supportive housing (PSH). PSH consists of a long-term housing subsidy coupled with supportive services. Veterans included in the VSSR initiative may have received PSH through a federal housing subsidy called HUD-VASH (U.S. Department of Housing and Urban Development–Veterans Affairs Supportive Housing) or through another PSH initiative, such as HUD's Continuum of Care Program (CoC),³ or other state or local initiatives.

Background on Veteran Homelessness and Supportive Housing

Permanent Supportive Housing Through HUD-VASH Has Proven Effective for Housing Stability

PSH is an effective intervention for increasing housing stability among people with co-occurring health conditions who are experiencing homelessness.⁴ Since 2008, the federal government has made significant investments in PSH for veterans through the HUD-VASH program, which provides a housing subsidy in the form of a voucher along with supportive services managed by the U.S. Department of Veterans Affairs (VA). As of 2024, HUD reported that more than 110,000 HUD-VASH vouchers were being administered nationwide. About 81,000 of these (approximately 74 percent) are actively used to lease units by veterans, while the remaining vouchers are reserved for veterans who have been issued assistance but are still searching for housing or awaiting placement. A national evaluation of the HUD-VASH program over a ten-year period (2007–2017) demonstrated that it has meaningfully contributed to a

¹ The pilot includes a three-year observational and formal reporting period (from July 1, 2023, to June 30, 2026) and a six-month wind-down phase (from July 2026 to February 28, 2027).

² CalVet, *Report to the Legislature: Veteran Support to Self-Reliance Pilot Grant*, February 2025b.

³ CoC is both a program and planning framework established by HUD to coordinate community efforts to end homelessness. It provides funding to rehouse individuals and families and promotes a community-wide commitment to ending homelessness.

⁴ Yinan Peng, Robert A Hahn, Ramona K C Finnie, Jamaica Cobb, Samantha P Williams, Jonathan E Fielding, Robert L Johnson, Ann Elizabeth Montgomery, Alex F Schwartz, Carles Muntaner, et al., "Permanent Supportive Housing With Housing First to Reduce Homelessness and Promote Health Among Homeless Populations With Disability: A Community Guide Systematic Review," *Journal of Public Health Management and Practice*, Vol. 26, No. 5, September/October 2020; Robert Rosenheck, Wesley Kaspro, Linda Frisman, and Wen Liu-Mares, "Cost-Effectiveness of Supported Housing for Homeless Persons with Mental Illness," *Archives of General Psychiatry*, Vol. 60, No. 9, September 2003.

significant reduction in veterans' homelessness over that same period.⁵ Because veterans may also access PSH through other federal, state, or local initiatives, there is no single, consolidated national figure for the exact number of veterans in PSH through CoC or other non-HUD-VASH programs.

Evidence on Health and Well-Being Outcomes Remains Limited

While PSH is effective in improving housing stability, there is less compelling evidence about the intervention's effectiveness on improving health and well-being, especially among veteran populations. A review conducted by the National Academies of Sciences (2018) found that while PSH reliably improves housing stability for people experiencing chronic homelessness, there is limited and inconsistent evidence that it directly enhances health outcomes.⁶ In their systematic review, Peng et al. (2020) found that Housing First–based PSH programs significantly reduced homelessness and improved housing stability relative to Treatment First or Treatment-as-Usual programs, with some evidence of health benefits, such as reduced hospital use and mortality among specific groups. However, the study noted that improvements in health outcomes were inconsistent and largely limited to certain subpopulations, such as individuals with HIV, with little evidence available on effects among veterans.

A systematic review of studies with predominantly one- to three-year follow-up periods by Ly and Latimer (2015) found that PSH may reduce the use of costly health and social services.⁷ Research on veteran populations is mixed. Studies of the HUD-VASH program show that recipients may use more inpatient mental health treatment than veterans receiving standard VA case management in shelters, transitional housing, or treatment programs.⁸

More recently, a cross-sectional study at the VA Greater Los Angeles (VAGLA)—the nation's largest homelessness services program for veterans—found that veterans in HUD-VASH used more treatment services for chronic physical illnesses, mental health, and substance use disorders relative to veterans who were currently homeless and receiving care at the VAGLA

⁵ William N. Evans, Sarah Kroeger, Caroline Palmer, and Emily Pohl, "Housing and Urban Development–Veterans Affairs Supportive Housing Vouchers and Veterans' Homelessness, 2007–2017," *American Journal of Public Health*, Vol. 109, No. 10, September 4, 2019.

⁶ National Academies of Sciences, Engineering, and Medicine, *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*, National Academies Press, July 11, 2018.

⁷ Angela Ly and Eric Latimer, "Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature," *Canadian Journal of Psychiatry*, Vol. 60, No. 11, November 1, 2015.

⁸ Ann E. Montgomery, Lindsay L. Hill, Vincent Kane, and Dennis P. Culhane, "Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH," *Journal of Community Psychology*, Vol. 41, No. 4, March 21, 2013; Rosenheck et al., 2003. Montgomery et al. (2013) examined outcomes during the first year after placement in permanent housing, and Rosenheck et al. (2003) followed veterans for three years.

Healthcare System.⁹ Given that people placed in PSH may suffer from multiple chronic health conditions, increased use of health services may not necessarily be considered a poor outcome, as the health severity of many PSH participants may be best managed by ongoing treatment receipt.

Veteran Homelessness Persists at High Levels in California

Despite robust efforts across the country to reduce veteran homelessness over the past decade, the number of veterans experiencing homelessness in the state of California remains relatively high (i.e., estimated to be over 9,000 in 2024, of which approximately 69 percent are unsheltered).¹⁰ These ongoing trends, partially due to the lack of affordable housing and service access, may lead to chronic or long-term episodes of homelessness. Homelessness can exacerbate physical decline, leading to functional limitations and falls at rates seen in housed adults decades older.¹¹ Veterans may also face unique challenges to obtaining stable housing due to the stress and trauma related to their military service.

Aging Veterans Need Enhanced Supports to Stay in Place

In addition to these trends in veteran homelessness, it is important to note that the veteran population as a whole is aging—the median age of all U.S. veterans in 2026 was 63 years.¹² More specifically, veterans aged 55 and over represent approximately 69 percent of the entire California veteran population, and 25 percent are over 75 years old.¹³ Aging is a well-established risk factor for the development of chronic health conditions and increased health care utilization.¹⁴ Chronic health conditions may also prevent employability and treatment access. As a result, there is a current and continuing need to provide appropriate supports for veterans to successfully age in place and prevent further episodes of homelessness.

⁹ Sonya Gabrielian, Anita H Yuan, Ronald M Andersen, and Lillian Gelberg, “Diagnoses Treated in Ambulatory Care Among Homeless-Experienced Veterans: Does Supported Housing Matter?” *Journal of Primary Care & Community Health*, Vol. 7, No. 4, June 24, 2016.

¹⁰ Tanya de Sousa and Meghan Henry, *The 2024 Annual Homelessness Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness*, U.S. Department of Housing and Urban Development, Office of Community Planning and Development, 2024. As of the timing of the writing of this report, the annual Point-In-Time estimates on the number of veterans experiencing homelessness in 2025 have yet to be released by the U.S. Department of Housing and Urban Development (HUD).

¹¹ Kevin Suh, Jordan Beck, Wendy Katzman, and Diane D. Allen, “Homelessness and Rates of Physical Dysfunctions Characteristic of Premature Geriatric Syndromes: Systematic Review and Meta-Analysis,” *Physiotherapy Theory and Practice*, Vol. 38, No. 7, 2022.

¹² U.S. Department of Veterans Affairs, “Honoring Service: 250 Years of Sacrifice and the Veterans We Serve,” 2026.

¹³ CalVet, “Veterans Services and Supports Report Notice of Funding Availability,” webpage, 2022.

¹⁴ Vincenzo Atella, Andrea P. Mortari, Joanna Kopinska, Federico Belotti, Francesco Lapi, Claudio Cricelli, and Luigi Fontana, “Trends in Age-Related Disease Burden and Healthcare Utilization,” *Aging Cell*, Vol. 18, No. 1, 2018.

Current HUD-VASH Programs May Fall Short in Meeting High Acuity Needs

While the HUD-VASH program has continued to expand over the years to serve formerly homeless veterans, recent research on large-scale implementation suggests that supportive services may not sufficiently meet veterans' needs, particularly among those with higher levels of clinical or social complexity. For example, studies assessing HUD-VASH program fidelity to the evidence-based Housing First model have found that many programs fall short in providing comprehensive supportive services, including multidisciplinary teams with round-the-clock capacity to respond to crises in the field.¹⁵ Consistent with these concerns, Harris et al. (2018) found that among 126 veterans entering PSH in Los Angeles, service utilization was uneven and strongly influenced by personal histories and mental health needs.¹⁶ The authors reported that veterans who receive social security income were less likely to use mental health services relative to veterans who did not receive social security income. Also, psychological disability, depression and/or posttraumatic stress disorder (PTSD; screened as probable in more than half the sample) were associated with increased use of basic needs (e.g., food banks and transportation) and mental health services. Additionally, having a case manager and having more frequent interactions with a case manager was associated with increased mental health and occupational development (e.g., job training and employment support) service receipt. More recently, Su et al. (2025) highlighted similar gaps specific to older veterans in HUD-VASH, identifying unmet needs related to aging in place and proposing a multidisciplinary, home-based intervention model focused on geriatric care, mental health, and medication management.¹⁷ The findings from their qualitative study with older veterans in HUD-VASH and staff that serve them emphasize the importance of tailoring supportive housing services to promote stability and independent living among aging veterans. Such gaps in coordination and alignment of supportive care are especially troubling given recent findings that veterans aged 55 years and older housed through HUD-VASH are more likely to have physical and behavioral health conditions, more likely to use emergency and inpatient services, and less likely to use outpatient medical care compared with similarly aged independently housed veterans.¹⁸ These findings underscore the

¹⁵ Stefan G. Kertesz, Erika L. Austin, Sally K. Holmes, Aerin J. DeRussy, Carol Van Deusen Lukas, and David E. Pollio, "Housing First on a Large Scale: Fidelity Strengths and Challenges in the VA's HUD-VASH Program," *Psychological Services*, Vol. 14, No. 2, May 2017.

¹⁶ Taylor Harris, Hailey Winetrobe, Harmony Rhoades, Carl Andrew Castro, and Suzanne Wenzel, "Moving Beyond Housing: Service Implications for Veterans Entering Permanent Supportive Housing," *Clinical Social Work Journal*, Vol. 46, No. 2, June 2018.

¹⁷ Kelly Su, Medha Romee Maitra, Amanda D. Peebles, Octavia Goodman, Jack Tsai, Deborah Lee, Kenneth Lam, Pauline Lubens, Kara Zamora, Emma Shak, and Rebecca T. Brown, "Developing an Intervention to Enhance Aging in Place for Older Veterans Living in Permanent Supportive Housing," *Gerontologist*, Vol. 65, No. 5, April 9, 2025.

¹⁸ Hind A. Beydoun, Dorota Szymkowiak, Rebecca Kinney, Audrey L. Jones, Jack Tsai, "Characteristics and Healthcare Utilization Among Aging Veterans in Supported Housing: A Comparison with Independently Housed Age-Matched Veterans," *Gerontologist*, Vol. 65, No. 6, January 6, 2025.

continuing need to strengthen the scope and effectiveness of supportive services within HUD-VASH to meet the complex needs of this population.

Veterans in Non-HUD-VASH Programs May Lack Access to Veteran-Specific Services

Additionally, veterans receive PSH through programs other than HUD-VASH. HUD has instructed CoC to prioritize veteran households for PSH.¹⁹ Some veterans entered other PSH programs before HUD-VASH expanded, while others do not qualify for HUD-VASH because of military service or discharge status.²⁰ As a result, these veterans may receive case management that is not veteran-specific or provided by the VA, unlike those in the HUD-VASH program.

Program Overview

In July 2023, CalVet awarded three-year pilot grants to four entities (Nation’s Finest, People Assisting the Homeless [PATH], Swords to Plowshares, and U.S.VETS) serving six counties across the state to provide enhanced supportive services to veterans in PSH to help them stay housed and to thrive as they age in place (see Table 1.1). The award amounts were based on the size of the population of veterans to be served. In summer 2026, the grantee organizations were approved for a six-month extension grant period to continue services until February 2027, but the RAND evaluation timeline was not extended. This report is therefore the final RAND evaluation product, and it covers participants and services through the end of the original grant period rather than through the close of program operations. Veterans enrolled during the extension period, and any changes in service delivery over those final months, fall outside its scope.

Table 1.1. Pilot Grantees

Grantee Organization	County	Supportive Housing Locations	Amount Awarded
Nation’s Finest–Mather	Sacramento	Rancho Cordova	\$2,781,240
Nations Finest–Sonoma	Sonoma	Windsor	\$1,927,725
PATH	San Diego	San Diego	\$3,340,315
Swords to Plowshares	San Francisco	San Francisco (6 sites)	\$4,271,750
U.S.VETS	Los Angeles	Inglewood, Long Beach, West Los Angeles	\$3,839,485
U.S.VETS	Riverside	March Air Reserve Base	\$3,839,485

SOURCE: Features information from CalVet, 2024.

¹⁹ U.S. Department of Housing and Urban Development, “Does HUD Expect CoCs and Recipients of CoC Program-Funded PSH to Also Prioritize Veterans?” webpage, HUD FAQ ID 1894, March 2015.

²⁰ Harris et al., 2018.

The awards are tailored to the population, region, and services provided by each awardee, supplementing the existing supportive services available to veterans in PSH. For example, the grant awards were designed to be flexible in terms of the exact number and staff assigned to the pilot program. More specifically, the pilot grant funding can be used to support any of the staff positions as described in Table 1.2. In addition, equipment and supplies are allowable, including age-related housing accommodation supports, such as assistive devices, transportation support for those in a wheelchair (excluding fuel, repairs, maintenance and vehicle modifications), specialized nutrition products not already available, and office supply and software for grantee reporting purposes.

Some of the funded entities previously offered a limited subset of the listed services in Table 1.2, and the VSSR initiative helped offset the costs of these services. Prior availability varied across grantees, but the pilot expanded onsite mental health, nursing, occupational therapy, and transportation support at most sites.

Table 1.2. Allowable Grant Funded Staff Positions

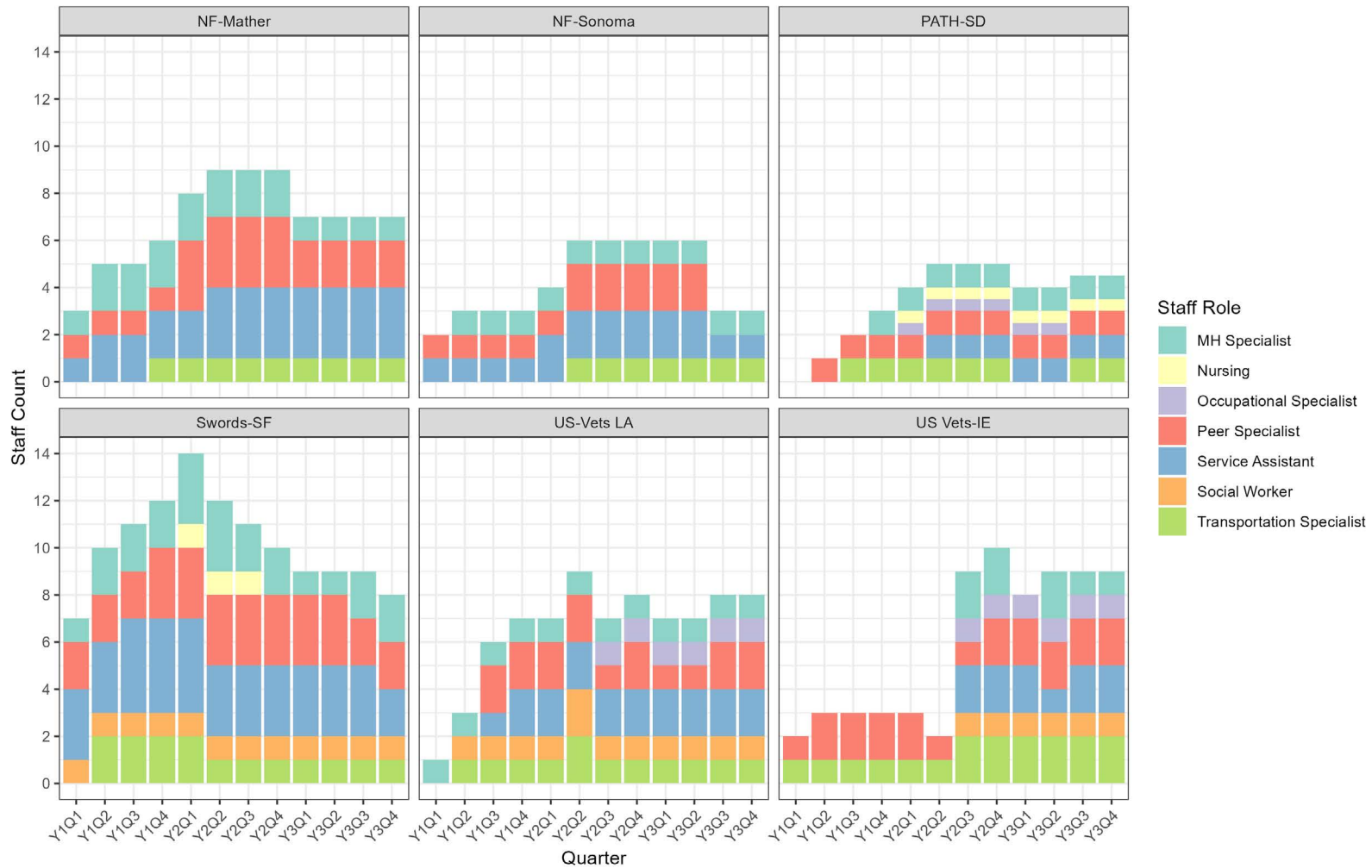
Position	Staffing Ratio (staff:resident)	Job Duties
Mental health specialist	1:25	Harm-reduction case management service provision; substance abuse and mental health services; monthly meetings with property management; community partner collaboration, recreational activity connection; assistance with housing retention, increased skills and income, connection to mainstream resources, rent payment, and money management; after hours availability for emergencies; appointment assistance and accompaniment; management of food acquirement and its distribution; occasional meal preparation and front desk duties, wellness checks; program documentation, data entry
Occupational therapist	1:25	Functional needs assessment and goal setting; occupational therapy treatment program planning and administration; special equipment instruction; home and workplace evaluation; resident observation and exercise demonstration; treatment documentation and evaluation
Nursing	Not specified	Not specified
Peer specialist	1:25	Resident observation and reporting; group coordination; deescalation/mediation; connector between residents, clinical staff, and property management; life skills, harm reduction, medication assistance, and well-being support; transportation coordination; resident activity, outing and event organization
Service assistant	1:25	Community resource connection support; housing stability skill support; transportation scheduling; appointment reminders; personal care assistance; habitability and food access assistance; medication assistance; resident observation and reporting; data entry and reporting
Social worker	1:50	Lead medication management support; senior resource connection; training provision in aging-related health issues for case and property management staff; case conferencing with other pilot staff; benefit assistance; transportation coordination; medical appointment assistance and accompaniment; tele-health assistance
Transportation specialist	Not specified	Provide transportation to medical appointments, shopping, errands and activities; assist veterans during travel; maintenance of transportation scheduling and daily travel logs
VSSR pilot specialist	1 per Pilot Grant	Support and coordinate the activities of the full team, including activity schedules, site availability, transportation scheduling, collecting VSSR data and ensuring compete and accurate reporting to CalVet

SOURCE: Features information from CalVet, 2022.

The VSSR program staffing continued to scale up at varying rates across the six sites over the full three-year period, becoming increasingly multidisciplinary and consistent over time, with peer specialists and service assistants as the most common roles. As shown in Figure 1.1, the early quarters were marked by lower staffing levels and high site-specific variability, while the latter half of the timeline demonstrated greater consistency and diversification of staff roles. Swords to Plowshares (San Francisco Bay area) remained the most heavily staffed site throughout, peaking in the second year and maintaining higher staffing levels through the third year. The two Nation's Finest sites (Mather and Sonoma) maintained the most stable, mid-staffing throughout the entire period. The U.S.VETS sites, which began with minimal staffing,

showed substantial growth and became the most consistently staffed sites by the second half of the timeline, sustaining these levels through the final quarters. PATH–San Diego consistently reported lower staffing levels overall. The number of service assistants and peer specialists doubled over the three years, with all sites employing these roles by quarter seven and all but Nation’s Finest–Sonoma continuing through the end of the grant period. Mental health specialists and transportation specialists were also frequently employed at the sites followed by social workers in three of the six sites. Nurses and occupational specialists were less common, appearing primarily in the mid-later half at PATH–San Diego, U.S.VETS–Los Angeles, and U.S.VETS–Inland Empire.

Figure 1.1. Staffing Levels, by Site, Across Time (program quarters)



NOTE: Quarters represent calendar time based on the overall program timeline spanning June 2023 (start of Q1) through May 2026 (end of Q12). The number of full-time staff are displayed, 0.5 refers to part-time position.

The VSSR Pilot Program logic model is shown in Figure 1.2.²¹ The program highlights that, because of the nature of military service and reintegration to civilian life, some veterans can be especially vulnerable to untreated medical conditions, unemployment, poverty, and homelessness. Also, veterans experiencing homelessness are predisposed to early onset dementia, heart disease, and other age-related conditions. Many veterans do not receive the care they need to effectively treat service-related conditions, avoid or overcome poverty and homelessness, and age in place. Moreover, the current veteran benefit system lacks funding for a continuum of care that would allow veterans to age in place rather than move into nursing home facilities prematurely.²² As a result, veterans with high acuity are at risk of losing housing because of behavioral health needs, inability to maintain habitability, and/or premature or preventable need for skilled nursing care.

The VSSR Pilot goals are to

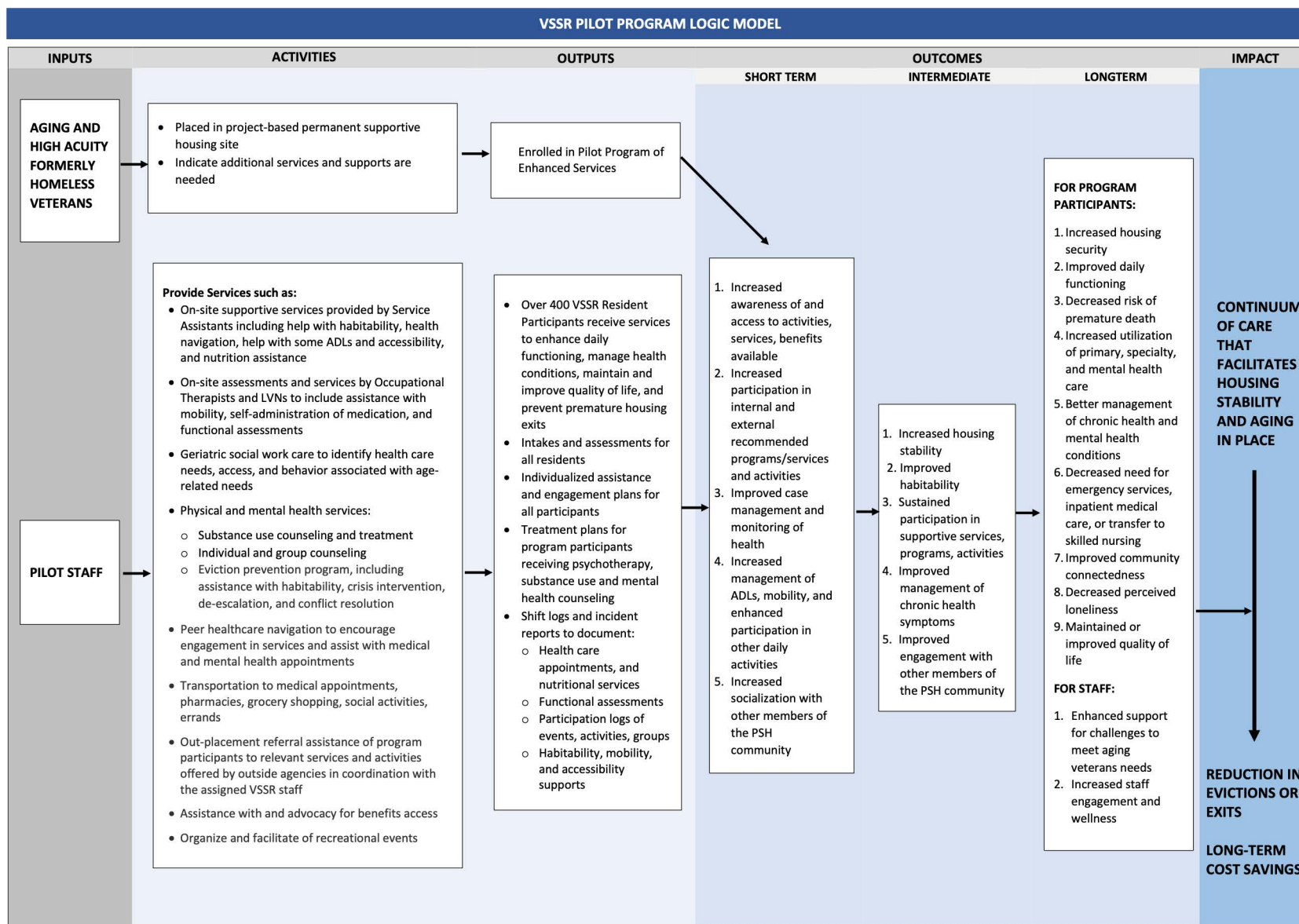
- demonstrate that the pilot’s enhanced supportive services can enable aging and high acuity veterans who have experienced chronic homelessness to age in place and maintain and/or improve their quality of life
- prevent premature need for skilled nursing care, an inability to maintain personal and unit hygiene, disruptive behavior, an inability to adjust to housing, isolation, increased mental health need, premature death, overdose, and suicide
- improve health and wellness through social work services, assistance with some activities of daily living (ADLs), functional assessments, medication management, individual and group counseling, peer support and community engagement, and health care navigation²³
- improve overall PSH housing site operations through adequate staffing and workloads, decreased staff burnout and increased staff retention, decreased property damage costs, decreased overall health care costs, and increased resources to meet the growing demand for higher levels of care.

²¹ The context provided here is drawn from the VSSR Theory of Change documentation, found in Appendix B of the Request for Proposals for the Impact Evaluation of the VSSR program.

²² California Association of Veteran Service Agencies, *The California Veteran Community: Three Year Review—2020 Annual Report*, 2020.

²³ Soo Kim, “Advancing Our Support for Aging Veterans,” *Swords to Plowshares*, March 28, 2024.

Figure 1.2. VSSR Pilot Program Logic Model



Impact Evaluation Overview

This report presents the final examination of 560 VSSR Pilot participants, describing their demographic and clinical characteristics at enrollment. We also examined the association between program service use and subsequent health outcomes, health behaviors, habitability, and social behaviors for participants enrolled in the VSSR program for at least one year ($n = 400$), and we extended that analysis to eight quarters for the 233 participants with two years of enrollment data. In addition, this report presents an analysis of program costs relative to alternative care settings, findings from interviews with grantee leadership, and a recommended research design for a future causal impact evaluation.

Outline of This Report

This report presents final evaluation findings for the VSSR program, based on data available as of June 2026. Chapter 2 describes our methods. Chapter 3 describes who took part in the pilot program at the time they enrolled (“baseline”). Chapter 4 presents housing stability across all participants and examines how service use and well-being changed over the first year of enrollment. Chapter 5 examines how the use of program services relates to outcomes in the following quarter, over both four and eight quarters of enrollment. Chapter 6 presents findings from the annual resident survey on the factors linked to residents’ quality of life, including health, housing experiences, and loneliness. Chapter 7 places program costs in context, comparing VSSR’s per-participant cost with alternative care settings and service models available to veterans with similar needs. Chapter 8 presents findings from interviews with grantee leadership on program implementation, perceived impact, and sustainability planning. Chapter 9 reviews the administrative data evidence base for PSH impact evaluation and recommends a research design for future causal impact studies of VSSR. Chapter 10 draws these findings together and presents recommendations.

Chapter 2. Methods

The VSSR pilot was designed to help aging, high-acuity veterans remain housed and age in place. As Chapter 1 describes, the evidence that PSH keeps people housed is strong, but the evidence that it improves health and well-being (particularly for veterans, and particularly for those with the functional needs that come with age) is thinner. VSSR was intended to fill that gap with enhanced services layered onto existing PSH. This evaluation asks whether the pilot reached the veterans it was designed for, what happened to them while enrolled, whether service use tracked with outcomes, what the program cost relative to the alternatives available in California, and what it would take to answer the question this design cannot: how much of what we observed VSSR caused.

Table 2.1 sets out the eight components of our approach, the question each addresses, and why each matters.

Table 2.1. Evaluation Components, Guiding Questions, and Rationale

Component	Question	Why It Matters	Chapter
Participant characteristics	Who enrolled in VSSR, and what were their needs at entry?	VSSR was designed for veteran seniors aged 55 and older, veterans who are high acuity, and veterans who receive assistance or have been assisted through HUD-VASH and reside at the selected sites. ^a Baseline characteristics establish the reference point for every change measured later.	3
Housing stability	Did VSSR participants stay housed, and when they left, why?	Keeping veterans housed and preventing premature exits are the pilot's central goals. Distinguishing preventable exits from health-driven transitions separates program failure from the ordinary course of aging.	4
Changes over time	How did participants' health, functioning, service use, and living conditions change over their first year?	The pilot's premise is that enhanced services improve well-being. These measures show whether participants' circumstances moved in the expected direction while enrolled.	4
Service use and outcomes	Is VSSR service engagement associated with participant health and functioning?	If services drive the changes above, uptake should track with outcomes. Testing that link is a step beyond documenting change.	5
Quality of life	Is a participant's quality of life associated with health, housing quality, housing safety, housing worry, and loneliness, and how did residents' own ratings in these domains change over their enrollment?	Staff assessments capture what services deliver; only residents can say how they are doing. Identifying what matters most to them indicates where services should concentrate.	6
Program costs	What does VSSR cost per veteran, and how does that compare with alternatives?	Sustainability decisions rely on cost. Placing VSSR beside residential and service-only alternatives shows what stakeholders would face if participants needed that care instead—and whether they could get it.	7
Leadership interviews	What did grantees learn from implementing the pilot, and is the VSSR program sustainable?	The people who operate the program know things the data cannot show: which roles mattered, what got in the way, and what their intentions are when the pilot funding ends.	8
Future evaluation design	What would it take to establish VSSR's causal impact?	This evaluation had no comparison group and cannot attribute the changes it documents to the VSSR Pilot. Reviewing how comparable programs have been evaluated identifies a feasible path for future evaluations.	9

^a Participant description is from the request for proposals for the impact evaluation of the VSSR program.

Below, we describe each of these components, followed by a description of methods for statistical analyses.

Program Participant Characteristics

Data

We used individual-level baseline data on program participants that were collected using an online data collection form that the Swords to Plowshares Technical Assistance (TA) team developed for this program with input from experts in homelessness, veterans, and aging populations. Pilot staff at each site completed online data collection forms on behalf of participants at the time of their enrollment. The specialist was instructed to enter this information “to the best of [their] knowledge,” and “in the event that staff cannot provide this information about the veteran,” staff were “able to ask veteran for the information” but to respect the wishes of the veteran if they choose not to self-disclose. The specialist may consult other onsite staff, site incident reports, or other agency records that detail service provision to complete the form. Specialists did not have access to participant medical records.

As enrollment in the program is ongoing, the baseline data collection period included in this report spans from June 1, 2023, to June 11, 2026. The baseline online data collection form recorded demographic information, current health status, and recent health and social behaviors in the months prior to enrollment. All data were de-identified prior to being transmitted to RAND. Although participating veterans may have been eligible for various VA programs and health care, we did not access VA data for this evaluation. Our analysis of these descriptive data included all participants, regardless of enrollment duration or whether they had exited the program.

Analysis

To achieve its mission, the pilot program needs to enroll the target populations who stand to benefit the most from its services. To that end, we described the demographics, health status, activity levels, and behaviors of participants prior to and at the time of enrollment.

We categorized enrollment by the six pilot grantee sites: Nation’s Finest–Sonoma, Nation’s Finest–Mather, PATH, Swords to Plowshares, U.S.VETS–Inland Empire, and U.S.VETS–Los Angeles. These grantees encompass a total of 13 PSH locations throughout California.

Because enrollment was rolling, participants entered in 12 quarterly cohorts between June 2023 and May 2026, and each participant’s quarters are counted from their own enrollment date rather than from a fixed point in program time. To examine outcomes, we restricted the sample to participants with at least four quarters of enrollment, covering the nine cohorts enrolling between June 2023 and August 2025. Table A.1 in Appendix A shows which program quarters each cohort was under observation.

We also categorized the length of time participants resided in PSH at the time of VSSR program entry as <1 year, 1–2 years, 3–4 years, and 5+ years. In addition to enrollment characteristics, we included participant characteristics age, gender, transgender status, race,

ethnicity, military service branch, service type and voucher type (i.e., whether they were using HUD-VASH or another housing voucher).

We conducted descriptive statistical analyses of baseline data to characterize program participants as of June 11, 2026. These analyses were performed using de-identified, resident-level data collected by pilot site staff. We examined the distribution of each variable through counts and percentages to summarize demographic profiles, military service history, health status, assistance needs, health service use, health behaviors, social behaviors, and habitability indicators. Analyses were unweighted and did not involve inferential testing, as the goal was to describe the sample rather than to estimate population parameters. Tabulations were produced both overall and, where relevant, by program site and enrollment quarter. To protect anonymity of enrollees, variables with fewer than ten respondents were reported as a count of “<10” or as the corresponding percentage of the sample size (i.e., less than 2 percent for the sample in Chapter 3 and less than 3 percent for the sample in Chapter 4).

Housing Stability Trends

Data

We used a spreadsheet that the Swords to Plowshares TA team provided, which listed each de-identified participant who left the VSSR program, along with their date of disenrollment and reason for leaving.

Analysis

We used the spreadsheet to calculate the number and percentage of participants who exited PSH during the study period and to classify each exit into one of three categories: (1) transition to another independent living situation, (2) transition to a higher level of care or death, or (3) negative exit, such as eviction, incarceration, or return to homelessness. These categories align with common PSH performance measures used in prior evaluations. Exit counts were summarized in six-month intervals from program start (June 2023) through May 2026 to examine trends over time in both total and type-specific exits. Veterans who left only the VSSR pilot program but continued residing at their PSH site were excluded from the analysis.

Outcomes over Time and Associations Between Service Use and Outcomes

Data

We used participant-level data spanning from baseline enrollment period through the end of the program’s fourth quarter in its third year (ending in May 2026), which represented the most recent and complete data we had available to us at the time of this report. Data were collected

quarterly in the same manner as described in the previous section describing program participant characteristics. We used measures assessing health status, health care use, health behavior, activity assistance, unmet needs related to activity assistance, social behaviors, and habitability.

Analysis

To examine outcomes using the individual-level data, we restricted the sample to participants who were enrolled in the program for at least four consecutive quarters to ensure sufficient duration for experiencing potential changes resulting from the program. See Table A.1 in Appendix A for additional details.

Since the hypothesized mechanism for improving health and social outcomes relies on participants' use of program services, it is important to measure their uptake of the services that the pilot offers. It is also crucial to measure potential changes in outcomes for all enrollees, regardless of their level of participation. Therefore, we analyzed initial trends in the utilization of pilot services alongside corresponding health and social outcomes. The pilot services that were measured at the individual level included: ADL/instrumental activity of daily living (IADL) assistance, group activity participation, and other general assistance.²⁴

Most numerical count variables related to assistance use, health care use, and health behaviors were dichotomized to indicate whether the resident had at least one event associated with the respective variable during the baseline or quarterly periods. Other numerical count variables were categorized into groups, such as the number of conditions and the number of group programs and activities participated in. To protect anonymity of enrollees, variables with fewer than ten respondents were reported as a count of "<10" or as the corresponding percentage of the sample size (i.e., less than 2 percent for the sample in Chapter 3 and less than 3 percent for the sample in Chapter 4).²⁵

We reported counts and percentages of outcome variables from the baseline period to the fourth quarter of each resident's first year. Individuals with responses of "not sure" or "don't know" in the baseline or fourth quarter for a given variable were excluded from the analysis for that variable. We calculated one-sample proportion, two-sided z-tests to compare outcomes at baseline to those in the resident's fourth quarter, using *p*-values of less than 0.05 to determine a statistically significant change. To estimate these statistics for truncated responses that had a count of less than 4 percent of the sample, we input a value of 4 percent as a conservative

²⁴ "Other general assistance" indicates that staff reported spending any nonzero amount of time in the prior three months on at least one of the following: issues of habitability (e.g., clutter, hygiene, odors, cleanliness); noise/disruptive behavior; assistance with self-administration of medication; participation in onsite and offsite activities and events; connection to medical services; connection to VA and other veteran benefits; connection to mental and/or behavioral health services; management of mental health; life skills; outreach and engagement in events/activities; nutrition assistance; peer support; transportation; or substance use management.

²⁵ Table 3.1 on program enrollment and Table 4.1 on housing stability were exceptions to this general approach.

estimate of the potential change. We used percentage changes to describe the magnitude of differences between baseline and fourth-quarter outcomes.

Program Participation and Subsequent Changes in Health, Habitability, and Social Indicators

Data

We used the same de-identified participant-level quarterly data described in the previous section. Quarterly indicators captured use of three service types—ADL/IADL assistance, group activity participation, and other general assistance—along with corresponding health, behavioral, and habitability outcomes. Individuals with missing or “don’t know/not sure” responses for a variable were excluded, and values below reporting thresholds (fewer than ten cases, or less than 4 percent) were truncated for privacy.

Analysis

We implemented lagged logistic mixed-effects models that estimated the association of service use in a given quarter and corresponding outcomes in the subsequent quarter. Services were treated as binary and categorized as receiving assistance for ADL/IADLs, participating in group programs, or other general assistance. Individuals with responses of “not sure” or “don’t know” in any of the observation periods for a given variable were excluded from the analysis for that variable. Because of low uptake rates, onsite nursing and occupational therapy services were not included as a service category. Outcomes in the quarter subsequent to service receipt were related to health (“good/very good” health status, any acute care use, any falls), health behaviors (substance use, missed medical appointments, taking medications as prescribed, eating three meals a day, and ability to manage chronic health symptoms), and habitability and social behaviors (complaints and leaving unit at least three times per week). For each outcome, we report the unadjusted outcome rate among individuals without treatment, the odds ratios (ORs) for those who received treatment, the 95 percent confidence intervals (CIs), and the percentage difference between treated and untreated groups. We also indicate *p*-values of less than 0.05 to determine a statistically significant difference. The regression models adjusted for age, gender, comorbidity burden, race/ethnicity, and time residing at the site prior to enrollment. Fixed effects were included for site and year-quarter of the program, and random effects were included for each resident, modeled with an unstructured covariance matrix.

These models examining the association between program participation and health, habitability, and social outcomes included residents who had some missing quarterly data within their full program enrollment time but were still observed for at least four quarters. We did not impute these missing data because mixed-effects models, such as the ones implemented for this analysis, suitably handle missing data under their maximum-likelihood approach for estimation.

In practice, this produces results akin to imputed data for missing observations over time. However, this approach relies on the assumption that the missing data are missing at random (MAR); as such, we checked for any systematic differences in residents who had no missing data throughout their program enrollment period and residents who did have any missing data.

We checked for these differences across site of enrollment, race/ethnicity, age, gender, and number of chronic conditions, presenting the share of respondents with missing and nonmissing data by these conditions in Table 2.2. Among the 411 residents with at least four enrollment quarters, 72 (17.5 percent) had missing quarterly data at some point during their enrollment period, and 339 (82.5 percent) had no missing data. Table 2.2 provides a comparison of baseline characteristics between these two groups. There are no substantial differences between residents with missing data and those without missing data across key demographic characteristics (age, gender, and race/ethnicity) or number of chronic health conditions.²⁶

²⁶ Because site is included as a fixed effect, this imbalance is unlikely to bias the estimates substantially, although it does mean observations from Swords to Plowshares, the largest site, are somewhat underrepresented in the analytic data. Because the imbalance is concentrated in one site rather than in participant characteristics, we judged the missing-at-random assumption reasonable.

Table 2.2. Demographic and Health Characteristics Among Residents with Missing and Nonmissing Data

Characteristic	Characteristics Among Those with Missing Data (%)	Characteristics Among Those without Missing Data (%)
Site		
Nation's Finest–Mather	5.6	27.1
Nation's Finest–Sonoma	20.8	6.8
PATH	9.7	12.7
Swords to Plowshares	56.9	20.9
U.S.VETS–Inland Empire	5.6	15.0
U.S.VETS–West Los Angeles	1.4	17.4
Race/ethnicity		
White (non-Hispanic, Latinx, Chicano, or Spanish origin)	52.8	42.2
Black or African American	27.8	34.2
Hispanic, Latinx, Chicano, or Spanish origin	8.3	10.3
Other or not specified	11.1	13.3
Age		
26–45	9.7	5.3
46–65	41.7	46.9
66–75	36.1	32.7
76–100	8.3	9.7
Not specified	4.2	5.3
Gender		
Man	94.4	87.9
Woman	5.6	10.3
Prefers not to disclose or not available	0	1.8
Number of chronic conditions		
0	15.3	18.9
1–3	55.6	52.5
4–6	26.4	26.8
7–9	2.8	1.8

NOTE: *N* = 411 residents with 4+ enrollment quarters; *n* = 72 with missing data, *n* = 339 without missing data.

Factors Associated with Residents' Overall Quality of Life

Data

In addition to the quarterly data collection forms completed by pilot staff on behalf of residents, participants themselves completed an annual resident survey. This self-administered questionnaire captures veterans' own perspectives on well-being and quality of life. It includes items on housing history and stability, physical and mental health, activity limitations, symptoms, daily living and assistance needs, social connectedness, and overall life satisfaction. Participants may complete the annual survey independently or with assistance, and all responses are confidential. Unlike the quarterly data collection form—which relies on staff assessments—the annual survey provides residents' direct self-reports of their experiences and health status.

The Swords to Plowshares TA team administered the Year 1 and 2 surveys during its annual visits to each participating site. The Year 1 and Year 2 survey completion dates do not align precisely with each veteran's VSSR program enrollment date; rather they correspond to the site visit schedule, typically occurring one to two years after the program roll-out (see Appendix Table A.2). The Year 3 survey was administered by site staff in June 2026. Residents also completed a baseline version of the annual survey at or near the time of program enrollment. Because enrollment was rolling, baseline survey dates are participant-specific rather than tied to the site visit schedule.

Our analysis of factors associated with residents' overall quality of life focused on the following survey items:

- **Quality of life:** Quality of life was assessed using a single-item measure asking participants to rate their overall quality of life on a five-point scale ranging from Very poor to Very good, taken from the WHOQOL-BREF measure.²⁷ For analysis, responses were dichotomized, with Very poor, Poor, and Neither poor nor good coded as 0, and Good and Very good coded as 1, representing lower versus higher perceived quality of life, respectively.
- **General health:** General health was measured using a single-item question asking participants to rate their overall health on a five-point scale ranging from Poor to Excellent. For analysis, responses were dichotomized into two main categories: 0 = Poor/Fair and 1 = Good/Very good/Excellent.
- **Housing quality:** Housing quality was evaluated using a single-item question asking participants to rate the overall quality of their housing ("How would you classify the quality of your housing?"). Responses were recorded on a six-point scale: Very poor, Poor, Fair, Good, Very good, and Excellent, reflecting participants' perceptions of the overall condition and adequacy of their housing. For analysis, responses were dichotomized as 0 = Very poor, Poor, or Fair, and 1 = Good, Very good, or Excellent,

²⁷ S. M. Skevington, M. Lotfy, and K. A. O'Connell, "The World Health Organization's WHOQOL-BREF Quality of Life Assessment: Psychometric Properties and Results of the International Field Trial—A Report from the WHOQOL Group," *Quality of Life Research*, Vol. 13, March 2004.

indicating lower versus higher perceived housing quality. Data from the baseline annual survey were not available due to an error in the response options used in the baseline survey.

- **Housing safety:** Housing safety was measured with a single-item question asking participants how safe they feel in their current housing (“How safe do you feel in your current housing?”). Responses were provided on a five-point scale: Very unsafe, Unsafe, Neither unsafe nor safe, Safe, and Very safe, indicating perceived levels of personal safety within the home environment. For analysis, responses were dichotomized as 0 = Very unsafe, Unsafe, or Neither unsafe nor safe, and 1 = Safe or Very safe, corresponding to lower versus higher perceived housing safety.
- **Housing worry:** Housing worry was assessed using a single-item question asking: “How often in the past 12 months would you say you were worried or stressed about your ability to stay in your current housing?” Responses were rated on a five-point scale: Always, Usually, Sometimes, Rarely, and Never, capturing varying levels of housing-related stress or insecurity. For analysis, responses were dichotomized as 0 = Always, Usually, or Sometimes, and 1 = Rarely or Never, reflecting higher versus lower levels of housing-related worry, respectively.
- **Loneliness:** The UCLA 3-Item Loneliness Scale was used to assess perceived social isolation and connectedness. Participants responded to three questions about feeling a lack in companionship, left out, or isolated from others, with three possible response options: Hardly ever (scored as 1), Some of the time (scored as 2), and Often (scored as 3). The three items were summed to produce a total score ranging from 3 to 9, where higher scores indicate greater loneliness. For analysis, scores were dichotomized such that participants with total scores between 3 and 5 were categorized as 1 = Not lonely, while those scoring between 6 and 9 were categorized as 0 = Lonely.

Missing or nonresponse values for all independent variables were coded as “not specified” so that residents with incomplete data could be retained in the models and the “not specified” category examined as an explanatory variable of interest.

Baseline data, collected separately at program enrollment, were used to provide demographic and health covariates in the full models to adjust the associations observed from the annual survey data.

The raw survey data comprised 166 resident observations in Year 1, 222 in Year 2, and 223 in Year 3.²⁸ Restricting the sample to residents who participated in two or more survey waves resulted in 252 residents.²⁹ Further excluding cases with missing data on the primary outcome variable, quality of life, produced a final analytic sample of 234 residents who had at least two survey responses across the three years and did not have missing data on the primary outcome variable. In sum, the analytic sample for the annual survey includes 234 residents observed in each year, yielding a total of 567 resident-time observations for all but the housing quality variable.

²⁸ The raw baseline data included 317 distinct residents.

²⁹ This analysis was not limited to those who completed the baseline survey.

Analysis

To examine factors associated with residents' self-reported quality of life from the annual resident survey, we estimated a series of mixed-effects logistic regression models using the dichotomized survey responses noted above. Our mixed-effects models accounted for repeated annual responses nested within residents and sites. To account for the fact that the same residents were observed over multiple (two or more) years, we included resident-level random intercepts in the mixed-effects logit model. This allowed the baseline probability of the quality-of-life outcome variable to vary across the residents, and therefore account for a given resident's data in their follow-up annual survey(s) given their responses in their first annual survey.

Each outcome model was estimated in three steps. The empty model included only survey year and resident-level random effects, providing baseline variance estimates and the intraclass correlation. The partial model added a single key explanatory variable (e.g., general health, housing quality, housing safety, housing worry, or loneliness) to assess the unadjusted association with quality of life. The full model further adjusted for age, gender, race/ethnicity, number of chronic conditions, and site to test whether the association remained after accounting for these covariates. Comparing results across models allowed us to evaluate the robustness of the main predictors. Because adjustment did not substantively change any of the five associations, Chapter 6 reports the fully adjusted estimates only.

Individual-Level Trajectories Across Annual Surveys

Data

We used the annual survey data described above, including the baseline survey administered at or near enrollment. The analytic sample for the paired trajectory analysis is defined differently from the sample for the mixed-effects models and is therefore larger in some domains: For each of the six measures, it includes every resident with a nonmissing response on that item at both their first and their most recent survey, without requiring nonmissing quality-of-life data or participation in any particular wave. Residents who completed only one survey cannot be paired and are excluded. Because item-level missingness varies, the sample differs by domain; Appendix Table C.1 reports the sample size for each.

For five of the six domains, the first survey is the baseline survey. For housing quality, an error in the baseline response options rendered that item unusable, so the pairing begins at the Year 1 survey instead; that domain therefore covers a shorter average interval than the others. The most recent survey is Year 1, Year 2, or Year 3 depending on enrollment date and which waves a resident completed, so the elapsed time between paired observations varies across residents and, because survey administration followed the site visit schedule, across sites as well (see Appendix Table A.2).

Analysis

To describe how many residents improved or declined in each domain, we paired each resident's first available annual survey with their most recent one and classified the change on each of the six dichotomized measures described above. Residents moving from the lower to the higher category were classified as improved, those moving from the higher to the lower category as worsened, and those in the same category at both time points as stable. We tested each domain using McNemar's test for paired binary outcomes, which compares the proportion who improved with the proportion who declined among discordant pairs—that is, among residents who changed category. Residents stable at both time points do not contribute to the statistic. We report exact *p*-values throughout.

Annual Survey Analysis of Service Use, Quality of Life, and Loneliness

Data

We used annual resident survey data from Years 1, 2, and 3, drawing the independent variables from the most recent quarterly assessment before each survey. Because survey timing followed the site visit schedule, the matching assessment varied by site. Appendix Table A.2 lists survey dates and the corresponding quarterly assessment.

Analysis

We conducted separate analyses for the Year 1, Year 2, and Year 3 annual surveys. For the analysis of each annual survey, residents who completed the annual survey and had a nonmissing response for the quality of life or loneliness measures were included. We dichotomized quality of life as Good or Very good (1) versus all other responses (0). We measured loneliness using the UCLA 3-Item Loneliness Scale and dichotomized it as Not lonely (score 3–5 = 1) versus Lonely (score 6–9 = 0). We drew four independent variables from the quarterly assessment immediately preceding each annual survey: meals per day (2–3 vs. 0–1), time spent with program staff (dichotomized based on distribution), group participation (3+ vs. 0–2 activities), and time out of unit (daily or 3+ times per week vs. less). We estimated associations using mixed-effects logistic regression with a random intercept for resident, adjusting for age, gender, race/ethnicity, number of chronic conditions, and site.

Cost Analysis

To situate VSSR's investment in context, we compared its estimated annual costs with a set of alternative long-term care settings and community-based service models in California.

Calculating VSSR's Cost per Veteran

We obtained VSSR site-level expenditure data from Swords to Plowshares for each program site and program year. To enable comparison across years, we converted all invoice amounts to May 2026 dollars using the Consumer Price Index for All Urban Consumers (CPI-U, All Items, not seasonally adjusted; series CUUR0000SA0), published by the U.S. Bureau of Labor Statistics.³⁰ We multiplied each invoice by the ratio of the May 2026 CPI-U value to the value for its invoice month. The Bureau of Labor Statistics did not release an October 2025 value because of a lapse in federal appropriations, so we interpolated that month as the average of the September 2025 (324.800) and November 2025 (324.122) values. For invoices lacking dates, we assigned the most plausible month based on the surrounding invoice sequence. Totals reflect invoices dated through May 2026.

A veteran-quarter represents one veteran enrolled for one quarter. We divided each site's total expenditures by its total veteran-quarters, then multiplied by four to get an annual cost per veteran. This accounts for the fact that participants were enrolled for different lengths of time.

The expenditure figures above capture only the enhanced services CalVet funded. Because most VSSR participants also received a housing subsidy and voucher-linked case management funded by other sources, we constructed estimates of those two components to represent the full public investment per veteran. We derived the housing subsidy from fiscal year (FY) 2026 Fair Market Rents and the applicable HUD-VASH and CoC payment standards for each VSSR county, and the case management estimate from the VA's mandated caseload ratio and federal salary schedules, benchmarked against local contracted rates. Chapter 7 gives each derivation in full. The resulting VSSR totals therefore combine actual grant expenditures with modeled estimates rather than observed spending.

Identifying Comparison Costs

A research assistant, supplemented by the team's knowledge of California's long-term services and supports landscape, identified costs and eligibility criteria for comparable settings, including assisted living, skilled nursing, memory care, home health care, and the Veterans Homes of California. We did not conduct a systematic search; we report figures only where a recent, California-specific estimate was publicly available. We represent memory care only through Veterans Home care levels that include it, since the available survey data do not price it separately.

Market-rate figures for assisted living, nursing facility care, adult day health care, and in-home care come from the CareScout 2025 Cost of Care Survey (data collected July–November

³⁰ U.S. Bureau of Labor Statistics, "CPI for All Urban Consumers (CPI-U): All Items in U.S. City Average, All Urban Consumers, Not Seasonally Adjusted," Series ID CUUR0000SA0, July 2026.

2025).³¹ Veterans Home figures come from CalVet’s FY2024–2025 levels-of-care cost summary and its Veterans Homes budget estimate package, both reporting net state cost per resident after fees and federal offsets, with eligibility details from CalVet program webpages. We drew payor information for remaining settings from a Congressional Research Service overview of long-term services and supports financing.³²

No statewide per-client Full Service Partnership (FSP) cost was available, so we derived per-client figures from two county examples, Tri-City Mental Health Authority’s Mental Health Services Act annual update and an Orange County Board of Supervisors staff report, by dividing each contract maximum by average daily clients. Because county contracts do not report FSP costs by tier, we supplemented with a published research estimate for Assertive Community Treatment (ACT), which we treat as a lower bound (see notes to Table 7.4). We drew eligibility criteria for ACT and FSP Intensive Case Management from Department of Health Care Services guidance.

Comparability Caveats

These figures rest on different pricing bases: median private-pay market rates (assisted living, nursing home, home care), net public cost after offsets (Veterans Homes), contract or reimbursement rates (FSP), a research estimate (ACT), and grant expenditures combined with modeled voucher and case-management costs (VSSR). Some figures are locality-specific and we present them as illustrative rather than statewide rates. We express all figures in May 2026 dollars via the CPI-U conversion described above, except where we note FY2025–2026 figures. Readers should treat these comparisons as indicative of relative magnitude rather than precise equivalents.

The settings also differ in what they provide, from around-the-clock licensed nursing care to VSSR’s veteran-specific peer support and community engagement. The relevant comparison is not whether VSSR replicates these settings, but what alternatives would cost, and whether veterans could access them, if VSSR participants instead required this care.

Leadership Interviews

Data

In March 2026, we approached leadership from the four pilot VSSR service providers (i.e., Nation’s Finest, PATH, Swords to Plowshares and U.S.VETS) about participating in interviews to discuss their organization’s experience with the VSSR pilot and plans for sustainment. More specifically, we described the opportunity as a 45-minute virtual interview to discuss pilot

³¹ CareScout, “Cost of Care,” webpage, 2026.

³² Congressional Research Service, *Who Pays for Long-Term Services and Supports?* IF10343, August 28, 2025.

initiative planning, services and resources expanded through the initiative, implementation successes and challenges, and plan to continue or discontinue VSSR pilot activities in the future. We described their participation as voluntary and that we would not disclose any identifiable information without permission. In most cases, leaders referred us to other personnel within their organization to participate in the interviews.

We used a semistructured interview format to allow flexibility while maintaining comparability across respondents (see Appendix D for interview protocol). The questions were developed by adapting interview guides used in previous research to assess program implementation³³ and sustainment.³⁴

We conducted the interviews remotely by videoconference in March and April 2026. Two members of the research team attended each interview, one leading the discussion and the other taking notes. We audio-recorded the interviews to support notetaking and transcription.

Analysis

We analyzed the interview data using a hybrid human-AI approach, combining the use of computer-assisted qualitative data analytic software (MuseQDA) and generative artificial intelligence (ChatGPT 4.1) guided by and informed by the research team. First, we cleaned the four transcripts by removing identifiers, clarifying roles between speakers (e.g., interviewer and interviewee), and correcting errors in the transcriptions (e.g., HUD-BASH to HUD-VASH). Next, we uploaded to MuseQDA the four transcripts and a researcher-derived codebook that included three major themes (pilot planning, pilot perceptions and experiences, and sustainability efforts) and 16 subthemes (see Appendix D for details on coding structure). These themes aligned with the questions in the interview guide. MuseQDA completed the initial organization and structural coding. Next we exported the output generated from MuseQDA and uploaded it to ChatGPT to help with organizational synthesis. We prompted ChatGPT to summarize the findings organized by theme and to consider consistencies and inconsistencies across the four interviews. To ensure that we did not miss any critical information, we also uploaded the four interview transcriptions directly to ChatGPT and asked it to summarize the findings using the three main themes and subthemes from the codebook as a guide. The output from these two

³³ Laura J. Damschroder, David C. Aron, Rosalind E. Keith, Susan R. Kirsh, Jeffery A. Alexander, and Julie C. Lowery, "Fostering Implementation of Health Services Research into Practice: A Consolidated Framework for Implementation Research (CFIR)," *Implementation Science*, Vol. 4, No. 1, 2009. Consolidated Framework for Implementation Research Leadership, *CFIR Interview Guide Tool*, undated.

³⁴ Sarah B. Hunter, Lynsay Ayer, Bing Han, Bryan R. Garner, Susan H. Godley, "Examining the Sustainment of the Adolescent-Community Reinforcement Approach in Community Addiction Treatment Settings: Protocol for a Longitudinal Mixed Method Study," *Implementation Science*. Vol. 9, August 13, 2014; Sarah B. Hunter, Melissa Felician, Alex R. Dopp, Susan H. Godley, Chau Pham, Kathryn Bouskill, Mary E. Slaughter, Bryan R. Garner, "What Influences Evidence-Based Treatment Sustainment After Implementation Support Ends? A Mixed Method Study of the Adolescent-Community Reinforcement Approach," *Journal of Substance Abuse Treatment*, Vol. 113, June 2020.

queries were not substantially different from one another. Next, one researcher read all the transcriptions and compared the responses with the computer-assisted outputs to ensure that no major topics or themes were erroneous or missing. Next, the researcher requested ChatGPT to incorporate illustrative quotes for each of the themes into the previously generated narrative summary. Again, one researcher reviewed and revised the output. A second member of the research team reviewed the final output against the original transcriptions and made revisions before finalization.

Administrative Data Review for Future Evaluation Design

Chapter 9 is based on a structured review of 16 peer-reviewed studies (2007–2026) using administrative data and comparison group designs to estimate the impact of PSH and related programs on health utilization, costs, and housing outcomes. We identified studies through targeted PubMed searches and Google Scholar searches, screened them for use of administrative data sources and a comparison group design, and summarized them in two evidence tables covering veteran-specific programs (Appendix Table E.1) and nonveteran PSH and other supportive housing programs (Appendix Table E.2). The review is not a formal systematic review or meta-analysis; its purpose is to characterize the methodological state of the art and identify a feasible research design for future VSSR causal impact evaluation.

Limitations

This report has several limitations. Our analyses are descriptive, so significant differences cannot be attributed to pilot program enrollment or to service use. While the baseline data offers information on resident service use immediately prior to program enrollment, data were not available on services already offered at each site by HUD-VASH and other programs, so it is not possible to isolate the incremental changes attributable to VSSR relative to other programs. Although we controlled for demographic and underlying health conditions, our estimates of the association between service use and outcomes may still reflect underlying health needs and/or motivation to engage in services, rather than the impact of utilizing these services. In addition, we did not have sufficient uptake of services to examine differences in overall frequency of service use, and a one quarter lag between service use and outcomes may be insufficient to observe changes.

Our analyses of change over time and of service use are also restricted to participants with sufficient follow-up data (at least one or two years of enrollment). As Appendix B shows, this subset differs systematically from other enrollees, including those who exited early: They have significantly lower rates of depression, anxiety, PTSD, and substance use disorder at baseline, and longer prior tenure at their PSH site. Findings from these analyses may therefore reflect a healthier, more stable subgroup of participants and may not generalize to the full enrolled population. The resident annual survey analyses in Chapter 6 are subject to a similar limitation:

The sample size dropped substantially after restricting to residents who completed more than one survey wave with nonmissing outcomes, likely selecting for a more stable and engaged subgroup.

Baseline data were entered by pilot specialists based on their knowledge of participants at enrollment, with differing opportunities for direct observation or participant self-report; consequently, data quality may vary across measures. Furthermore, changes in the staff completing assessments over time and potential social desirability or recall bias in veterans' self-disclosures to pilot specialists may introduce variability that could influence comparisons between baseline and follow-up outcomes. Because pilot specialists likely became more familiar with participants as engagement continued, it is possible that their later assessments reflect a deeper understanding of veterans' circumstances. This potential difference in assessor familiarity should be acknowledged as a caveat in interpreting observed changes over time. In addition, the annual self-administered resident survey on quality of life is based on self-reported data, which are also subject to social desirability and recall bias. Other data sources, such as claims or medical records, were not available for this analysis.

The data collection tools used in this project were developed prior to the evaluation team's involvement, and data from the initial program quarters had already been collected before the evaluation team gained access. Although the evaluation team provided feedback that led to some minor refinements of the quarterly online data collection instrument, the response options—including the availability of “not sure” or “don't know”—were not standardized across all instrument items. This inconsistency may have influenced how staff reported on individuals and could contribute to differences in response patterns across questions. We acknowledge that these variations are a limitation of the study and may affect the comparability of responses across data collection items. The service use association analyses in Chapter 5 face constraints related to multiple comparisons and sample size. Across approximately 30 statistical tests, the probability of at least one false positive is elevated, and sample sizes of roughly 400 (four-quarter analyses) and 230 (eight-quarter analyses) limit power to detect small effects. Findings from these analyses should be treated as exploratory.

Finally, the leadership interviews in Chapter 8 relied on a single interview per grantee organization. Because these organizations have an interest in the program's continuation, their perspectives on impact and sustainability may be more favorable than an independent assessment would suggest and should be interpreted as leaders' perceptions rather than as an objective measure of program effects.

Chapter 3. Program and Participant Characteristics

In this chapter, we present data about the veteran participants who enrolled in VSSR between June 2023 and May 2026. We present information collected at baseline, which is the point at which each veteran enrolled in the program. Because enrollment was rolling, baseline is not a single calendar date but a participant-specific one: A veteran who enrolled in the pilot’s first quarter has a baseline in mid-2023, while one who enrolled in the final quarter has a baseline in spring 2026. Baseline measures therefore describe each participant’s circumstances at their own point of entry, and the counts and percentages below pool participants observed across nearly three years of program operation. As further detailed below, participants matched the pilot’s target profile. The 560 veterans who enrolled between June 2023 and May 2026 were predominantly older (79 percent were 56 or older) with substantial chronic disease and behavioral health burden.

Enrollment

Table 3.1 shows enrollment characteristics for the 560 VSSR participants who enrolled between June 2023 and May 2026. Swords to Plowshares enrolled the largest share of participants (30.5 percent), followed by Nation’s Finest–Mather (21.2 percent), and then U.S.VETS–Los Angeles (15.2 percent). Most participants enrolled during the first two program years, and roughly half had resided at their current site for less than two years at enrollment. HUD-VASH vouchers covered more than a third of participants (37.5 percent), while CoC vouchers covered an additional 15.4 percent; voucher status was not available for 25.5 percent of enrollees.³⁵

³⁵ Voucher status was collected separately from the quarterly assessments; this category reflects participants who could not be matched to a voucher record.

Table 3.1. Program Enrollment Characteristics

Variable	Percentage	Count
Site		
Nation's Finest–Mather	21.2	119
Nation's Finest–Sonoma	8.8	49
PATH	12.1	68
Swords to Plowshares	30.5	171
U.S.VETS–Inland Empire	12.1	68
U.S.VETS–Los Angeles	15.2	85
Enrollment Quarter		
June–August 2023	20.2	113
September–November 2023	25.4	142
December–February 2024	5.7	32
March–May 2024	12.1	68
June–August 2024	11.4	64
September–November 2024	4.6	26
December–February 2025	3.0	17
March–May 2025	2.1	12
June–August 2025	4.3	24
September–November 2025	2.9	16
December 2025–February 2026	4.1	23
March–May 2026	2.5	14
Not available	–	<10
Time residing at site		
1 year	28.6	160
1–2 years	20.9	117
3–4 years	20.5	115
5 or more years	29.8	167
Not available	–	<10
Housing voucher type		
HUD-VASH	37.5	210
CoC	15.4	86
Other voucher type	12.1	68
None	9.5	53
Not available	25.5	143

NOTE: Sample size of 560 unique residents enrolled between June 2023 and May 2026.

Participant Demographics and Military Service Characteristics

Table 3.2 displays the demographic and military service characteristics of the enrolled veteran participants. Approximately 79 percent of the sample was 56 or older at the time of program enrollment. Ninety percent of the sample identified as men, 8 percent identified as women, and fewer than 2 percent of the sample described as transgender. Forty-one percent identified as White, Non-Hispanic and 33 percent identified as Black or African American. Four percent endorsed more than one race/ethnicity.

Military service among participants was distributed as follows: 43 percent in the Army, 23 percent in the Navy, 14 percent in the Marine Corps, 10 percent in the Air Force, and fewer than 2 percent in the Coast Guard. Fewer than 2 percent served in multiple branches. Most of the sample served on active duty only (86 percent), with small shares serving in the reserve (3 percent), in some combination of active duty, reserve, and/or National Guard service (2 percent), or in the National Guard only (fewer than 2 percent).

Table 3.2. Participant Demographics and Military Service Characteristics

Variable	Percentage	Count
Age		
26–45	7.5	42
46–55	9.1	51
56–65	37.0	207
66–75	32.0	179
76–100	9.6	54
Not available	4.8	27
Gender		
Man	90.4	506
Woman	8.2	46
Prefers not to disclose or not available	<2	<10
Transgender status		
No	96.6	541
Yes, male to female	<2	<10
Yes, female to male	<2	<10
Prefers not to disclose/unknown	<2	10
Race/ethnicity		
White (non-Hispanic, Latinx, Chicano, or Spanish origin)	41.2	231
Black or African American	32.5	182
Hispanic, Latinx, Chicano, or Spanish origin	11.6	65
Multiple	3.9	22

Variable	Percentage	Count
Asian-American	<2	10
American Indian or Alaska Native	<2	<10
Native Hawaiian or other Pacific Islander	<2	<10
Middle Eastern or North African	<2	<10
Prefer not to disclose/unknown	2.0	11
Not available	4.5	25
Branch		
Army	42.7	239
Navy	23.0	129
Marine Corps	14.3	80
Air Force	10.2	57
Coast Guard	<2	<10
Army plus other branch	<2	<10
Not available	7.5	42
Service type		
Active	85.5	479
Reserve	2.7	15
Active, reserve, and/or National Guard combination	2.0	11
National Guard only	<2	<10
Not available	9.3	52

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. "Not available" was assigned to fully missing values. The "Multiple" race/ethnicity category includes participants who selected more than one race or ethnicity, as well as those who selected "Multiple" itself.

Health Status

In Table 3.3, we provide staff-reported health status at program enrollment. Just over a third of participants (35.9 percent) were rated as having good or very good general health, and 39.8 percent were rated as fair and 20.5 percent as poor or very poor. Falls were the most commonly reported acute event in the three months prior to enrollment, affecting nearly one in four participants (23.8 percent). The majority of participants had at least one diagnosed chronic condition; depression (38.2 percent), anxiety (33.2 percent), and PTSD (31.4 percent) were the most frequently reported diagnoses.

Table 3.3. Health Status at Program Enrollment

Variable	Percentage	Count
General health status at program enrollment		
Good/very good	35.9	201
Fair	39.8	223
Poor/very poor	20.5	115
Unknown	3.8	21
Number of conditions		
0	17.1	96
1–3	51.8	290
4–6	28.0	157
7–9	3.0	17
Frequency of conditions		
Depression	38.2	214
Anxiety	33.2	186
PTSD	31.4	176
Hypertension	28.6	160
Other conditions	25.2	141
Arthritis	24.1	135
Substance use disorder	19.8	111
Diabetes	17.9	100
Heart disease	15.7	88
Respiratory	10.7	60
Asthma	8.6	48
Disability	4.8	27
Chronic kidney disease	3.4	19
Dementia	3.0	17
Experienced acute events in the three months prior to enrollment		
Falls	23.8	133
Loss of consciousness	5.0	28
Heart attack	2.0	11
Stroke	2.1	12
Seizures	<2	10
None	72.7	407

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. The value of “Unknown” for general health status included both the value of “Unknown/prefers not to disclose” and fully missing values.

Activities of Daily Living Assistance

Table 3.4 presents staff reports on veteran participant assistance needs. First, staff reported whether veteran participant received any assistance with 17 types of care (i.e., 16 specific types plus an “other” category) prior to the start of the pilot. Next, staff reported whether veteran participant needed assistance with any of these types of care that they were not currently receiving. Roughly 11 percent or fewer of participants received any individual type of daily living assistance prior to program enrollment.

In terms of assistance need without receipt, the most frequently reported assistance need was housekeeping/managing household at 32 percent, followed by companionship/emotional support at 25 percent, assistance/accompanying for grocery shopping/errands at 24 percent, and assistance/accompanying for medical purposes at 22 percent. Laundry and meal preparation assistance were also frequently endorsed, at 18 percent and 16 percent, respectively. Around 8 to 10 percent endorsed assistance using the telephone or computer, mobility assistance, and self-administration of medications. Staff less frequently reported assistance needs for grooming/hygiene, other types of assistance, assistive devices, bathing or showering, dressing, eating (including cutting up food), toileting, and transferring in and out of a chair or bed.

Table 3.4. Assistance Use and Unmet Needs at Program Enrollment

Variable	Received Assistance Prior to Enrollment		In Need of Assistance but Did Not Receive Prior to Enrollment	
	Percentage	Count	Percentage	Count
Companionship/emotional support	10.9	61	24.6	138
Assistance/accompanying for medical purposes	10.5	59	22.1	124
Assistance/accompanying for grocery shopping/errands	10.5	59	23.9	134
Using the telephone or computer	9.6	54	9.5	53
Laundry	9.5	53	17.7	99
Housekeeping/managing household	8.8	49	32.1	180
Mobility	8.8	49	9.1	51
Self-administration of medications	8.6	48	8.0	45
Meal preparation	8.4	47	16.4	92
Grooming/hygiene	8.2	46	5.7	32
Bathing or showering	8.0	45	3.8	21
Dressing	7.1	40	2.5	14
Eating, including cutting up food	6.8	38	<2	<10
Toileting	6.8	38	<2	<10
Assistive devices	7.0	39	4.1	23
Transferring in and out of a chair or bed	6.4	36	<2	<10
Other	4.3	24	4.5	25

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. The time period for receiving assistance was not specified. Missing or unknown values were not available on these variables.

Health Service Use

In Table 3.5, we present veteran participant health service use in the three months prior to program enrollment. Forty-three percent of participants received primary care, 24 percent received specialty care, 15 percent received outpatient mental health care, and about 5 percent received outpatient substance use disorder treatment. Sixteen percent visited or received treatment in a hospital emergency room, 11 percent had an ambulance or 911 service call, and fewer participants—8 percent, 3 percent, and 2 percent, respectively—received inpatient medical, emergency mental health, or inpatient mental health care. Two percent received nursing home services, and fewer than 2 percent received on-site VSSR clinical services (pilot nurse or occupational therapy) prior to program enrollment.

Table 3.5. Health Service Use During Three Months Prior to Program Enrollment

Variable	Percentage	Count
Outpatient care		
Primary care	42.5	238
Specialty care	23.6	132
Mental health care	15.0	84
Substance use disorder treatment	4.5	25
None	47.7	267
Acute care		
Visit to or treatment in a hospital emergency room	16.1	90
Ambulance or 911 service calls	10.9	61
Inpatient medical	8.4	47
Emergency mental health care	2.9	16
Inpatient mental health	2.1	12
None	76.4	428
Nursing home or other rehabilitation		
Nursing home	2.1	12
None	97.9	548
Onsite VSSR clinical services		
Pilot nurse	<2	<10
Occupational therapy	<2	<10
None	98.0	549

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. Missing or unknown values were not available on these variables.

Health Behaviors

Table 3.6 lists staff reports on various veteran participant health behaviors prior to the start of the program or at program enrollment. Staff reported that 24 percent of veterans missed one or more medical appointments in the past three months, while 41 percent did not miss any appointments. Staff were unsure about 25 percent of the sample, and 9 percent of the sample did not have any medical appointments during this period. Information was not available for fewer than 2 percent. Staff reported that 51 percent of veteran participants were taking medications as prescribed. In contrast, 8 percent were not taking medications as prescribed. Staff were not sure for 6 percent of the sample. Fourteen percent were not taking any medications, and information was not available for 21 percent of the sample. Staff reported that 38 percent of the sample self-managed their chronic health symptoms “very well” or “well.” Thirty-two percent managed “somewhat well.” Fifteen percent self-managed their chronic health symptoms “not well” or “not

at all.” Fifteen percent were not sure or missing. Staff reported that fewer than 2 percent of veteran participants were eating no meals a day, 11 percent were eating one meal a day, 37 percent were eating two meals a day, and 30 percent were eating three meals a day, while about 21 percent reported they did not know or the data were missing. Finally, staff reported whether veteran participants were actively engaged in the use of any of nine substances (with an option to endorse “other”). Thirty-six percent were using alcohol, and 26 percent were using cannabis. Eighteen percent were using stimulants, and 15 percent were using opioids. Ten percent were using barbiturates, benzodiazepines, hallucinogens, and solvents, and 5 percent were using other substances.

Table 3.6. Health Behaviors Prior to Start or at Program Enrollment

Variable	Percentage	Count
Missed medical appointments in the past 3 months		
Yes	23.8	133
No	40.9	229
Not Sure	25.2	141
Veteran has not had any appointments	8.6	48
Not available	<2	<10
Veteran taking medications as prescribed		
Yes	51.4	288
No	7.9	44
Not sure	5.9	33
Not taking medications	14.1	79
Not available	20.7	116
Ability to self-manage chronic health symptoms		
Well/very well	38.2	214
Somewhat well	31.8	178
Not well or not at all	15.4	86
Not sure/not available	14.6	82
Average number of meals eating per day		
0	<2	<10
1	11.2	63
2	36.8	206
3	30.4	170
Don't know; not available	20.7	116
Substance use		
Alcohol	36.1	202
Cannabis	25.9	145
Stimulants	18.4	103
Opioids	14.5	81
Barbiturates	10.4	58
Benzodiazepines	10.4	58
Hallucinogens	10.4	58
Solvents	10.2	57
Other	5.2	29

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. With the exception of missed medical appointments, the time period for all other behaviors was not specified. The value of "Not available" was assigned to fully missing values, while "Not sure" and "Don't know" were valid responses; in some instances, these were aggregated due to the data collection form changing over time.

Social Behaviors

In Table 3.7, we present the results from staff responses regarding participant socialization and engagement at baseline. Staff reported the number of group programs and activities (described as behavioral health/substance use support groups, recreational/social events, or any other on-site or off-site gatherings) that each participant engaged in. Staff left 28 percent blank, as instructed when the answer was unknown. Otherwise, 36 percent of participants did not regularly engage in any group activities. The other approximately one-third engaged in one or more group activities. Next, we describe how often veteran participants left their apartment, as staff reported. Sixty-five percent of veteran participants came out of their apartment daily. About 20 percent came out of their apartment three or more times a week, but not daily. Fewer than 10 percent came out of their apartment one to two times a week, one to two times a month, or never. Staff did not know or the data were missing on this item for 7 percent of the sample.

Table 3.7. Social Behaviors at Program Enrollment

Variable	Percentage	Count
Number of group programs and activities participating in		
0	35.9	201
1–2	25.5	143
3–4	6.4	36
5+	4.1	23
Not available	28.0	157
Frequency that veteran comes out of their apartment		
Daily	65.2	365
3 or more times per week, but not daily	19.6	110
1–2 times per week	5.2	29
1–2 times per month	2.3	13
Never	<2	<10
Don't know; not available	6.6	37

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. The time period for these behaviors was not specified. The value of “Not available” was assigned to fully missing values, while “Don’t know” were valid responses; in some instances, these were aggregated due to the data collection form changing over time.

Habitability

In Table 3.8, we present the results from items related to the number of participants who had behavior and habitability complaints during the three months prior to program enrollment that

staff recorded. All types of complaints were relatively low, with cleanliness (7.9 percent) and clutter (7.1 percent) the most frequent, followed closely by pest infestation (6.6 percent). The next most common were hygiene (5.5 percent) and noise or disruptive behavior (5.2 percent), followed by odor (4.3 percent) and other (3.6 percent).

Table 3.8. Behavior and Habitability Complaints During Three Months Prior to Program Enrollment

Variable	Percentage	Count
Cleanliness	7.9	44
Clutter	7.1	40
Pest infestation	6.6	37
Hygiene	5.5	31
Noise or disruptive behavior	5.2	29
Odor	4.3	24
Other	3.6	20

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. All observations below 2 percent were truncated to <2 percent. Missing or unknown values were not available on these variables.

Chapter 4. Outcomes over Time

This chapter presents data on housing stability among all VSSR participants to date. It also examines changes in health, social, behavioral, and habitability outcomes over time among a subset of participants that had been enrolled for at least one year. As further detailed below, housing remained stable across the three years of the pilot, with negative exits rare and showing no upward trend, and most exits reflecting health trajectories rather than housing failure. Among participants with a full year of enrollment, measures of acute health events, emergency and inpatient care, and unmet daily living needs generally moved in a favorable direction. Measures of overall health status held roughly steady, which is a notable result for an aging and medically complex population in which some decline would be expected over time.

Housing Stability

In Table 4.1, we present the number of housing exits for all participants by three exit types in six-month increments between program start-up (June 2023) through May 2026. The percentages of “Total exited” represent the sum of all exits out of the number of unique participants who were enrolled during the specified six-month increment.

We categorized housing exits into three groups, following an approach used in other PSH evaluations to inform performance metrics.³⁶ A transition to another independent living situation, such as moving in with family/friends was the first category. This category represents a “positive” exit in that it reflects that the veteran was able to maintain living independently without additional supports. The second category reflects transitioning into a higher level of care, including long-term care facility, assisted living or hospital-like setting, and also participant death. These exits reflect increased health care needs or end of life but do not directly indicate program effectiveness, so we classify them separately from the third and final category. The third category includes exits due to eviction, incarceration, moving to a locked mental health facility, returning to living unhoused, and whereabouts unknown. These types of housing exits are considered preventable and are a key program focus. Veterans who left only the VSSR pilot program but remained housed at the site were not included in this analysis, as participation in the program was voluntary.

As shown, the total number of housing exits increased after the first six-month interval, peaking between December 2023 and May 2024, before leveling off at 24 exits per interval for each of the subsequent periods for a rate around 6 percent. Negative exits (those due to eviction,

³⁶ Sarah B. Hunter and Stephanie Mercier, “Addressing Homelessness Among People with Justice Involvement: Los Angeles County’s Just in Reach Pay for Success Demonstration Project,” *Cityscape: A Journal of Policy Development and Research*, Vol. 25, No. 2, 2023.

incarceration, locked facility placement, homelessness, or whereabouts unknown) remained relatively low overall, ranging from 1 to 4 exits per six-month interval and accounting for only a small portion of total exits in each period. The number of exits to higher levels of care or death declined sharply from its peak of 22 (December 2023–May 2024) to a low of 11 (December 2024–May 2025), before rising again to 15 and 16 in the two most recent intervals. For context, a study of 2,712 veterans housed through HUD-VASH in Los Angeles reported that 15 percent experienced a negative housing exit over an average of about three years, using a broader definition that included program disengagement and noncompliance alongside eviction and returns to homelessness.³⁷

³⁷ Talia J. Panadero, Sonya Gabrielian, Marissa J. Seamans, Lillian Gelberg, Jack Tsai, and Taylor Harris, “Addressing Racial and Ethnic Disparities in Premature Exits from Permanent Supportive Housing Among Residents with Substance Use Disorders,” *BMC Public Health*, Vol. 25, No. 1, January 28, 2025.

Table 4.1. Number (and Percentage) of Housing Exits Through Year 3, Quarter 4

Exit Type	Jun–Nov 2023 (Y1Q1–Q2)	Dec 2023– May 2024 (Y1Q3–Q4)	Jun–Nov 2024 (Y2Q1–Q2)	Dec 2024– May 2025 (Y2Q3–Q4)	Jun–Nov 2025 (Y3Q1–Q2)	Dec 2025– May 2026 (Y3Q3–Q4)
Other independent living situation	1	7	6	9	5	4
Higher level of care or death	4	22	14	11	15	16
Eviction, incarceration, locked mental health facility, unhoused or whereabouts unknown	1	3	4	4	4	4
Total exited	6 (2.5%)	32 (9.0%)	24 (5.8%)	24 (6.0%)	24 (6.1%)	24 (5.6%)

NOTE: Sample size of 237 enrollees from June to November 2023, 357 enrollees from December 2023 to May 2024, 416 enrollees from June to November 2024, 400 enrollees from December 2024 to May 2025, 391 enrollees from June to November 2025, and 428 enrollees from December 2025 to May 2026.

Changes in Outcomes

Between June 2023 and May 2026, 411 individuals had been enrolled in the program for at least one year. This section compares outcomes for these individuals during their baseline period, which reflects their three months prior to enrollment, with outcomes from their respective fourth quarter of enrollment in the program. Given this set-up, the “fourth quarter” of a resident’s enrollment may have occurred as early as Year 1, Quarter 4 (i.e., March to May 2024) if they enrolled during Year 1 Quarter 1, all the way through Year 3, Quarter 4 of the program (i.e., March to May 2026) if they enrolled during Year 3, Quarter 1. Note that of the 411 individuals enrolled for at least one year, 11 had missing data at their fourth quarter of enrollment and therefore could not be included in analysis. The sample size for these analyses of changes in outcomes between baseline and the fourth quarter of enrollment is therefore 400.

Appendix Table B.1 shows descriptive statistics comparing the sample of the 400 participants who were eligible to be included in the analytical sample to the other 160 participants who had less than a full year of enrollment (either due to exiting [$n = 109$] or later enrollment [$n = 51$]). A significantly higher share of residents from Nation’s Finest–Mather and U.S.VETS–Inland Empire, and a significantly lower share of residents from Swords to Plowshares, had complete data from a full year. The group with complete data for a full year had a significantly higher proportion of participants residing at the PSH site for five or more years and a lower proportion of individuals with depression, anxiety, PTSD, and substance use disorders. There were no significant differences by age, branch of military, general health status, and number of conditions. However, there was a significant difference by race/ethnicity, with a lower proportion of Hispanic, Latinx, Chicano, or Spanish origin participants in the group with complete data for a full year.

Health Status

In Table 4.2, we present the pilot staff's assessments of the enrollees' general health status. From baseline to Quarter 4 of the program, the percentage of individuals in Good or Very good health had a nonsignificant increase from 37.6 percent to 42.0 percent, while those in Poor or Very poor health had a nonsignificant decline from 20.3 percent to 17.0 percent.

These aggregate percentages mask movement in both directions at the individual level. Among the 364 residents with health status data at both time points, 91 (25.0 percent) improved by at least one category between baseline and the fourth quarter, 70 (19.2 percent) declined, and 203 (55.8 percent) held steady. More residents improved than declined, and four in five either improved or maintained their health status over the year, a pattern worth noting for a population in which some decline would be expected over time.

The proportion of individuals who experienced falls had a significant decline of 58.6 percent, from 21.8 percent at baseline to 9.0 percent by the fourth quarter of enrollment. Loss of consciousness declined from 4.5 percent at baseline to below 3 percent by the fourth quarter. Strokes, heart attacks, and seizures remained below 3.0 percent at both baseline and the fourth quarter of enrollment; percentage differences for these acute events are not reported due to the small number of observations. The proportion of residents reporting no acute events increased significantly, from 74.0 percent to 90.2 percent.

Table 4.2. Health Status Through End of First Year of Enrollment

Variable	Baseline	4th Quarter	Percentage Difference
General health status			
Good/very good	37.6% (137)	42.0% (153)	+11.7%
Fair	42.0% (153)	40.9% (149)	-2.6%
Poor/very poor	20.3% (74)	17.0% (62)	-16.2%
Experienced acute events in the past three months			
Falls	21.8% (87)	9.0% (36)	-58.6%**
Loss of consciousness	4.5% (18)	<3% (<10)	-
Stroke	<3% (<10)	<3% (<10)	-
Heart attack	<3% (<10)	<3% (<10)	-
Seizures	<3% (<10)	<3% (<10)	-
None	74.0% (296)	90.2% (361)	+22.0%**

NOTE: Sample size of 364 unique residents with data on general health status at baseline and in the fourth quarter of enrollment and 400 unique residents for all other variables. To protect the anonymity of enrollees, variables with fewer than ten respondents are reported as <10 (below 3 percent of the sample); percentage differences and significance tests are not reported when either time point is masked. * = $p < 0.05$, ** = $p < 0.01$.

Daily Living Assistance Delivered

Table 4.3 reports the rates of residents receiving assistance with ADLs and IADLs. We do not have comparable data from when participants entered the program, rather information about assistance they received at any point prior to entry (see prior chapter, Table 3.4). By the end of the first year of enrollment, the highest rates of assistance among participants were for companionship or emotional support (37.2 percent), housekeeping or managing household tasks (25.5 percent), medical purposes (21.5 percent), and grocery shopping or errands (18.5 percent). Moderate levels of assistance were also reported for using the telephone or computer (15.5 percent), mobility (9.0 percent), laundry (8.0 percent), and meal preparation (7.2 percent). Support with self-administration of medications, assistive devices, and grooming or hygiene ranged between 5.0 and 6.8 percent of participants. The lowest rates of assistance were reported for bathing or showering, eating, transferring in and out of a chair or bed, dressing, and toileting, each ranging between 3.0 and 3.8 percent.

Table 4.3. Assistance Use Through End of First Year of Enrollment

Value	4th Quarter
Companionship/emotional support	37.2% (149)
Housekeeping/managing household	25.5% (102)
Medical purposes	21.5% (86)
Grocery shopping/errands	18.5% (74)
Using the telephone or computer	15.5% (62)
Mobility	9.0% (36)
Laundry	8.0% (32)
Meal preparation	7.2% (29)
Self-administration of medications	6.8% (27)
Assistive devices	5.2% (21)
Grooming/hygiene	5.0% (20)
Bathing or showering	3.8% (15)
Eating, including cutting up food	3.8% (15)
Transferring in and out of a chair or bed	3.8% (15)
Dressing	3.5% (14)
Toileting	3.0% (12)
Other	3.8% (15)

NOTE: Sample size of 400 unique residents in the baseline and fourth quarter of enrollment. We do not have comparable data from when participants entered the program, rather information about assistance they received at any point prior to entry (see Table 3.4).

Table 4.4 presents the rates of residents with unmet needs for assistance with ADLs and IADLs. There were significant declines in unmet need for housekeeping/managing household (a

decline of 57.7 percent), grocery shopping/errands (a decline of 77.3 percent), meal preparation (a decline of 49.2 percent), and laundry (a decline of 54.2 percent). Despite these improvements, unmet need for housekeeping/managing household remained above 10 percent in the fourth quarter.

Unmet needs for companionship/emotional support and accompaniment for medical purposes also declined significantly between baseline and the fourth quarter, falling from 25.2 to 3.2 percent and from 23.2 to 3.5 percent, respectively. Unmet need for mobility likewise declined significantly, from 8.5 to 3.0 percent, while unmet need for grooming/hygiene declined nonsignificantly from 4.5 to 3.2 percent. There was little change in unmet need for self-administration of medications, which declined slightly and nonsignificantly from 6.8 to 6.5 percent. Unmet needs for using the telephone or computer and for assistive devices fell to fewer than 10 residents by the fourth quarter; percentage differences for these items are not reported because of the small number of observations. The remaining items—bathing or showering, dressing, eating, transferring in and out of a chair or bed, and toileting—affected fewer than ten residents at one or both time points.

Table 4.4. Unmet Need for Assistance Through End of First Year of Enrollment

Value	Baseline	4th Quarter	Percentage Difference
Housekeeping/managing household	30.8% (123)	13.0% (52)	–57.7**
Companionship/emotional support	25.2% (101)	3.2% (13)	–87.1**
Grocery shopping/errands	24.2% (97)	5.5% (22)	–77.3**
Medical purposes	23.2% (93)	3.5% (14)	–84.9**
Meal preparation	15.2% (61)	7.8% (31)	–49.2**
Laundry	14.8% (59)	6.8% (27)	–54.2**
Using the telephone or computer	9.2% (37)	<3% (<10)	–
Mobility	8.5% (34)	3.0% (12)	–64.7**
Self-administration of medications	6.8% (27)	6.5% (26)	–3.7
Assistive devices	4.5% (18)	<3% (<10)	–
Grooming/hygiene	4.5% (18)	3.2% (13)	–27.8
Bathing or showering	3.0% (12)	<3% (<10)	–
Dressing	<3% (<10)	<3% (<10)	–
Eating, including cutting up food	<3% (<10)	<3% (<10)	–
Transferring in and out of a chair or bed	<3% (<10)	<3% (<10)	–
Toileting	<3% (<10)	<3% (<10)	–
Other	4.0% (16)	<3% (<10)	–

NOTE: Sample size of 400 unique residents at Baseline and in the fourth quarter of enrollment. To protect the anonymity of enrollees, variables with fewer than ten respondents are reported as a count of <10 (below 3 percent of the sample); percentage differences and significance tests are not reported when either time point is masked. * = $p < 0.05$, ** = $p < 0.01$.

Health Service Use

Table 4.5 lists the changes in health service use during the pilot program. From baseline to the fourth quarter of enrollment, use of primary care significantly declined by 16 percent, from 42 percent to 35 percent. Specialty medical care increased by 13 percent, from 23 percent to 26 percent, although this change did not reach statistical significance. Outpatient mental health visits significantly declined by 44 percent, from 14 percent to 8 percent, and substance use disorder treatment fell from 4 percent at baseline to less than 3 percent by the fourth quarter.

Overall, both medical and emergency visit rates declined notably over the period. The proportion of cases involving an ambulance or 911 call fell by 24 percent (from 10 percent to 8 percent), although this decline was not statistically significant. Emergency medical visits significantly dropped by 75 percent (from 15 percent to 4 percent), and inpatient medical visits significantly declined by 36 percent (from 8 percent to 5 percent). Emergency and inpatient mental health visits remained low, both under 3 percent throughout the period.

There was growing engagement with onsite VSSR clinical services. By the fourth quarter, 5 percent of residents were receiving care from the pilot nurses and 5 percent were receiving services from occupational therapy—both increases from less than 3 percent at baseline. These figures are relatively low overall because most sites did not offer nursing care or occupational therapy. Nursing home or rehabilitation stays remained rare.

Table 4.5. Health Service Use Through End of First Year of Enrollment

Variable	Baseline	4th Quarter	Percentage Difference
Outpatient care			
Primary care	41.8% (167)	35.2% (141)	-15.6*
Specialty care	23.2% (93)	26.2% (105)	+12.9
Mental health	14.2% (57)	8.0% (32)	-43.9**
Substance use disorder treatment	4.2% (17)	<3% (<10)	-
Acute care			
Ambulance or 911 calls	10.2% (41)	7.8% (31)	-24.4
Emergency mental health	<3% (<10)	<3% (<10)	-
Emergency medical	14.8% (59)	3.8% (15)	-74.6**
Inpatient medical	8.2% (33)	5.2% (21)	-36.4*
Inpatient mental health	<3% (<10)	<3% (<10)	-
Nursing home or other rehabilitation	<3% (<10)	<3% (<10)	-
Onsite VSSR clinical services			
Pilot Nurse	<3% (<10)	5.0% (20)	-
Occupational Therapy	<3% (<10)	5.2% (21)	-

NOTE: Sample size of 400 unique residents in the Baseline and fourth quarter of enrollment. All observations with fewer than ten respondents are reported as <3 percent. * = $p < 0.05$, ** = $p < 0.01$.

Health Behaviors

Table 4.6 reports outcomes related to health behavior. There was a substantial, statistically significant decrease in the proportion of participants who missed medical appointments, from 22 percent at baseline to 10 percent in the fourth quarter of enrollment. The proportion taking medications as prescribed remained stable at about half of participants (50 percent at baseline, 52 percent in the fourth quarter). However, the proportion responding “Not sure” about medication adherence significantly increased from 6 to 17 percent, while the proportions reporting they were not taking any medications (14 to 9 percent) and those with no adherence information available (24 to 14 percent) both significantly declined. The decline in residents not taking medications could indicate improvements in underlying health conditions (for example, controlled hypertension or reduced depressive symptoms), although the growth in “Not sure” responses suggests some of these shifts may reflect changes in reporting rather than true changes in adherence. These changes coincided with a significant increase in residents who reported having no medical appointments (from 8 to 18 percent), suggesting fewer residents were actively engaged in appointment-based care in the fourth quarter of their enrollment. The proportion of residents who reported managing their chronic health symptoms “Well” or “Very well” remained stable, increasing slightly from 51 to 53 percent (nonsignificant).

The rate of residents eating three meals per day rose significantly by 41 percent (from 37 to 53 percent), while the proportions eating one meal per day (14 to 5 percent) and two meals per day (48 to 40 percent) declined significantly.

Substance use declined broadly over the period. Alcohol use significantly decreased by 40 percent (from 38 to 23 percent), opioid use significantly declined by 47 percent (from 15 to 8 percent), and stimulant use significantly declined by 51 percent (from 18 to 9 percent). Cannabis use decreased slightly (from 26 to 23 percent), although this change was not statistically significant. Barbiturate, benzodiazepine, hallucinogen, and solvent use, each reported by about 12 percent of residents at baseline, all fell below the reporting threshold by the fourth quarter, as did use of other substances. Consistent with these declines, the proportion of residents reporting no substance use significantly increased from 50 to 61 percent.

Table 4.6. Health Behaviors Through End of First Year of Enrollment

Variable	Baseline	4th Quarter	Percentage Difference
Missed medical appointments in the past 3 months			
Yes	22.2% (89)	10.2% (41)	-53.9**
No	40.7% (163)	34.0% (136)	-16.6**
Has not had any appointments	8.0% (32)	18.0% (72)	+125.0**
Not sure	27.5% (110)	23.7% (95)	-13.6
Not available	1.5% (6)	14.0% (56)	+833.3**
Taking medications as prescribed			
Yes	50.2% (201)	52.2% (209)	+4.0
No	6.0% (24)	7.8% (31)	+29.2
Not sure	5.8% (23)	17.0% (68)	+195.7**
Not taking medications	14.2% (57)	8.7% (35)	-38.6**
Not available	23.7% (95)	14.2% (57)	-40.0**
Ability to self-manage chronic health symptoms			
Well/very well	50.7% (154)	52.6% (160)	+3.9
Somewhat well	30.9% (94)	31.6% (96)	+2.1
Not well/not at all	18.4% (56)	15.8% (48)	-14.3
Average number of meals per day			
0	<3% (<10)	<3% (<10)	-
1	13.9% (34)	4.5% (11)	-67.6**
2	48.0% (117)	40.2% (98)	-16.2*
3	37.3% (91)	52.5% (128)	+40.7**
Substance use			
Alcohol	38.0% (152)	22.8% (91)	-40.1**
Barbiturates	11.5% (46)	<3% (<10)	-
Benzodiazepines	11.5% (46)	<3% (<10)	-
Cannabis	25.8% (103)	23.0% (92)	-10.7
Hallucinogens	11.5% (46)	<3% (<10)	-
Opioids	14.5% (58)	7.8% (31)	-46.6**
Solvents	11.5% (46)	<3% (<10)	-
Stimulants	18.0% (72)	8.7% (35)	-51.4**
Other substance	5.0% (20)	<3% (<10)	-
None	49.8% (199)	61.0% (244)	+22.6**

NOTE: Sample size of 400 for missed appointments, 400 for medication adherence, 304 for self-management of chronic symptoms, 244 for meals per day, and 400 for substance-use variables. All observations with fewer than ten respondents are reported as <3 percent. * = $p < 0.05$, ** = $p < 0.01$.

Social Behaviors

As shown in Table 4.7, those participating in three or more group programs and activities significantly increased from 12 percent to 37 percent, while those who did not participate in any groups significantly declined from 50 percent to 29 percent. Participation among those attending one to two activities decreased slightly from 39 to 34 percent, although this change was not statistically significant. Participants largely declined in the frequency by which they came out of their apartment. Those who came out daily significantly decreased by 26 percent (from 71 to 52 percent), while those who left their unit fewer than three times per week significantly increased by 112 percent (from 8 to 16 percent). Meanwhile, those who came out three or more times per week (but not daily) significantly increased by 46 percent (from 22 to 32 percent), a change likely attributable to residents who reduced their daily frequency of leaving their units.

Table 4.7. Social Behaviors Through End of First Year of Enrollment

Variable	Baseline	4th Quarter	Percentage Difference
Number of group programs/activities			
0	50.0% (117)	29.1% (68)	-41.9**
1–2	38.5% (90)	34.2% (80)	-11.1
3+	11.5% (27)	36.8% (86)	+218.5**
Frequency of veteran leaving apartment			
Daily	70.8% (242)	52.3% (179)	-26.0**
3 or more times per week, but not daily	21.6% (74)	31.6% (108)	+45.9**
Fewer than 3 times per week	7.6% (26)	16.1% (55)	+111.5**

NOTE: Sample sizes: Sample size of 234 for group programs and activities and 342 for frequency of leaving apartment. All observations with fewer than ten respondents are reported as <3 percent. * = $p < 0.05$, ** = $p < 0.01$.

Habitability

As shown in Table 4.8, habitability complaints declined across all categories between baseline and the fourth quarter of enrollment. Complaints related to cleanliness significantly declined by 53 percent (from 8 to 4 percent), and complaints in the “other” category significantly declined by 65 percent (from 9 to 3 percent). Declines in clutter complaints (from 6 to 4 percent) and noise or disruptive behavior complaints (a 12 percent relative decline) were not statistically significant, likely due to low baseline complaint rates. Complaints related to hygiene, odor, and pest infestation each fell below the reporting threshold by the fourth quarter; because of the small number of respondents in these categories, we do not report their percentage differences or significance test results.

Table 4.8. Habitability Complaints Through End of First Year of Enrollment

Value	Baseline	4th Quarter	Percentage Difference
Cleanliness	7.5% (30)	3.5% (14)	–53.3**
Clutter	6.0% (24)	4.0% (16)	–33.3
Hygiene	3.5% (14)	<3% (<10)	–
Noise or disruptive behavior	6.2% (25)	5.5% (22)	–12.0
Odor	4.0% (16)	<3% (<10)	–
Pest infestation	5.0% (20)	<3% (<10)	–
Other	8.5% (34)	3.0% (12)	–64.7**

NOTE: Sample size of 400 unique residents with data at both baseline and 4th quarter assessment. All observations with fewer than ten respondents are reported as <3 percent.

* = $p < 0.05$, ** = $p < 0.01$.

Table 4.9 lists the topics by which participants engaged in discussions with staff related to behavior and habitability concerns. These conversations served multiple purposes, such as addressing current issues, preventing future complaints, and connecting participants to appropriate services. Most topics showed significant increases over the first year of enrollment. The largest of these was for life skills (11 to 38 percent), followed by peer support (26 to 67 percent), participation in onsite and offsite activities and events (30 to 66 percent), nutrition assistance (10 to 20 percent), issues of habitability (14 to 28 percent), management of health (15 to 25 percent), other discussions (9 to 14 percent), outreach and engagement in activities (26 to 38 percent), substance use management (6 to 8 percent), and transportation (30 to 38 percent). Discussions of assistance with self-administration of medication, reported for fewer than 3 percent of residents at baseline, rose to 7 percent by the fourth quarter. In contrast, discussions on the management of mental health significantly declined (11 to 7 percent), while noise or disruptive behavior, connection to medical services, and connection to VA and other veteran benefits remained statistically unchanged.

Table 4.9. Discussions on Behavior and Habitability Through End of First Year of Enrollment

Value	Baseline	4th Quarter	Percentage Difference
Issues of habitability	14.2% (57)	27.8% (111)	+94.7**
Noise or disruptive behavior	6.8% (27)	6.5% (26)	-3.7
Assistance with self-administration of medication	<3% (<10)	7.0% (28)	-
Participation in onsite and offsite activities and events	29.8% (119)	66.0% (264)	+121.8**
Connection to medical services	19.8% (79)	21.0% (84)	+6.3
Connection to VA and other veteran benefits	10.2% (41)	8.7% (35)	-14.6
Management of health	14.5% (58)	25.0% (100)	+72.4**
Management of mental health	11.0% (44)	7.2% (29)	-34.1*
Life skills	11.0% (44)	38.2% (153)	+247.7**
Outreach and engagement in events/activities	25.5% (102)	37.5% (150)	+47.1**
Nutrition assistance	9.8% (39)	19.5% (78)	+100.0**
Peer support	25.5% (102)	67.0% (268)	+162.7**
Transportation	30.2% (121)	38.0% (152)	+25.6**
Substance use management	5.5% (22)	8.0% (32)	+45.5*
Other	8.5% (34)	13.5% (54)	+58.8**

NOTE: Sample size of 400 unique residents with data at both baseline and 4th quarter assessment. All observations with fewer than 10 respondents are reported as <3%. * = $p < 0.05$, ** = $p < 0.01$.

Chapter 5. Associations of Service Use and Outcomes

Between June 2023 and May 2026, 411 individuals had been enrolled in the program for at least one year. This chapter estimates how utilizing three types of services—(1) receiving assistance for ADLs/IADLs, (2) participating in group programs, and (3) other general assistance³⁸—was associated with differences in health outcomes, health behaviors, habitability and social behaviors. We examined this by looking at the association between each participant’s service utilization during each quarterly period (i.e., at baseline, in Quarter 1, Quarter 2, or Quarter 3) to outcomes in the following quarter (i.e., Quarter 1, Quarter 2, Quarter 3 or Quarter 4, respectively). This approach uses a maximum of 1,644 person-quarters of data (i.e., four observations for up to 411 participants). Some of the analyses had a smaller sample after excluding observations for which staff responded “Not sure” or “Don’t know” for a given outcome.

As further detailed below, service use did not relate to subsequent outcomes in a uniform direction. Services delivered to residents with greater underlying need tended to precede poorer measured outcomes, a pattern consistent with how staff targeted those services rather than with any effect of the services themselves. Most tested associations were not statistically significant, and, given the number of tests and modest sample sizes, these analyses should be treated as exploratory.

Three features of this analysis shape how the results should be interpreted. First, service receipt was not randomly assigned. Staff directed ADL/IADL assistance and other general assistance toward residents who were already experiencing difficulties in those areas. Residents who used a given service therefore differed systematically from those who did not, in ways only partially captured by the covariates in these models. Associations in which service use predicts poorer outcomes are consistent with services being directed toward residents with greater underlying need, and do not indicate that the services produced those outcomes. Second, although outcomes are measured in the quarter following service use, this ordering does not rule out the possibility that need present in the earlier quarter influenced both service receipt and the subsequent outcome. Third, precision varies substantially across outcomes. Several outcomes were uncommon, and the corresponding ORs rest on a small number of events; where CIs are wide, the direction of an estimate is more informative than its magnitude. Conversely, the

³⁸ As noted above, “Other general assistance” indicates that staff reported spending any nonzero amount of time in the prior three months on at least one of the following: issues of habitability (e.g., clutter, hygiene, odors, cleanliness); noise/disruptive behavior; assistance with self-administration of medication; participation in onsite and offsite activities and events; connection to medical services; connection to VA and other veteran benefits; connection to mental and/or behavioral health services; management of mental health; life skills; outreach and engagement in events/activities; nutrition assistance; peer support; transportation; or substance use management.

absence of a statistically significant association does not establish the absence of a relationship, particularly for low-frequency outcomes where these models have limited power to detect moderate differences.

Health Outcomes

The results for health outcomes by each of the three types of service utilization are presented in Table 5.1.

Assistance for ADLs/IADLs

Among participants who did not receive any assistance for ADLs/IADLs in a given quarter, 43 percent were subsequently assessed as having Good or Very good health, 7 percent utilized acute care, and 10 percent experienced at least one fall in the following quarter. Those who received assistance had significantly lower odds of being assessed as having Good or Very good health (OR = 0.45; 95% CI: 0.31, 0.67; $p < 0.001$) and significantly higher odds of acute care use (OR = 2.12; 95% CI: 1.22, 3.68; $p < 0.01$) in the following quarter. Receiving ADL/IADL assistance was associated with higher but not significantly different odds of experiencing a fall (OR = 1.38; 95% CI: 0.81, 2.35). As with the discussion findings below, the associations with poorer health status and greater acute care use likely reflect the underlying needs of residents receiving assistance, as those requiring help with daily activities tend to be in poorer health, rather than an adverse effect of the assistance itself.

Group Programs

Among individuals who did not participate in group programs, 38 percent were assessed as having Good or Very good health, 8 percent utilized acute care, and 7 percent experienced at least one fall in the following quarter. Participation in group programs was not significantly associated with odds of Good or Very good health (OR = 1.15; 95% CI: 0.79, 1.67), acute care utilization (OR = 1.60; 95% CI: 0.91, 2.79), or experiencing a fall (OR = 0.90; 95% CI: 0.55, 1.46) in the following quarter. These outcomes were uncommon among residents who did not participate: 8.2 percent used acute care and 6.5 percent experienced a fall in the following quarter. At these base rates the models have limited power, and the CIs around each estimate remain consistent with moderate differences in either direction. These results indicate that no association was detected, not that none exists.

Other General Assistance

Among individuals who did not receive other general assistance (as defined above), 50 percent were assessed as having Good or Very good health, 3 percent utilized acute care, and 7 percent experienced at least one fall in the following quarter. Receiving other general assistance was associated with significantly lower odds of Good or Very good health status (OR = 0.60;

95% CI: 0.37, 0.98) and significantly higher odds of acute care use (OR = 3.38; 95% CI: 1.24, 9.16) in the following quarter, but was not associated with a statistically significant difference in falls. These associations should not be interpreted as evidence that other general assistance receipt worsen health outcomes. Other general assistance may be more likely to occur with residents already experiencing health, behavioral, or habitability challenges, so these findings may reflect confounding by underlying need, with staff directing attention toward residents at elevated risk, rather than a harmful effect of the assistance itself.

Table 5.1. Service Receipt and Health Outcomes in the Following Quarter

Service Use During Quarter <i>t</i>	Outcomes in Quarter <i>t+1</i>		
	Good/Very Good Health Status	Any Acute Care Use	Any Falls
Assistance with ADLs			
Percentage of those <i>without</i> assistance	42.5	6.8	9.7
Odds ratio (95% CI) for those who used assistance	0.452*** (0.307, 0.666)	2.118** (1.219, 3.680)	1.379 (0.809, 2.350)
Group programs			
Percentage of those <i>without</i> group programs	37.8	8.2	6.5
Odds ratio (95% CI) for those who used group programs	1.148 (0.787, 1.674)	1.597 (0.913, 2.794)	0.897 (0.550, 1.462)
Other general assistance			
Percentage of those with <i>no</i> other general assistance	50.0	2.8	6.6
Odds ratio (95% CI) for those who had other general assistance	0.598* (0.365, 0.978)	3.375* (1.243, 9.164)	0.881 (0.443, 1.751)

NOTE: Longitudinal regression analysis of veteran-level data, from June 2023 to June 2026. Sample size of 408 unique residents for models on health status, and 411 residents for models on acute care use and falls. Odds ratios represent the association of utilizing a given service during the baseline, first, second, or third enrollment quarter and the odds of experiencing an outcome in the subsequent quarter (i.e., between the first and fourth enrollment quarter). Models adjust for age, gender, race/ethnicity, and comorbidity burden. Fixed effects were included for site and year-quarter of the program. Random effects were included for each resident. * = $p < 0.05$, ** = $p < 0.01$, *** = $p < 0.001$.

Health Behaviors

The results for five health behaviors (i.e., substance use, missed medical appointments, taking medications as prescribed, meals eaten per day, and symptom management) by each of the three types of service utilization are presented in Table 5.2. Each of these outcomes is drawn from staff quarterly reports and is therefore subject to recall and social desirability effects, which may vary with the frequency of a resident's contact with program staff.

Assistance for ADLs/IADLs

Among individuals who did not receive assistance with ADLs/IADLs during a given quarter, 41 percent reported substance use, 4 percent missed medical appointments, 37 percent took medication as prescribed, 28 percent ate three meals per day, and 73 percent were able to manage symptoms in the following quarter. Receiving assistance with ADLs/IADLs was not significantly associated with any of the five health behaviors: substance use (OR = 0.85; 95% CI: 0.59, 1.22), missed medical appointments (OR = 0.38; 95% CI: 0.05, 3.28), taking medications as prescribed (OR = 1.90; 95% CI: 0.62, 5.83), eating three meals per day (OR = 1.09; 95% CI: 0.74, 1.58), or managing chronic health symptoms (OR = 0.78; 95% CI: 0.43, 1.43).

Group Programs

Among individuals who did not participate in group programs during a given quarter, 38 percent reported substance use, 6 percent missed medical appointments, 46 percent took medication as prescribed, 36 percent ate three meals per day, and 69 percent were able to manage symptoms in the following quarter. Participation in group programs was likewise not significantly associated with any of the five behaviors: substance use (OR = 1.00; 95% CI: 0.70, 1.43), missed medical appointments (OR = 0.88; 95% CI: 0.15, 5.20), taking medications as prescribed (OR = 0.98; 95% CI: 0.28, 3.39), eating three meals per day (OR = 1.33; 95% CI: 0.92, 1.93), or managing chronic health symptoms (OR = 1.17; 95% CI: 0.64, 2.12). As with the health outcomes above, these CIs remain wide enough to accommodate moderate associations in either direction, and the absence of statistical significance should not be read as evidence that group programs are unrelated to these behaviors.

Other General Assistance

Among individuals who did not receive other general assistance during a given quarter, 35 percent reported substance use, 51 percent took medications as prescribed, 30 percent ate three meals per day, and 66 percent were able to manage symptoms well in the following quarter; fewer than 3 percent missed medical appointments. Other general assistance receipt was associated with significantly higher odds of substance use in the following quarter (OR = 1.68; 95% CI: 1.06, 2.67). This association may reflect staff assisting residents already experiencing substance use challenges, or greater staff awareness and documentation of substance use among residents they engaged with more frequently, rather than an effect of the assistance itself. No other outcomes were significantly associated with other general assistance receipt: ORs were near one for eating three meals per day (OR = 1.05; 95% CI: 0.64, 1.73) and symptom management (OR = 1.05; 95% CI: 0.42, 2.64), and the estimates for medication adherence (OR = 0.71; 95% CI: 0.13, 3.86) and missed medical appointments (OR = 6.63; 95% CI: 0.21, 208.96) were imprecise, with wide CIs reflecting the small number of respondents for these outcomes.

Table 5.2. Service Receipt and Health Behaviors in the Following Quarter

Service Use During Quarter <i>t</i>	Outcomes in Quarter <i>t+1</i>				
	Substance Use	Missed Medical Appointments	Taking Medications as Prescribed	Three Meals Per Day	Able to Manage Symptoms
Assistance with ADLs					
Percentage of those <i>without</i> assistance	40.8	3.9	36.9	28.3	72.9
Odds ratio (95% CI) for those who used assistance	0.847 (0.589, 1.217)	0.382 (0.045, 3.282)	1.898 (0.618, 5.834)	1.085 (0.744, 1.582)	0.782 (0.429, 1.425)
Group programs					
Percentage of those <i>without</i> group programs	38.0	5.7	46.3	35.9	68.8
Odds ratio (95% CI) for those who used group programs	0.998 (0.697, 1.431)	0.880 (0.149, 5.198)	0.975 (0.280, 3.389)	1.333 (0.922, 1.927)	1.167 (0.641, 2.123)
Other general assistance					
Percentage of those with <i>no</i> other general assistance	34.6	<3	51.0	30.1	66.4
Odds ratio (95% CI) for those who had other general assistance	1.684* (1.062, 2.669)	6.629 (0.210, 208.962)	0.706 (0.129, 3.860)	1.049 (0.635, 1.734)	1.053 (0.420, 2.638)

NOTE: Longitudinal regression analysis of veteran-level data, from June 2023 to June 11 2026. Sample size of 411 unique residents for models on substance use, 405 for models on managing symptoms, 309 residents for models on missed medical appointments, 340 residents for taking medications, and 394 residents for three meals per day. Odds ratios represent the association of utilizing a given service between baseline and the third enrollment quarter and the odds of experiencing an outcome in the subsequent quarter (i.e., between the first and fourth enrollment quarter). Models adjust for age, gender, comorbidity burden, race/ethnicity, and time residing at housing site prior to enrollment in the pilot. Fixed effects were included for site and year-quarter of the program. Random effects were included for each resident. To protect the anonymity of enrollees, variables with fewer than ten respondents are reported as <10 (below 3 percent of the sample); percentage differences and significance tests are not reported when either time point is masked. * = $p < 0.05$, ** = $p < 0.01$.

Habitability and Social Behaviors

The results for social behaviors (i.e., complaints about noise or disruptive behavior, habitability complaints, and time spent outside one's housing unit) by each of the three types of service utilization are presented in Table 5.3.

Assistance for ADLs/IADLs

Among individuals who did not receive assistance with ADLs/IADLs during a given quarter, 5.4 percent received complaints about noise or disruptive behavior, 9.3 percent received complaints about habitability, and 76.9 percent were out of their unit at least three times per week. Receiving assistance was associated with ORs of 0.92 (95% CI: 0.41, 2.05) for complaints

about noise or disruptive behavior, 1.04 (95% CI: 0.61, 1.77) for complaints about habitability, and 0.52 (95% CI: 0.24, 1.15) for being out of the unit at least three times per week. None of these associations were statistically significant.

Group Programs

Among individuals who did not participate in group programs during a given quarter, 5.7 percent received complaints about noise or disruptive behavior, 13.6 percent received complaints about habitability, and 70.7 percent were out of their unit at least three times per week. Those who participated in group programs had ORs of 0.62 (95% CI: 0.22, 1.74) for complaints about noise or disruptive behavior, 0.42 (95% CI: 0.23, 0.76; $p < 0.01$) for complaints about habitability, and 1.97 (95% CI: 0.92, 4.20) for being out of the unit at least three times per week. The only statistically significant association was lower odds of receiving complaints about habitability among those who participated in group programs.

Other General Assistance

Among individuals who did not receive other general assistance during a given quarter, 3.8 percent received complaints about noise or disruptive behavior, 5.9 percent received complaints about habitability, and 72.4 percent were out of their unit at least three times per week. Those who received other general assistance had ORs of 0.96 (95% CI: 0.24, 3.85) for complaints about noise or disruptive behavior, 1.94 (95% CI: 0.83, 4.52) for complaints about habitability, and 1.44 (95% CI: 0.54, 3.86) for being out of the unit at least three times per week. None of these associations were statistically significant.

Table 5.3. Service Receipt and Habitability and Social Behaviors in the Following Quarter

Service Use During Quarter <i>t</i>	Outcomes in Quarter <i>t+1</i>		
	Complaints About Noise or Disruptive Behavior	Complaints About Habitability	Out of Unit at Least 3 Times per Week
Assistance with ADLs			
Percentage of those <i>without</i> assistance	5.4	9.3	76.9
Odds ratio (95% CI) for those who used assistance	0.920 (0.413, 2.045)	1.037 (0.607, 1.772)	0.521 (0.235, 1.154)
Group programs			
Percentage of those <i>without</i> group programs	5.7	13.6	70.7
Odds ratio (95% CI) for those who used group programs	0.619 (0.220, 1.744)	0.422** (0.233, 0.764)	1.967 (0.921, 4.201)
Other general assistance			
Percentage of those with <i>no</i> other general assistance	3.8	5.9	72.4
Odds ratio (95% CI) for those who had other general assistance	0.963 (0.241, 3.845)	1.936 (0.828, 4.523)	1.443 (0.539, 3.862)

NOTE: Longitudinal regression analysis of veteran-level data, from June 2023 to June 2026. Sample size of 411 unique residents for models on complaints about noise or disruptive behavior and habitability, and 404 residents for models on leaving the unit at least three times per week. Odds ratios represent the association of utilizing a given service between baseline and the third enrollment quarter and the odds of experiencing an outcome in the subsequent quarter (i.e., between the first and fourth enrollment quarter). Models adjust for age, gender, comorbidity burden, race/ethnicity, and time residing at housing site prior to enrollment in the pilot. Fixed effects were included for site and year-quarter of the program. Random effects were included for each resident. * = $p < 0.05$, ** = $p < 0.01$.

Extended Analysis Using Eight Quarters of Data

The analyses above use up to four quarters of follow-up for all 411 residents enrolled for at least one year. To examine whether these associations persist over a longer period, we repeated the analyses using eight consecutive quarters of data (service use at baseline through Quarter 7 predicting outcomes in Quarters 1 through 8) for the 233 residents enrolled long enough to contribute up to eight person-quarters, yielding a maximum of 1,839 person-quarters (233 residents for most outcomes; 226 for taking medications as prescribed; 213 for missed medical appointments). Model specifications, covariates, and fixed and random effects were identical to those described above. Because this sample is restricted to longer-tenured residents, differences from the main results may reflect both the longer observation window and compositional differences in who remains enrolled for two years.

Results for all 11 outcomes are presented in Table 5.4. For example, the first row shows that among residents who did not receive ADL/IADL assistance in a given quarter, 49.8 percent were subsequently assessed as having good or very good health; those who did receive assistance had significantly lower odds of being assessed as having good or very good health in the following

quarter (OR = 0.48; 95% CI: 0.34, 0.67; $p < 0.001$). The remaining rows and columns follow the same format for each of the three services (ADL/IADL assistance, group programs, and other general assistance) across all 11 outcomes. Associations flagged with † were not statistically significant in the four-quarter analysis (Tables 5.1–5.3) but reached significance here, most likely reflecting the greater precision afforded by additional person-quarters; associations flagged with ‡ were significant at four quarters but attenuated and lost significance at eight quarters and should be interpreted with caution. Overall, the two associations most central to the main findings, poorer health status and greater acute care use following ADL/IADL assistance, and greater acute care use following other general assistance, remained significant with similar or larger effect sizes. As in the main analysis, associations linking service use to poorer outcomes most plausibly reflect staff directing service assistance toward residents with greater underlying needs, rather than adverse effects of the services themselves.

Table 5.4. Service Receipt and Outcomes in the Following Quarter, Eight-Quarter Analysis, with Comparison to Four-Quarter Results

Outcome in Quarter t+1	ADL/IADL: % without Service	ADL/IADL: OR (95% CI)	Group Programs: % without Service	Group Programs: OR (95% CI)	Other General Assistance: % without Service	Other General Assistance: OR (95% CI)
Health outcomes						
Good/very good health status	49.8	0.479*** (0.343, 0.671)	42.2	1.054 (0.774, 1.437)	54.7	0.637‡ (0.402, 1.009)
Any acute care use	5.3	3.145*** (1.932, 5.118)	7.0	1.147 (0.734, 1.794)	2.0	4.497** (1.514, 13.361)
Any falls	8.0	2.141**† (1.328, 3.453)	6.6	1.050 (0.655, 1.683)	4.9	1.271 (0.582, 2.779)
Health behaviors						
Substance use	40.5	1.113 (0.812, 1.524)	39.0	0.982 (0.730, 1.321)	35.2	1.330‡ (0.867, 2.040)
Missed medical appointments	3.5	0.769 (0.378, 1.568)	3.9	1.149 (0.613, 2.155)	<1	1.848 (0.355, 9.629)
Taking medications as prescribed	45.7	1.649 (0.838, 3.244)	50.9	1.316 (0.737, 2.348)	53.8	1.393 (0.561, 3.458)
Three meals per day	33.3	0.834 (0.603, 1.153)	36.2	1.243 (0.919, 1.681)	33.6	1.108 (0.707, 1.738)
Able to manage symptoms	79.1	0.658 (0.402, 1.079)	76.3	1.391 (0.879, 2.201)	76.5	0.756 (0.346, 1.653)
Habitability and social behaviors						
Complaints about noise/disruptive behavior	4.2	0.967 (0.444, 2.109)	4.5	0.868 (0.403, 1.872)	2.0	1.733 (0.407, 7.392)
Complaints about habitability	11.0	1.311 (0.883, 1.944)	14.9	0.785‡ (0.537, 1.148)	7.3	1.989*† (1.010, 3.916)
Out of unit at least 3×/week	78.3	0.561*† (0.345, 0.913)	72.0	1.834**† (1.180, 2.850)	73.3	1.402 (0.677, 2.907)

NOTE: Longitudinal regression analysis of veteran-level data, from June 2023 to June 2026, using eight consecutive quarters of resident data. Sample of 233 unique residents (up to 1,839 person-quarters) for most outcomes; 226 residents for models on taking medications as prescribed and 213 residents for models on missed medical appointments. Percentages are the share of residents who did not use the given service in quarter t who experienced the outcome in quarter t+1. Odds ratios represent the association of utilizing a given service between baseline and the seventh enrollment quarter and the odds of experiencing an outcome in the subsequent quarter (i.e., between the first and eighth enrollment quarter). Model specifications, covariates, fixed effects, and random effects are identical to those in Tables 5.1 through 5.3. † = not significant in the four-quarter analysis but significant here. ‡ = significant in the four-quarter analysis but not significant here. * = $p < 0.05$, ** = $p < 0.01$, *** = $p < 0.001$.

Chapter 6. Factors Linked to Residents' Quality of Life

This chapter presents results from the annual self-administered resident survey on quality of life. As described in Chapter 2 (Methods), each year veterans completed a questionnaire assessing wellbeing across multiple domains: housing stability, health, daily activities, social connections, and overall life satisfaction. These self-reports complemented quarterly staff assessments and provided insight into residents' own perceptions of their quality of life.

To examine how key factors relate to self-rated quality of life, we estimated mixed-effects logistic regression models using the dichotomized outcomes noted in Chapter 2, one each for general health, housing quality, housing safety, housing worry, and loneliness. For each factor, we fitted three nested models: a base model with survey year only, a partial model adding the focal predictor, and a full model further adjusting for age, gender, race/ethnicity, number of chronic conditions, and site. Adjustment made no substantive difference. Every association kept the same direction, remained significant at $p < 0.001$, and changed only modestly in magnitude between the partial and full models. We therefore report the fully adjusted estimates below as our primary results and do not present the partial and base models separately.

As further detailed below, residents' own perceptions of their health, housing, and social connection were consistently and strongly associated with how they rated their quality of life. Measured service use showed much weaker relationships with the same outcomes.

Resident-Reported Factors and Quality of Life

Table 6.1 presents results for all five factors: general health, housing quality, housing worry, loneliness, and housing safety. Each row reports a separate model; the predictors were not entered simultaneously, so the estimates should be read as five parallel associations rather than as independent contributions within a single model.

Table 6.1. Association Between Resident-Reported Factors and Overall Quality of Life, Fully Adjusted Models

Factor (contrast)	OR (95% CI)	Marginal R ²	Resident-Level SD
General health (Good/Very good vs. Poor/Fair)	13.06*** (7.72, 22.1)	0.472	1.079
Housing quality (Good vs. Poor/Fair)	4.467*** (2.41, 8.29)	0.403	1.246
Housing worry (Not worried vs. Worried)	2.28*** (1.43, 3.63)	0.429	1.233
Loneliness (Not lonely vs. Lonely)	4.42*** (2.72, 7.17)	0.355	1.140
Housing safety (Safe vs. Unsafe)	4.96*** (3.01, 8.16)	0.564	1.213

NOTES: SD = standard deviation. Each row reports a separate model adjusting for survey year, age, gender, race/ethnicity, number of chronic conditions, and site, with a resident-level random intercept. ORs greater than 1 indicate higher odds of reporting good or very good quality of life for the first-named category. Unadjusted estimates were similar in direction and magnitude for all five factors, ranging from 2.60 to 11.94 and all significant at $p < 0.001$. A base model containing survey year only explained almost none of the variation between residents (marginal $R^2 = 0.000$; resident-level SD = 1.470). The analytic sample yields 567 resident-time observations. *** $p < 0.001$.

All five factors were significantly associated with residents' self-rated quality of life:

- **General health** showed by far the strongest association. Residents who rated their health as good or very good had roughly 13 times the odds of reporting good or very good quality of life compared with those describing their health as poor or fair.
- **Housing quality and loneliness** each carried roughly four and half times the odds. Residents who rated their housing good and who scored in the “not lonely” range on the UCLA 3-Item Loneliness Scale all reported substantially better quality of life than their counterparts.
- **Housing worry** showed that those without housing worry had two times the odds of reporting good or very good quality of life compared with those who reported housing worry, the smallest of the five associations but still highly significant.
- **Housing safety** carried roughly five times the odds. Residents who rated their housing as safe or very safe were more likely to report better quality of life relative to those reporting unsafe or very unsafe housing conditions.

Model fit improved substantially with the addition of predictors. A model containing survey year alone explained almost none of the variation between residents, while the fully adjusted models explained between 36 and 56 percent of the marginal variation, with the resident-level standard deviation falling to between 1.079 and 1.246.

Individual-Level Changes Across Annual Surveys

The mixed-effects models above describe which resident-reported factors associate with quality of life, but they do not directly show how many individuals improved or declined in each domain over their enrollment period. To address this, we examined individual-level trajectories from each resident's first available annual survey to their most recent annual survey across all six

quality-of-life and housing domains. For five domains, the first survey is the baseline survey administered around the time of enrollment; for housing quality, where baseline data were unusable, the first survey is the Year 1 survey. For each resident and domain, we classified the trajectory as improved (moving from the lower to the higher category), worsened (moving from the higher to the lower category), or stable (remaining in the same category at both time points).

The analytic sample ranges from 120 to 243 residents across domains, depending on item-level missingness. Across the five baseline-anchored domains, residents' most recent annual survey was Year 1 for about 10 percent, Year 2 for about 15 percent, and Year 3 for about 75 percent. Housing quality follows a different schedule, since its first observation is the Year 1 survey: for that domain, the most recent survey was Year 2 for 13 residents (10.8 percent) and Year 3 for 107 (89.2 percent). Figure 6.1 shows the flows between categories for each domain; Appendix Table C.1 reports the full cross-tabulation, net shifts, and McNemar *p*-values.

Figure 6.1. Individual-Level Trajectories from First to Most Recent Annual Survey



NOTE: Band width is proportional to the number of residents making that transition. Left-hand bars show the distribution at residents' first survey, right-hand bars the distribution at their most recent surveys. For all domains except housing quality, the first survey is the baseline survey conducted around the time of enrollment; because an error in the baseline response options rendered the housing quality item unusable (see Chapter 2), housing quality pairs each resident's Year 1 survey with their most recent one. Appendix Table C.1 gives the underlying counts and statistical test results.

Quality of life and general health showed clear and statistically significant net improvement. Among 243 residents with paired quality-of-life data, 23.9 percent moved from Poor/fair to Good (improved) and 10.3 percent moved from Good to Poor/fair (worsened), yielding a net positive shift of 13.6 percentage points ($\chi^2 = 13.12, p = 0.0004$). Conditional improvement was also high: 49.2 percent of the 118 residents who started at Poor/fair quality of life had shifted to Good by their last survey. Most residents were stable: 41.2 percent held

consistently Good quality of life and 24.7 percent held consistently Poor/fair across both surveys. General health followed a similar pattern—22.7 percent improved, 9.9 percent worsened, and 67.4 percent held steady—for a net shift of 12.8 percentage points ($\chi^2 = 12.16$, $p = 0.0006$), with 44.7 percent of those starting at Poor/fair shifting to Good.

Housing quality also improved on net, although the finding rests on a smaller sample.

Of the 120 residents with paired housing quality data, 17.5 percent improved and 7.5 percent worsened, a net shift of 10.0 percentage points ($\chi^2 = 4.80$, $p = 0.043$). Conditional improvement was the highest of any domain: 56.8 percent of the 37 residents who started at Poor/fair had shifted to Good by their last survey. This estimate rests on 30 residents who changed category, and the p -value sits near the conventional threshold, so it should be read as suggestive rather than as firm evidence of net improvement. Housing quality is also measured over a shorter interval than the other domains, since its first observation is the Year 1 survey rather than baseline.

Housing worry showed bidirectional movement with no significant net change. Of 238 residents with paired housing worry data, 23.5 percent moved from Worried to Not worried and 19.3 percent moved in the opposite direction, for a net shift of 4.2 percentage points that did not reach statistical significance ($p = 0.37$). As the crossing bands in Figure 6.1 show, housing tenure worry did not uniformly decline over the observation period; some residents experienced greater security while others developed new concerns, consistent with the aging and health trajectories of this population.

Housing safety showed no significant net directional change, but this result should not be read as evidence of limited individual improvement. Among the 80 residents reporting unsafe housing at their first survey, 47.5 percent (38) had shifted to Safe by their last—a conditional improvement rate comparable to quality of life (49.2 percent). Net change is near zero only because the safe pool at the first survey was roughly twice the size of the unsafe pool; a lower per-person worsening rate among that larger group offset the gains ($p = 1.00$). Nearly half of residents (49.6 percent) reported safe housing at both surveys—the wide light-blue band in Figure 6.1—limiting the headroom for net upward movement.

Loneliness showed virtually no net directional change. Of 238 residents with paired loneliness data, 16.0 percent moved from Lonely to Not lonely and 15.5 percent moved in the reverse direction, a net difference of less than one percentage point ($p = 1.00$). The largest groups were those consistently Not lonely (41.2 percent) and consistently Lonely (27.3 percent), together accounting for 68.5 percent of the sample. Conditional improvement among those starting Lonely was 36.9 percent—lower than other domains—consistent with the persistence of social isolation among older adults in supportive housing even when other outcomes improve.

Notably, a null McNemar result does not mean residents did not change. It means roughly equal numbers moved in each direction. Staying steady may also mean more in an aging group with health problems than it would in the general population, although the analysis cannot show that.

Service Use and Quality-of-Life Outcomes

The analyses above examined how residents' own perceptions of health, housing, and social connection related to their quality of life. We performed a second set of analyses to address a related question: whether residents' use of program services and their level of social engagement in the months preceding each annual survey related to how they rated their quality of life and loneliness at the time of the survey. We examined four service-related variables: nutritional support (meals per day), time spent with program staff, group participation, and time spent outside the unit. Because these measures come from staff-completed quarterly assessments rather than from the annual resident survey itself, they let us link observed program engagement to residents' self-reported well-being.

We analyzed the Year 1, Year 2, and Year 3 annual surveys separately. For each wave, the analytic sample included residents who had completed at least four quarterly assessments before the annual survey, and we drew the independent variables from the most recent quarterly assessment preceding it. We dichotomized quality of life as Good or Very good versus all other responses, and we measured loneliness with the UCLA 3-Item Loneliness Scale, dichotomizing it as Not lonely (score 3–5) versus Lonely (score 6–9), matching the outcome we used earlier in this chapter. We modeled each service-use variable separately using logistic regression, adjusting for age, gender, race/ethnicity, number of chronic conditions, and site. Chapter 2 gives full variable definitions and the analysis plan.

None of the 24 associations reached conventional levels of statistical significance (Table 6.2). One association was marginally significant: residents who left their unit three or more times per week had higher odds of reporting no loneliness at the Year 2 survey (OR = 2.52, 95% CI: 0.94–7.24, $p = 0.073$). Meal adequacy, time spent with staff, and group participation showed no significant associations with quality of life or loneliness in any year, with p -values of 0.103 or higher. At Year 3, none of the four variables approached significance for either outcome, with ORs between 0.67 and 1.62 and p -values of 0.270 or higher.

Table 6.2. Service Use and Engagement as Predictors of Quality of Life and Loneliness, by Survey Year

Outcome and Service Predictor	Year 1 OR (95% CI) <i>p</i>-value	Year 2 OR (95% CI) <i>p</i>-value	Year 3 OR (95% CI) <i>p</i>-value
Quality of Life (Good/Very Good)			
Meal adequacy (2–3 meals/day)	3.25 (0.55, 22.12) <i>p</i> = .198	3.17 (0.51, 22.78) <i>p</i> = .221	1.62 (0.59, 4.37) <i>p</i> = .338
Time with staff (3+ hours)	0.81 (0.29, 2.23) <i>p</i> = .683	1.11 (0.47, 2.61) <i>p</i> = .807	0.67 (0.32, 1.35) <i>p</i> = .270
Group programs (3+ programs)	2.26 (0.77, 7.09) <i>p</i> = .146	1.30 (0.68, 2.51) <i>p</i> = .434	0.91 (0.51, 1.60) <i>p</i> = .738
Time out of unit (3+ times/week)	4.33 (0.58, 34.80) <i>p</i> = .147	1.28 (0.48, 3.34) <i>p</i> = .611	0.90 (0.49, 1.63) <i>p</i> = .728
Loneliness (Not Lonely)			
Meal adequacy (2–3 meals/day)	1.22 (0.19, 8.40) <i>p</i> = .834	1.58 (0.26, 8.62) <i>p</i> = .599	0.85 (0.31, 2.27) <i>p</i> = .741
Time with staff (3+ hours)	0.64 (0.23, 1.80) <i>p</i> = .401	2.02 (0.88, 4.78) <i>p</i> = .103	1.32 (0.68, 2.58) <i>p</i> = .409
Group programs (3+ programs)	2.42 (0.83, 7.55) <i>p</i> = .114	1.26 (0.67, 2.40) <i>p</i> = .476	1.12 (0.64, 1.95) <i>p</i> = .700
Time out of unit (3+ times/week)	0.44 (0.04, 3.39) <i>p</i> = .450	2.52+ (0.94, 7.24) <i>p</i> = .073	0.93 (0.51, 1.67) <i>p</i> = .801

NOTE: ORs adjusted for age, gender, race/ethnicity, number of chronic conditions, and site. CIs and *p*-values are from the adjusted logistic regression models. * *p* < .05; + *p* < .10. Sample sizes by outcome, predictor, and year. Quality of life: Year 1: meals *n* = 114, staff *n* = 138, group programs *n* = 113, time out of unit *n* = 135; Year 2: meals *n* = 175, staff *n* = 215, group programs *n* = 222, time out of unit *n* = 222; Year 3: meals *n* = 306, staff *n* = 310, group programs *n* = 305, time out of unit *n* = 311. Loneliness: Year 1: meals *n* = 112, staff *n* = 134, group programs *n* = 112, time out of unit *n* = 132; Year 2: meals *n* = 169, staff *n* = 209, group programs *n* = 216, time out of unit *n* = 216; Year 3: meals *n* = 297, staff *n* = 302, group programs *n* = 297, time out of unit *n* = 301. The ORs for three of the four predictors decline across survey years, most likely because the Year 1 estimates rest on much smaller samples with very wide CIs. As samples grew, estimates converged toward 1.0 (an OR of 1.0 indicates no difference between groups)."

Several features of the study design likely contributed to these predominantly null findings. Residents who complete annual surveys represent a relatively stable and engaged subgroup, namely those who stayed in the program and stayed well enough to attend annual site visits. As Chapter 4 documents, many had already made meaningful gains in health status, acute care use, and social engagement by their fourth program quarter, which compresses the remaining variation in quality of life and loneliness that these models can detect. The resident population is

also relatively homogeneous in housing setting, care access, and social support, because all residents live in PSH with ongoing care coordination. Limited variation in both exposures and outcomes reduces statistical power even where real benefits exist.

Summary

Taken together, the results in this chapter show clear and consistent patterns linking residents' own perceptions to their overall quality of life. Across all five domains (general health, housing quality, housing safety, housing worry, and loneliness), each factor significantly predicted veterans' self-rated well-being. Residents who reported poor or fair health, lower housing quality, unsafe housing, housing worry, or loneliness had markedly lower odds of reporting good quality of life than peers with more favorable conditions, and these associations held whether or not we adjusted for demographics, chronic conditions, and site. Because the predictors and the quality-of-life outcome are measured at the same time in each survey wave, the directional relationship remains ambiguous. Veterans who feel their quality of life is good may for that reason report less worry and less loneliness, rather than the reverse. Similarly, residents with fewer unmet needs may simply require less staff contact, rather than staff contact reducing quality of life. Looking at individual residents rather than at associations, self-rated quality of life, general health, and housing quality improved significantly between residents' first and most recent surveys, with net shifts of 13.6, 12.8, and 10.0 percentage points. The remaining three domains—housing worry, housing safety, and loneliness—showed offsetting movement in both directions and no significant net change.

Our final set of analyses, which examined program service use and social engagement (meals, staff contact, group participation, and time outside the unit) as predictors of quality of life and loneliness, found null results across all three survey years. None of the 24 tested associations reached conventional significance; one association was marginally significant (residents who left their unit three or more times per week were more likely to be nonlonely at Year 2, OR = 2.52, $p = .073$). Limited variation among a stable, engaged subgroup of residents who remained in the program and stayed well enough to complete annual surveys likely explains this pattern.

Chapter 7. Program Costs in Context

To contextualize the VSSR program's investment, we compared VSSR's estimated annual costs with those of a set of alternative long-term care settings and community-based service models operating in California. We selected these alternatives to represent the broader landscape of long-term services and supports in the state: residential settings that bundle housing with care (assisted living, nursing homes, and the Veterans Homes of California) and service models delivered to people living in the community (FSPs, adult day health care, and in-home care). These alternatives differ from VSSR, and from one another, in eligibility, target population, service intensity, and availability; most are not veteran-specific, and none serves a population identical to VSSR's. The comparison is therefore intended to situate VSSR's per-veteran investment within this landscape, not to identify direct substitutes.

We present two comparisons: (1) VSSR's combined cost (services, case management, and housing voucher) against residential settings and (2) VSSR's services cost alone against service-only models. We then discuss availability, because an alternative that is unaffordable, geographically absent, or rationed through waitlists is not a realistic option for many of the people VSSR serves.

As the methodology chapter notes, these cost comparisons come with important caveats. Figures are drawn from different pricing bases, including market rates, net public costs, contract rates, grant expenditures, and published research estimates, and some are locality-specific illustrations rather than statewide figures. Except for dollar figures from FY 2025–2026, all figures are converted to May 2026 dollars via CPI-U. However, because the cost figures measure different things, comparisons should be read as indicative of relative magnitude, not precise equivalents. The settings also differ in what they provide: Skilled nursing offers 24/7 licensed care that VSSR does not, while VSSR offers veteran-specific supports that market settings lack. The question is not whether VSSR replicates these settings, but what alternatives would cost, and whether they'd even be accessible, if VSSR participants needed that care instead. As we explain in Chapter 2, the VSSR figures combine actual grant expenditures with modeled voucher and case management estimates, and so are not purely expenditure-based.

As further detailed below, VSSR's estimated cost per veteran falls below every residential alternative for which current California figures were available, and its services-only cost sits within the range of comparable publicly funded service models. Availability differs as well: Most alternatives are rationed by price, waitlist, geography, or eligibility. The underlying figures rest on different pricing bases and indicate relative magnitude rather than precise equivalence.

Annual VSSR Cost Per Veteran

VSSR Services

Table 7.1 presents total program expenditures, veteran-quarters of participation, and estimated annual cost per veteran by site through May 2026. Across all six sites, total expenditures through May 2026 were approximately \$18.6 million in May 2026 dollars, with 4,262 veteran-quarters of participation and an overall annual cost per veteran of \$17,437. Annual cost per veteran varied across sites as detailed in Table 7.1.

Table 7.1. Total Program Expenditures, Veteran-Quarters Served, and Annual Cost per Veteran, by Site, Through May 2026

Site	Total Expenditures (May 2026 \$)	Veteran-Quarters	Annual Cost per Veteran (May 2026 \$)
Nation's Finest–Mather	\$2,981,259	904	\$13,191
Nation's Finest–Sonoma	\$2,110,712	390	\$21,648
PATH	\$2,282,318	471	\$19,383
Swords to Plowshares	\$4,084,017	1,265	\$12,914
U.S.VETS–Inland Empire	\$3,471,642	604	\$22,991
U.S.VETS–Los Angeles	\$3,649,484	628	\$23,245
Total/overall	\$18,579,432	4,262	\$17,437

HUD-VASH and CoC Vouchers

As shown in Table 3.1, more than half of VSSR participants (53 percent, $n = 296$ of 560) used either a HUD-VASH or CoC voucher to secure permanent housing. Given this, we use HUD-VASH and CoC payment standards as a proxy for estimating housing subsidy costs across the VSSR population. Voucher payment standards offer a standardized, publicly available benchmark for the maximum housing subsidy amount by county and unit size, allowing for a consistent cost estimate even where individual rent and subsidy data were not available for all participants. The HUD-VASH voucher pairs Housing Choice Voucher rental assistance with “case management and clinical services” provided by the VA, which delivers these services to participating veterans at VA Medical Centers and community-based outpatient clinics.³⁹

Both voucher types are federally funded through HUD: HUD-VASH vouchers are administered locally by public housing authorities (PHAs),⁴⁰ while CoC rental assistance is provided through HUD grant funds administered by local CoC grant recipients.⁴¹ Under HUD-

³⁹ U.S. Department of Housing and Urban Development, *HUD-VASH HMIS Manual: A Guide for HMIS End Users and HMIS Leads/System Administrators*, October 2025.

⁴⁰ Congressional Research Service, *The Section 8 Housing Choice Voucher Program*, IF12546, December 11, 2023.

⁴¹ 24 CFR § 578.51(a)(1).

VASH, voucher holders “contribute between 30–40 percent of their monthly income towards rent and the subsidy covers the rest.”⁴² Under CoC-funded rental assistance, participants pay the highest of three amounts: “30% of the household’s Monthly Adjusted Income,” “10% of the household’s Monthly Gross Income,” or welfare assistance specifically designated for housing costs.⁴³

HUD-VASH PHAs may set a local payment standard of up to 120 percent of the applicable Fair Market Rent (FMR), and may approve an Exception Payment Standard (used as a reasonable accommodation) of up to 140 percent of FMR.⁴⁴ CoC-funded leasing assistance is capped more strictly: Per 24 CFR § 578.49(b)(2), “the amount you pay with CoC Leasing Funds cannot exceed FMR.”⁴⁵ Table 7.2 presents FY 2026 FMRs and corresponding maximum annual subsidy amounts under each payment standard, for both studio/efficiency and one-bedroom units, for the six counties where VSSR sites are located.

⁴² U.S. Department of Housing and Urban Development, “HUD-VASH Landlord FAQ,” undated.

⁴³ U.S. Department of Housing and Urban Development, “CoC Rent Calculation: Charging Rent,” webpage, undated.

⁴⁴ U.S. Department of Housing and Urban Development, “HUD-VASH Operating Requirements 2024 Update,” briefing slides, August 21, 2024, slide 13, “Administrative Flexibilities.” The slide states: “In addition to setting a HUD-VASH payment standard up to 120%, allowing PHAs to approve Exception Payment Standards as reasonable Accommodations up to 140%.”

⁴⁵ U.S. Department of Housing and Urban Development, “Fair Market Rent FMR?” webpage, undated.

Table 7.2. Maximum Voucher Subsidy by County, Unit Size, Voucher Type, and Payment Standard (FY 2026)

County (VSSR Site)	Studio FMR	1-BR FMR	CoC Max (100% FMR), Annual— Studio	CoC Max (100% FMR), Annual— 1-BR	HUD- VASH Standard (120% FMR), Annual— Studio	HUD- VASH Standard (120% FMR), Annual— 1-BR	HUD- VASH Exception (140% FMR), Annual— Studio	HUD- VASH Exception (140% FMR), Annual— 1-BR
Los Angeles (U.S.VETS)	\$2,079	\$2,328	\$24,948	\$27,936	\$29,938	\$33,523	\$34,927	\$39,110
San Diego (PATH)	\$2,288	\$2,459	\$27,456	\$29,508	\$32,947	\$35,410	\$38,438	\$41,311
Sacramento (Nation's Finest – Mather)	\$1,748	\$1,832	\$20,976	\$21,984	\$25,171	\$26,381	\$29,366	\$30,778
San Francisco (Swords to Plowshares)	\$2,485	\$2,977	\$29,820	\$35,724	\$35,784	\$42,869	\$41,748	\$50,014
Sonoma (Nation's Finest – Sonoma)	\$1,949	\$2,155	\$23,388	\$25,860	\$28,066	\$31,032	\$32,743	\$36,204
Riverside (U.S.VETS)	\$1,692	\$1,777	\$20,304	\$21,324	\$24,365	\$25,589	\$28,426	\$29,854

SOURCE: FMR figures are from HUD, “FY2026 Final Fair Market Rents Documentation System,” webpage, undated.
NOTE: CoC maximum reflects the statutory cap of 100 percent of FMR (24 CFR § 578.49(b)(2)). HUD-VASH Standard and Exception amounts reflect the 120 percent and 140 percent FMR payment standard caps, respectively (HUD, “HUD-VASH Operating Requirements Update,” slide 13). BR = bedroom.

Because HUD-VASH voucher holders accounted for 71 percent ($n = 210$) of the 296 participants using either voucher type (Table 3.1), and because most VSSR participants have minimal or no earned income, we weight the housing cost estimate toward the HUD-VASH standard payment amount (120 percent of FMR) as the primary benchmark, while treating the CoC cap (100 percent of FMR) as a lower-bound estimate. Across the six VSSR counties, maximum annual housing subsidies under these voucher programs range from \$20,304 (Riverside, CoC standard, studio unit) to \$50,014 (San Francisco, HUD-VASH Exception standard, one-bedroom unit). These figures represent the maximum public subsidy amount; the actual subsidy paid on behalf of any individual veteran depends on the rent of their specific unit, unit size, and their share of the rent.

Case Management Services for Participants with HUD-VASH and CoC Vouchers

Under CoC voucher-based PSH, providers “must provide supportive services for the residents to enable them to live as independently as is practicable throughout the duration of their residence in the project,” with case management encompassing “assessing, arranging,

coordinating, and monitoring the delivery of individualized services” to meet participant needs.⁴⁶ Using the VA’s mandated caseload ratio of one case manager per 25 veterans⁴⁷ and a loaded GS-11/12 annual salary of \$120,000–\$140,000⁴⁸—reflecting 2025 base pay of \$63,163–\$98,422,⁴⁹ adjusted for the Los Angeles locality pay rate of 36.47 percent⁵⁰ and a standard federal benefits load—the implied per-veteran annual cost of case management is approximately \$5,100 to \$5,900 in May 2026 dollars (base figures divided by 25, converted from January 2025 dollars using CPI-U ratio 335.1/317.7). Current LA County contracted billing rates for PSH case management provide a point of comparison: the LA County Housing for Homeless Solutions (HSH) billing rate sheet sets low-intensity case management (1:40 caseload) at \$258.75 per month and high-intensity case management (1:20 caseload) at \$517.50 per month,⁵¹ yielding annual rates of approximately \$3,300 and \$6,600 in May 2026 dollars respectively (converted from FY 2024–2025 using CPI-U ratio 335.1/315.7). The VA-derived range of \$5,100–\$5,900 falls within this local benchmark range. For context, the California Department of Housing and Community Development’s maximum allowable supportive services cost of \$10,000 per unit per year for PSH serving persons experiencing homelessness, effective January 2025 (approximately \$10,500 in May 2026 dollars),⁵² represents a policy ceiling for fully loaded supportive services rather than a case management benchmark alone, and exceeds the case management estimates above by roughly 60 to 200 percent.

We carry the VA-derived range of \$5,100 to \$5,900 forward as the primary case management benchmark in the comparisons that follow, weighting toward it for the same reason we weight toward the HUD-VASH payment standard: HUD-VASH holders account for 71 percent of participants using either voucher type. As with the housing subsidy estimate, we apply this figure as a proxy across the VSSR population, although case management as costed here attaches to the 53 percent of participants who secured housing through a HUD-VASH or CoC voucher. These

⁴⁶ 24 C.F.R. § 578.53 (2024).

⁴⁷ U.S. Department of Housing and Urban Development, “Section 8 Housing Choice Vouchers: Revised Implementation of the HUD-Veterans Affairs Supportive Housing Program,” Docket No. FR-6476-N-01, August 7, 2024.

⁴⁸ U.S. Department of Labor, Bureau of Labor Statistics, “News Release: Employer Costs for Employee Compensation—March 2026,” news release, USDL-26-0827, June 12, 2026.

⁴⁹ U.S. Office of Personnel Management, “Salary Table 2025-GS,” effective January 2025. GS-11 Step 1 base: \$63,163; GS-12 Step 10 base: \$98,422.

⁵⁰ U.S. Office of Personnel Management, “Salary Table 2025-LAA: Los Angeles–Long Beach,” effective January 2025 (locality adjustment: 36.47%); see also FederalPay, “General Schedule (GS) Locality Pay Map,” webpage, undated, for a summary of all 2025 locality rates.

⁵¹ Los Angeles County Housing for Homeless Solutions, “ICMS Billing Rate Designations and Multifactorial Analysis Tip Sheet,” updated May 4, 2026..

⁵² California Department of Housing and Community Development, Administrative Notice No. 24-05, “Supportive Services Costs Limits,” October 7, 2024.

services are distinct from, and additional to, the enhanced supportive services delivered by VSSR grantees and costed in Table 7.1; the two are not double-counted.

Residential Alternatives: Housing and Services Combined

Table 7.3 compares VSSR's estimated total annual cost per veteran to residential settings that bundle housing and care. We calculated the VSSR total by adding the overall annual services cost from Table 7.1 (\$17,437) and the estimated annual case management cost (\$5,100 to \$5,900) to the annual maximum voucher amounts from Table 7.2. Under the primary HUD-VASH standard benchmark (120 percent of FMR), totals range from \$46,902 (\$22,537 plus \$24,365, a Riverside County studio, the lowest such amount) to \$66,206 (\$23,337 plus \$42,869, a San Francisco one-bedroom, the highest). Using the CoC cap (100 percent of FMR) as a lower bound yields a minimum of \$42,841 (\$22,537 plus \$20,304, a Riverside studio). We round this range to approximately \$42,800 to \$66,200. Because voucher amounts are payment-standard maximums and veterans contribute a share of income toward rent, the true public housing cost is likely somewhat lower.

Table 7.3. Annual Per Client Cost Comparison: VSSR and Residential Alternative Care Settings (May 2026 Dollars)

Program/Setting	Estimated Annual Cost	What Is Included	Funding Source(s)/Payor
VSSR (PSH voucher + case management + enhanced services)	~\$42,800 to \$66,200 ^a	Enhanced supportive services as described in Chapters 1 and 3, plus voucher, and case management	CalVet VSSR grant (enhanced services); VA (case management for HUD-VASH participants) or CoC grantees (supportive services for CoC participants); HUD voucher via PHAs or CoC grantees (housing) for 50%+ of participants (see Table 3.1)
Assisted living (Residential Care Facility), California median ^b	\$85,471	Private one-bedroom unit; care ranging from basic to more substantial (not itemized in the survey)	Private pay; those ineligible for Medicaid and without long-term care insurance pay directly ³
Nursing home, semi-private room, California median ^b	\$150,640	Semi-private room; three meals a day, laundry, sundries, basic nurse supervision, generic nonprescription pharmaceuticals	Private pay rates shown; Medicaid and Medicare cover eligible individuals ^c
Nursing home, private room, California median ^b	\$187,924	Private room; same bundled services as semi-private	Private pay rates shown; Medicaid and Medicare cover eligible individuals ^c
Veterans Home of California, Domiciliary ^d	\$113,628 to \$239,458	Housing, meals, activities, minimal supervision for self-sufficient residents; onsite clinic	Resident fee of 47.5% of income; remainder from CA General Fund, offset by federal VA per diem, Medi-Cal, and Medicare
Veterans Home of California, RCFE ^d	\$160,528 to \$340,122 (net state cost, by campus)	Assistance with bathing, grooming, medications, and other daily activities; memory care available	Resident fee of 55% of income; remainder as above
Veterans Home of California, Intermediate Care Facility ^d	\$358,424 to \$617,710 (net state cost, by campus)	Daily nursing care, medication assistance, personal hygiene, and meal-time support under licensed nursing supervision	Resident fee of 65% of income; remainder as above
Veterans Home of California, Skilled Nursing Facility level ^d	\$175,018 to \$434,303 (net state cost, by campus)	Continuous skilled nursing and rehabilitation with around-the-clock professional nursing plus physician, dietary, pharmaceutical, and therapeutic services; memory care available	Resident fee of 70% of income; remainder as above

^a VSSR enhanced services: \$17,437 overall (see Table 7.1) + case management of \$5,100 to \$5,900 + housing voucher ranging from \$20,304 to \$42,869 (see Table 7.2). Low endpoint pairs the CoC housing floor with the low case management estimate; high endpoint pairs the highest HUD-VASH standard amount with the high case management estimate.

^b CareScout, 2025a; CareScout, *Cost of Care Survey 2025: Methodology*, March 2, 2026b.

^c Congressional Research Service, 2025

^d CalVet, "Veterans Home of California: Summary—Post Revenue—FY 24–2025, Level of Care Cost (LOCC) Per AB-1365," July 30, 2025c; CalVet, *Budget Estimate Package Budget Year 2025–26*, January 10, 2025a; CalVet, "Welcome to the Veterans Homes of California," web page, undated-b; CalVet, "How Much Will It Cost Me to Become a Resident?" website, undated-a. RCFE = Residential Care Facility for the Elderly.

VSSR’s combined cost compares favorably even under conservative assumptions. The upper-bound total of \$66,206 is 23 percent below the private assisted living median ($(\$85,471 - \$66,206)/\$85,471 = 22.5$ percent), equals 44 percent of the semi-private nursing home rate ($\$66,206/\$150,640$), and falls below the lowest-cost Veterans Home Domiciliary campus (\$113,628). At more typical values, VSSR’s services cost plus the studio-rate HUD-VASH amounts (\$24,365 to \$35,784 across counties) yields totals of \$46,902 to \$59,121, which is 31 to 45 percent below assisted living and 31 to 39 percent of semi-private nursing home cost (each endpoint divided by \$150,640), or roughly one-third. To the extent that VSSR delays or prevents transitions to residential care among even a fraction of participants, the avoided costs are large relative to the program’s investment; as noted in the “Limitations” section of Chapter 2, however, this design does not support causal estimates of transitions prevented, so these comparisons describe relative costs rather than net savings.

It is important to note that, for many VSSR participants, these alternatives are not realistically accessible, so cost comparisons alone understate the distinction. The assisted living and nursing home figures are private-pay rates, and most VSSR participants have minimal or no income; an \$85,000-per-year assisted living unit is out of reach for a veteran whose housing depends on an income-based subsidy.⁵³ Publicly financed pathways are rationed: Medi-Cal generally does not pay for assisted living outside its Assisted Living Waiver, which operates in only 15 of California’s 58 counties with capped enrollment, and as of December 2025 approximately 18,365 people were waitlisted, more than were enrolled, with waits of months to years and priority given to nursing facility transitions and Adult Protective Services referrals.⁵⁴ The Veterans Homes admit residents regardless of income but operate only eight campuses statewide with waitlists that vary by home, and no campus is located in San Francisco, Sonoma, Sacramento, or Riverside counties, where four of the six VSSR sites operate.⁵⁵ VSSR’s contribution is thus not only lower cost, but the delivery of aging-in-place support, with veteran-specific staffing such as peer specialists with lived military experience, where residential alternatives are effectively unavailable.

Service-Only Alternatives

Table 7.4 compares VSSR’s services cost alone to service models delivered to people housed in the community, which range from publicly funded programs of broadly similar intensity to market-purchased in-home care.

⁵³ Congressional Research Service, 2025.

⁵⁴ California Department of Health Care Services, “Assisted Living Waiver,” webpage, undated-a; Justice in Aging, “Assisted Living Waiver,” fact sheet, 2026; American Council on Aging, “Medi-Cal (California Medicaid) Assisted Living Waiver: Benefits, Eligibility, and How to Apply,” webpage, last updated April 21, 2026.

⁵⁵ California Department of Veterans Affairs, undated-b.

Older adult FSPs, intensive team-based specialty mental health programs, are a close publicly funded analogue to VSSR’s multidisciplinary model. During the period covered by these cost examples, adult and older adult FSP enrollment under California’s Mental Health Services Act of 2004 required a serious mental disorder as defined in California Welfare and Institutions Code Section 5600.3(b), and under the state’s Behavioral Health Services Act (BHSA; effective July 1, 2026) enrollment remains limited to eligible adults and older adults with serious mental illness and, as newly added, substance use disorders.⁵⁶ FSPs were designed to provide a “whatever it takes” approach to help people achieve their goals, including mental health and non-mental health care. Non-mental health care could include employment, education, and integrated treatment for mental illness and substance use disorders. Housing could be provided under some circumstances; however, housing support is provided under a different funding allocation. Under the newly enacted BHSA, FSP is a tiered category rather than a single service intensity: Counties must offer Assertive Community Treatment (ACT) as the highest-intensity tier, with Intensive Case Management available as a step-down or for individuals whose acuity does not meet ACT criteria. ACT is a manualized, field-based team model requiring a multidisciplinary team of at least ten full-time equivalents serving 80 to 110 individuals—roughly a 1:10 ratio—with crisis coverage 24 hours a day, seven days a week. Eligibility requires an established serious mental illness diagnosis, and California Department of Health Care Services guidance specifies that ACT is not appropriate for individuals diagnosed solely with a substance use disorder, a personality disorder, or an intellectual or developmental disability.⁵⁷ VSSR participants, whose needs stem from aging, physical illness, and functional decline rather than a qualifying behavioral health diagnosis, would not meet these criteria.

At the higher end of the services spectrum, replicating VSSR’s in-home support privately with a nonmedical aide at the survey’s 44-hours-per-week assumption would cost \$94,429 per year, roughly four times VSSR’s overall services and case management cost ($\$94,429/\$22,537 = 4.2$), albeit for one-on-one care far more intensive than VSSR’s shared staffing model.

⁵⁶ California Welfare and Institutions Code Section 5600.3(b); California Welfare and Institutions Code, Section 5887; California Welfare and Institutions Code, Section 5892(d); California Department of Health Care Services, *Behavioral Health Services Act County Policy Manual*, webpage, undated-b, Chapter 7; Los Angeles County Department of Mental Health, “Older Adult Full Service Partnership,” webpage, undated-b.

⁵⁷ California Department of Health Care Services, *Full Service Partnership Adult Levels of Care Comparison Chart*, undated-c, Tables 1–3; California Department of Health Care Services, undated-b, Chapter 7, Section B.

Table 7.4. Annual Per Client Cost Comparison: VSSR Services and Service-Only Alternatives (May 2026 dollars)

Program/Service	Estimated Annual Cost	What Is Included	Funding Source(s)/Payor
VSSR case management + enhanced supportive services ^a	\$22,500 to \$23,300 overall (\$18,000 to \$29,100 across sites)	Enhanced supportive services as described in Chapters 1 and 3, plus voucher-linked case management	CalVet VSSR pilot grant (state funds, enhanced services); VA or CoC grantees (case management); no participant fee
FSP, older adults, Tri-City, California, ^b and Orange County, California ^c	Tri-City FSP: ~\$18,757 Orange County FSP: \$25,770 per client	Intensive team-based specialty mental health services for adults 60+ with serious mental illness; 24/7 availability in homes and community settings; intensive case management and medical care coordination; not veteran-specific	Federal and state funding sources ^e
ACT, research benchmark ^d	~\$16,000 to \$17,100 per patient (lower-bound estimate)	Highest-intensity FSP tier under BHSA: multidisciplinary field-based team at ~1:10 client-to-staff ratio, 24/7 crisis coverage, daily team meetings, integrated psychiatric, nursing, SUD, employment, and peer services; time-unlimited	BHSA FSP allocation (35% county set-aside) and Medi-Cal specialty mental health services; no participant fee
Adult day health care, California median ^f	\$25,217 (daily rate, 5 days/week)	Structured health, social, and support services in a protective daytime setting for functionally or cognitively impaired adults; requires travel to the site	Private-pay or community-subsidy rates shown; Medicaid covers eligible individuals ^f
Home care: nonmedical caregiver, California median ^f	\$94,429 (44 hours/week)	In-home aide assistance with ADLs (bathing, dressing, transferring, toileting) and homemaker services (light cleaning, meal preparation)	Private pay rates shown; Medicaid home- and community-based services and some Medicare home health for eligible individuals ^g
Home care: private duty nurse, California median ^f	\$5,902 (1 hour/week) (reference point for licensed nursing time, not a comprehensive alternative)	Licensed (licensed practical nurse/registered nurse) in-home nursing: wound care, injections, IV therapy, catheters, medication management, family training	Private pay rates shown; Medicaid and Medicare cover some home health for eligible individuals ^g

NOTES

^a RAND analysis of grantee expenditure data (Table 7.1), plus estimated case management cost of \$5,100 to \$5,900 per veteran annually. Site range reflects the lowest and highest site-level expenditures from Table 7.1 combined with the low and high case management estimates, respectively.

^b Tri-City Mental Health Authority (Pomona, Claremont, and La Verne), *Mental Health Services Act (MHSA) Annual Update FY 2024–25*, 2024 (\$16,745 in FY 2022–23, or \$18,757 converted to May 2026 dollars).

^c Orange County Board of Supervisors, Agenda Staff Report 24-000538, May 6, 2025 (\$5,540,583 contract maximum/215 average daily clients = \$25,770 in FY 2025–26).

^d Runnels Dolber and Pronovost, “Assertive Community Treatment for Complex and Costly Patients,” *American Journal of Managed Care*, Vol. 31, No. 7, July 2025, reports ACT program costs of roughly \$15,000 to \$16,000 per patient per year in 2024 dollars, based on cost-effectiveness analyses conducted in New Hampshire and Baltimore. Converted to May 2026 dollars using CPI-U ratio 335.1/313.689 (2024 annual average), yielding \$16,025 to \$17,093, rounded to \$16,000–\$17,100. This range should be treated as a lower bound for California: The underlying trials were conducted in the mid-1990s and inflation-adjusted twice, and the source figures are not California-specific.

^e FSPs are publicly funded; clients are not the primary payer. During the periods covered by these examples, funding flowed through California's Mental Health Services Act (Proposition 63) and Medi-Cal, with Medi-Cal federal financial participation covering the majority of costs in at least some county contracts (85 percent in Orange County's FY 2025–26 contract). Effective July 1, 2026, the Behavioral Health Services Act (Proposition 1), which amended and renamed the Mental Health Services Act, requires counties to dedicate 35 percent of their BHSA allocations specifically to FSPs (California Welfare and Institutions Code, Section 5892(a)(2); California Department of Health Care Services, undated-b, Chapter 6; California Department of Health Care Services, "MHSA vs. BHSA Funding," undated-d; California Revenue and Tax Code, Section 17043; Orange County Board of Supervisors, 2025.

^f CareScout, 2025a; CareScout, 2025b.

^g Congressional Research Service, 2025.

Three observations follow. First, VSSR's services and case management cost falls between the two older adult FSP examples, its closest publicly funded analogue, as illustrated by the Tri-City and Orange County figures, while serving veterans whose needs may leave many ineligible for FSP itself. Second, VSSR's shared, on-site staffing model delivers hands-on support at a small fraction of the cost of purchasing equivalent hours privately: Its overall services cost equals about one quarter of the California median for a 44-hour-per-week nonmedical aide (\$22,537/\$94,429 = 0.24). Third, the private-market alternative is constrained by supply and price: National projected direct care workforce shortfalls range from roughly 600,000 to more than 3 million workers,⁵⁸ with demand for aides projected to grow more than 40 percent from 2020 to 2035,⁵⁹ a constraint grantee VSSR leadership echoed (Chapter 8). VSSR pooled staffing across residents of a site uses this scarce workforce more efficiently than individually purchased home care.

Conclusion

Taken together, these comparisons indicate that VSSR occupies a distinct and difficult-to-replace position in the continuum of care. On cost, VSSR's combined services, case management, and voucher investment of roughly \$42,800 to \$66,200 per veteran per year falls below every residential alternative with recent California figures: approximately 23 to 50 percent below the private assisted living median (the difference between \$85,471 and each endpoint of the VSSR range, divided by \$85,471), roughly one-quarter to just under one-half the cost of semi-private nursing facility care, and below the net state cost of even the most independent Veterans Home level. Its services-and-case-management cost of roughly \$22,500 to \$23,300 falls between the two older adult FSP examples, sits modestly above the lower-bound ACT benchmark, and remains a small fraction of equivalent privately purchased in-home care. On comparability, no identified alternative combines VSSR's elements: residential settings provide more intensive clinical care but require veterans to leave their homes, contrary to the aging-in-place preferences and institutionalization-prevention goals documented in this report, and no

⁵⁸ Public Policy Institute of California, *California's Care Workforce*, 2025.

⁵⁹ Commonwealth Fund, "Addressing the Shortage of Direct Care Workers: Insights from Seven States," issue brief, March 2024.

alternative offers the veteran-specific peer support and benefit navigation grantees identified as central to the program's value. On availability, the alternatives are rationed in ways VSSR is not: Private-pay rates exceed participants' means, the Assisted Living Waiver covers a minority of counties with a waitlist exceeding its enrollment, the eight Veterans Homes maintain waitlists and are absent from four of the six VSSR counties, and the direct care workforce is in structural shortage.

Chapter 8. Leadership Interviews

This section discusses findings from interviews conducted with leadership at each of the four grantee organizations in spring 2026. We organized the findings thematically by the following: pilot program planning, perspectives and experiences with program implementation, and sustainability efforts. Table 8.1 provides illustrative quotes from the interviews. As further detailed below, leaders across all four grantee organizations described the pilot as filling a real gap, converged on which roles mattered most, and identified the end of pilot funding as the central threat to continuing them.

Pilot Program Planning

Rationale for Applying for the Grant

All organizations applied for the VSSR grant in response to a clear, growing need among aging and/or high-acuity veterans in PSH. Each described a gap in existing services for this population, particularly around health, daily living support, and social isolation. Organizations saw the pilot as an opportunity to bring in new resources and staffing to address these gaps, and to help veterans remain housed and independent for longer.

Staffing Roles Funded

All organizations used the grant to add or enhance roles, such as peer support specialists, service assistants, and transportation specialists. Organizations had varying interpretations of the original grant guidance on staffing ratios and required positions. Several organizations initially misunderstood which roles were mandatory and the appropriate number of staff needed, leading to staffing adjustments. Most organizations adapted the staffing model to fit their existing teams and residents' needs, with some formally amending their original grant proposals to reflect these refinements.

Need for the Pilot

All organizations described a strong need for the pilot, citing both internal data and anecdotal evidence of veterans struggling to age in place. There was a sense of urgency and a recognition that existing service models were insufficient for the need of older and/or more medically complex veterans.

Organizations provided specific demographic context for the need. One organization noted that most veterans they serve are Vietnam-era cohort members now in their 70s, and their community has almost no affordable boarding care or long-term care options, making the

organization a default long-term care provider without adequate resources. Organizations also noted that veterans often have no family or their families are no longer living, so staff become their family. Multiple organizations reported that veterans passed away during the pilot and emphasized the importance of enabling veterans to age and pass away with dignity in safe, stable housing rather than in institutional settings or on the streets.

Pilot Program Perceptions and Experiences

Alignment (or Fit) to Veterans Served

All organizations felt the pilot was a strong fit for their veteran population, especially those with complex health and social needs. Organizations viewed the program as providing a higher level of support and engagement than previous models that ultimately led to better outcomes for the veterans.

Relative Advantage over Previous Efforts

Organizations described the addition of peer support, service assistants, and transportation as a major improvement over previous staffing models. Before the pilot, mental health specialists and case managers were often responsible for all veteran needs, what one leader described as “one-stop shopping,” which contributed to significant staff burnout. The pilot’s team approach spread the workload more effectively.

Service assistants addressed critical habitability issues, helping veterans maintain clean units, take out trash, and manage clutter and hoarding behaviors. They also supplemented county in-home support services, which were often inconsistently delivered or provided insufficient hours. Peer support specialists, many of whom were veterans themselves, built trust and rapport more quickly. Peers provided practical assistance, such as teaching veterans to use technology, cook, do laundry, and navigate community resources independently.

Transportation specialists, equipped with wheelchair-accessible vehicles, eliminated previous challenges with commercial ride services that frequently rejected veterans, enabling consistent attendance at medical appointments and community activities.

These roles enabled more community-building activities, including group outings, on-site meals, and social gatherings that drew veterans out of their units. Organizations observed improved health outcomes from consistent medical care, reduced social isolation, and better housing retention, with some veterans avoiding lease violations they might otherwise have received for habitability issues.

Staffing and Nonstaffing Resources Provided

All sites used grant funds for both staffing and nonstaffing resources, such as meals, outings, medical equipment, and transportation vans. Organizations viewed these resources as critical for engagement, socialization, and meeting veterans' daily needs.

Organizations established important health care partnerships to supplement services. These included partnerships with providers offering dental care, pharmacy services, home health, hospice care, and comprehensive health access programs. Several organizations noted the value of bringing services to veterans in their homes rather than requiring them to travel to appointments. One organization reported purchasing occupational therapy equipment and medical supplies including walkers, which veterans greatly appreciated. Organizations also used creative transportation solutions when their transportation specialists were unavailable, partnering with such services as Uber Health to ensure that veterans could reach medical appointments.

Program Improvement Suggestions

All organizations recommended clearer guidance and flexibility in staffing requirements for future pilots. For example, some noted that the staff-to-client ratios were challenging to meet. Several suggested more support for data collection and documentation, as well as changes to required clinical roles. For example, while the grant specified the option to support an occupational therapist, staff told us that the responsibilities associated with that position were more in line with a physical therapist. Some recommended additional resources for grief, end-of-life support, and addressing complex medical needs.

Program Outcomes

All organizations reported positive outcomes, including improved veteran health, increased engagement, reduced isolation, and better housing retention. Organizations especially valued peer support and service assistant roles for their impact on community-building and daily living support.

Pilot Program Sustainability

Organizational Support for Continuation

All organizations expressed strong support for continuing some or all VSSR activities, especially peer support and service assistant roles. However, all noted that continuation is contingent on securing new funding.⁶⁰

⁶⁰ After the interviews were conducted, the state approved a one-year extension to the VSSR pilot.

Strategic Planning for Sustainability

Most organizations are actively seeking alternative funding sources, including grants, Medicaid/CalAIM, local fundraising, and partnerships. Two of the grantees have developed or are developing sustainability plans but acknowledge that full continuation is unlikely without new funding. One grantee indicated that they are not prioritizing VSSR sustainability because they are facing broader organizational funding challenges.

Funding for Sustainment and Cost Barriers

The end of the pilot funding is the primary barrier to sustainability for all organizations. Some noted that Medicaid/CalAIM (i.e., California Advancing and Innovating Medi-Cal⁶¹) or similar programs could help, but administrative and eligibility barriers exist. Some organizations are exploring creative solutions, such as integrating VSSR roles into other grants or seeking donations for specific activities.

Policy Facilitators and Barriers

Most organizations did not identify strong policy facilitators for sustainability, although some are exploring Medicaid/CalAIM as a potential avenue. Sites expressed concern about potential federal policy changes (e.g., Medicaid cuts, HUD/VA changes) that could threaten sustainability.

Strategies to Overcome Barriers

Organizations are pursuing a mix of grant applications, partnerships, and advocacy to sustain key roles and activities. There is a focus on prioritizing the most impactful roles (peer support, service assistant) if only partial funding can be secured.

Marketing and Dissemination

All organizations have shared information about the pilot with stakeholders, funders, or the public through social media, presentations, or reports. Two grantees have been more active in policy advocacy and dissemination, while the other two grantees have focused more on sharing success stories. One organization's leadership planned to present on VSSR at a congressional roundtable focused on policies to reduce veteran homelessness. They also discussed the pilot with their local Department of Public Health to explore how the model might be adapted for PSH serving nonveteran populations. Another organization shared information with national aging-focused conferences and working groups. Organizations highlighted specific veteran success stories through Instagram posts featuring participant spotlights, social media campaigns, and

⁶¹ CalAIM is a series of initiatives and reforms by the California Department of Health Care Services to California's state Medicaid program (i.e., Medi-Cal) to create a more coordinated, person-centered, and equitable health system (see CalAIM, homepage, undated).

discussions at community outreach events. Organizations also distributed pilot reports to community stakeholders.

Staffing Shortages and Workforce Challenges

Organizations expressed that broader challenges with staffing supportive housing programs that serve aging and formerly homeless populations were difficult and reflective of the national labor market rather than the VSSR program specifically. When facing staffing difficulties, organizations appreciated being able to consult with both CalVet and the technical assistance provider (Swords to Plowshares) to strategize solutions and learn what other grantees were experiencing.

Summary and Conclusions from the Leader Interviews

Organizations widely viewed the VSSR pilot as a valuable and much-needed enhancement to services for aging and high-acuity veterans in PSH. The most consistent finding was the critical importance of peer support and service assistant roles, which all organizations hope to sustain. However, all face significant funding barriers, and sustainability is uncertain without new resources. Organizations recommended clearer staffing guidance, more flexibility, and more support for data collection in future pilots, and are actively seeking ways to continue the most impactful aspects of the program.

Table 8.1. Illustrative Quotes from the Leadership Staff Interviews

Theme	Subtheme	Illustrative Quotes
Pilot planning	Rationale for applying for the grant	“VSSR was critical to being able to bring in that additional resource and services needed to keep folks in the least restrictive housing as long as possible. Because ultimately, there are some folks who will need . . . hospice or skilled nursing care. But . . . a number of folks, we just try to keep them in their community as long as we can. So that was the reason that we applied.” (Site 3) “We have a veteran-only . . . a veteran-specific supportive housing program, and the intent of the program to keep veterans in home longer when we know just in supportive housing in general that quite often the kind of the next after supportive housing, like the next place, if someone’s having trouble living independently in supportive housing, like there’s not a lot of places, there’s not many places for someone to go except like nursing care, right? . . . We felt that that really could allow folks to remain in their housing longer and independent, more independently. And so we thought that would be amazing, and that ultimately is why we decided to apply for this program.” (Site 2)
	Staffing/roles to fund	“To create community . . . so that’s the biggest need and also just the ongoing, just maintaining clients appointments. . . . Because you have a nurse on site, we have a mobile medical unit that comes every other month. And we also have a physical therapist on site as well. I mean, the clients are, they don’t always use the services, but it definitely helps to have a nurse on site as she’s able to . . . just help with coordinating care and just making sure that she has more access to information available because she is the nurse and it’s just a lot easier to connect clients to services and also to be able to follow up on those referrals because we have . . . that one person that we can contact.” (Site 2) “ . . . then we started to use our data. . . . That was where we decided to do occupational therapy, which is something we don’t have in our organization. It’s not our forte, it’s not our expertise. So we decided to do us a contract for occupational therapists to come and help support.” (Site 4)
	Need for pilot/tension of change	“100% needed. You know, before the before the pilot, we were doing some of this work, but it definitely has been taking a toll on a much smaller team.” (Site 3)
Pilot program perceptions and experiences	Fit/alignment to veterans served	“ . . . the VSSR program in all of my experience at [organization name] has been one of those programs where I very rarely hear anything negative from the veterans regarding how their program has been operated . . . providing that additional extra that is needed, and especially as our veterans are aging, a lot of them either don’t have families, some of their families are no longer with them, and we become their family. And so I definitely think it’s been a positive overall experience for the veterans.” (Site 4) “Having that contact with the nurse and being able to like when a veteran can’t articulate. What happened at their doctor’s appointment or what their next referral is, like we have that resource there, so we’re able to follow up on every single one. So it’s not just that I think we’re keeping veterans in housing for longer, we’re keeping them healthier in housing.” (Site 2)

Theme	Subtheme	Illustrative Quotes
	Relative advantage over previous efforts	“Our mental health specialists and case managers are often like Walmart. They’re like one-stop shopping for the veteran. And that is a lot to put on one person. So having a team approach really helped to spread and share the workload and really trying to, you know, serve folks and limit burnout amongst our team. So it was definitely necessary.” (Site 3) “One of the largest gaps for our veterans really has to do with that, with the service assistant and kind of the peer support, so there was a strong need. We unfortunately have, you know, a hard time with hoarding with a lot of our veterans and/or just basic, just hygiene, cleanliness, just normal upkeep of just life in general. And so someone who was able to kind of provide that hands-on in the home has been extremely helpful. Peer support.. I don’t care what program you have, having someone with lived experience . . . especially in the veteran community, like to have a veteran also, you know, helping you.” (Site1)
	Staffing and nonstaffing resources provided	“We have [name] who’s our service assistant, she provides weekly meals to the clients. For the clients that don’t make it in the community room, she goes and delivers the meals. We have trips to like the [park name] . . . we have a van that is wheelchair accessible, which is amazing. It’s . . . such a game changer.” (Site 2) “OK because like trying to get like a Lyft ride to an appointment back in the day was a nightmare. A lot of times they would get rejected. So that’s been a huge help, and it’s . . . just made it so much easier for clients, again, to stay consistent . . . with their appointments. “ (Site 2) “I can’t tell you how many walkers we’ve given and clients are just like so grateful. So it’s been, it’s been awesome to see.” (Site 2)
	Program improvement suggestions	“I feel like we could have done a better job of having our teams understand the importance of the documentation. . . . Documentation is not usually the reason people say they want to do this work. You know, so really, I think the paperwork was the piece where we struggled quite a bit.” (Site 3) “Adding some component of like grief and loss. . . . end-of-life planning, but maybe more intense coordination when it came to like high medical complex cases that we’ve had.” (Site 4)
	Program outcomes	“There have been folks who otherwise would not have retained their housing if we didn’t have staff who could come in and help with habitability, just making sure folks can take out trash, you know, helping folks keep units clean. . . . So really bringing in that service assistant team to be able to help. Because the other piece that we found where that a number of the veterans we were serving who had . . . in-home support services through the county, either the workers weren’t actually doing the work they should have been doing, so having the service assistance helped us kind of tease that out, or they didn’t have enough hours. So . . . this was a way to kind of supplement the work that they were approved for in terms of county in-home support services, but to really give them that access In terms of the real care that they needed.” (Site 3) “I think it’s definitely been made a huge difference. Again, just in community and just veterans just coming out of their units more and overall just like health and engagement. . . . So having this like whole other team that’s the support team has made such a huge difference in just being able to be consistent with services.” (Site 2)

Theme	Subtheme	Illustrative Quotes
Sustainability	Organizational support for continuation	“The aging population for veterans is growing in our organization. So I do want to take the lessons that we learned here, whether or not funding is attached and already expand it to other locations. But with funding, yeah, of course, it will allow us to continue. And our organization is very much in support of wanting to find ways to continue this.” (Site 4) “The pilot should continue. It should be expanded, quite frankly . . . there are . . . more veterans in need of this care than I think we think about.” (Site 3)
	Strategic planning for sustainability	“Because locally, [region name] has a serious deficit in terms of the budget. So it’s very little opportunity for us to look at [region name] general funding as a way to keep the pilot going.” (Site 3) “The service assistant is something that my CEO likes. We’re going to be looking for funding for that. So that one’s more in the air, but on our radar because that is something that was new to our agency. And so trying to figure out how like if there’s county dollars or whatever the case is, we just know that there’s current. No current VA funding, which is where a lot of our funding comes from.” (Site 1)
	Funding for sustainment and cost barriers	“I mean, I think the thing we keep hearing from folks is really looking into CalAIM, which is . . . drawing down Medicaid dollars to fund these services. . . . But the level of administrative work it would take for our team to do that kind of billing is what, you know, we really have to consider in the requirements around doing billing and what they will pay for, right? Because it is tied to the person. . . . That’s more work. We have to figure out the numbers. . . . the President’s One Big Beautiful Bill where there are a lot of cuts to Medicaid. It’s a little unclear how that’s going to impact like the Medicaid waivers that a lot of states, including California, in terms of expanding Medicaid to folks. Like, how is that going to play into the world of if we do go down a road of wanting to do, you know, this CalAIM billing, will there even be money there for that if there are going to be major cuts to programs like Medicaid in the future?” (Site 3)
	Policy facilitators and barriers	“We’re not an agency that’s fully billing yet, but we have talked about maybe the home health model being a fiscal sustainability strategy for working with this population. And of course, we’ve started, you know, we’ve applied to all of, you know, Medi-Cal, you know, Medicare, like all of those, we’re Medicare approved. but Medi-Cal has been taking some time. But with the, you know, current administration, it’s always, it’s always uncertain, you know, in terms of like, if there’s any policies that affect the ability to bill for services that might impact us or at least our strategy”. (Site 4)
	Strategies to overcome barriers	“We are currently in the process of developing, for sure, at a bare minimum, if we are able to, so we’ll still be able to provide, the transportation support specialist, the peer specialist, those are pretty stable. Those are staples for us. So those will probably be things that we will continue on.” (Site 4) “We have a like kind of a suicide prevention program that has peer support attached to it with some looser regulations. So that’s an available kind of peer support that could check in on our residents.” (Site 1)
	Marketing and dissemination	“Yes, we disseminate information about the pilot as often as we can. I talk it up all the time. I’m going to be talking it up in DC in a couple of weeks” (Site 3) “We have put some stuff out on social, of course, at our events, like we do a lot of outreach events. In the community, we are always incorporating some of what we do with aging.” (Site 4)

Theme	Subtheme	Illustrative Quotes
	Staffing shortages and workforce	“There was not enough staffing. There was a lot of turnover for burnout. And it’s not an easy population to work with.” (Site 2) “I think nationwide, right? There’s A shortage of folks to help serve older adults. And this program is really showing that . . . there are folks who still want to do this work, who can do this work, who do great work. but you got to be able to pay them. And so really thinking about . . . just how to highlight folks who have made a difference in the lives of veterans, whether they’re veterans themselves or folks who just care deeply about the population.” (Site 3)

Chapter 9. Research Design for Future Impact Evaluation

As further detailed below, the literature on evaluating PSH points to a well-established approach for establishing causal impact: linking program records to administrative data that also capture a comparable non-enrolled population, then constructing a matched comparison group. This chapter summarizes that evidence base and sets out recommendations for a future VSSR evaluation, beginning with the steps most immediately actionable.

The analyses in Chapters 3 through 8 are primarily descriptive and pre-post: They document who enrolled, how outcomes changed, and what factors associate with quality of life. They cannot support causal claims, because the evaluation included no comparison group. Without one, there is no way to know what would have happened to these same veterans in the pilot's absence. Participants aged, their conditions progressed, and surrounding conditions changed over the same period. A comparison group experiences those same trends, so the difference between the two groups isolates what the program contributed.

We focus on administrative data because such data avoid two limitations of the staff- and self-reported measures used here: The data are not subject to social desirability bias and are less likely to be missing due to nonresponse. Appendix E describes the 16 studies we reviewed. The recommendations below focus on quasi-experimental designs, which (unlike randomized trials) can be implemented retrospectively using data already collected, without disrupting program operations.

Summary of the Administrative Data Evidence Base

A review of 16 peer-reviewed studies (2007–2026) using administrative data and comparison group designs to evaluate PSH and related veteran programs suggests a reasonably well-developed evaluation strategy. Researchers across the PSH evaluation literature have applied this core approach at the state, county, and national levels, linking program enrollment records to an external administrative data source that also captures a comparable non-enrolled population.

Studies of veteran-specific programs, including HUD-VASH (the VA/HUD-funded PSH voucher program discussed in Chapter 2) and SSVF (the VA Supportive Services for Veteran Families rapid rehousing program, also discussed in Chapter 2), have used VA electronic health records (EHRs) linked to Homeless Management Information System (HMIS) and program enrollment files to construct propensity-matched comparison groups and estimate program effects using difference-in-differences or inverse probability weighting designs. The most consistent findings across these studies are reductions in emergency department visits, inpatient hospitalizations, and ambulance/911 calls. A 2026 national study of 26,649 SSVF enrollees using inverse probability of treatment weighting found inpatient costs fell by \$10,020 over three

years, with a \$7,534 increase in outpatient costs partially offsetting those savings, a net shift from acute to preventive care consistent with program theory.⁶² A study of SSVF by Yoo et al. (2026) found no statistically significant rural-urban differences for inpatient, outpatient, or total cost outcomes, although the pattern differed for ED outcomes: Urban veterans had small post-enrollment ED reductions while rural veterans showed no significant ED change (the rural-urban divergence was statistically significant across most post-enrollment quarters, although small in magnitude).⁶³

Studies of nonveteran PSH programs show consistent patterns of ED reductions and mixed cost results using Medicaid and other administrative claims, typically linked to HMIS data. The Pennsylvania Medicaid study linked Pennsylvania Medicaid claims to HMIS records from 54 counties to construct a matched comparison cohort of housing-unstable Medicaid enrollees who did not receive PSH.⁶⁴ Using difference-in-differences, researchers found that PSH entry reduced ED visits by 4.7 per 100 person-months and cut total Medicaid spending by \$145/month at three years. The New Jersey study linked the Medicaid Management Information System to statewide HMIS data and compared PSH-placed enrollees to matched homeless Medicaid beneficiaries not in PSH.⁶⁵ PSH placement reduced ED visits by 14 percent and ED-associated spending by 25 percent, although total costs did not decrease significantly because of offsetting pharmacy spending. The Seattle Housing First study found a 53 percent reduction in total multisector service costs in the first six months; billed medical services (hospital and Medicaid costs) drove the majority of that reduction, accounting for 76.6 percent of the between-group cost offset, with lower jail, shelter, and sobering center use contributing additionally.⁶⁶ A Los Angeles County initiative that linked jail, homeless services, Medicaid, and housing records found that PSH reduced jail days and use of homeless services relative to a matched comparison group, with an estimated net program cost that may approach cost-neutrality when savings across county service

⁶² Richard E. Nelson, Alec B. Chapman, Ann Elizabeth Montgomery, Ying Suo, Atim Effiong, Christa Shorter, Tom Greene, Jack Tsai, Lillian Gelberg, Stefan G. Kertesz, and Thomas Byrne, “Health Care Outcomes of Homelessness Prevention Programs in Veterans Experiencing Housing Instability,” *JAMA Health Forum*, Vol. 7, No. 1, January 23, 2026.

⁶³ Minkyong Yoo, Alec B. Chapman, Ying Suo, Thomas Byrne, Ann E. Montgomery, and Richard E. Nelson, “Differential Impact of the Supportive Services for Veteran Families (SSVF) Program on Veterans Affairs Healthcare Utilization and Costs Among Rural and Urban Veterans Experiencing Housing Instability,” *Journal of Rural Health*, Vol. 42, No. 2, spring 2026.

⁶⁴ Marta A. Hollander, Gwynn, Mark Unruh, Walid F. Gellad, Xinhua Zhao, Judith R. Lave, and Everette James, “Permanent Supportive Housing is Associated with Lower Medicaid Costs and Utilization,” *Journal of General Internal Medicine*, Vol. 36, No. 6, June 2021.

⁶⁵ Darin DeLia, Joel C. Cantor, Derek DeLia, and Joel C. Cantor, “Effects of Supportive Housing on Medicaid Utilization and Spending,” *Medical Care*, Vol. 59, No. 4, April 2021.

⁶⁶ Larimer, Mary E., Daniel K. Malone, Michelle D. Garner, David C. Atkins, Bonnie Burlingham, Heather S. Lonczak, Kenneth Tanzer, Joshua Ginzler, Seema L. Clifasefi, William G. Hobson, and G. Alan Marlatt, “Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems,” *JAMA*, Vol. 301, No. 13, April 2009.

systems are aggregated.⁶⁷ In California, the FSP evaluation found \$12,056 higher total annual costs overall, with increased outpatient mental health engagement accounting for much of that difference; inpatient costs declined significantly in San Diego and Los Angeles counties but rose in Orange County, yielding no significant overall inpatient change.⁶⁸ One study of North Carolina Medicaid data found contrasting results by prior living setting: Those entering PSH from institutional settings showed more hospitalizations and ED visits, while community-entry participants showed no significant differences, a pattern that underscores prior living situation as a critical moderator.⁶⁹

The two randomized controlled trial (RCT) studies of the 1990s HUD-VASH program did measure housing retention directly:⁷⁰ Cheng et al. found HUD-VASH participants accumulated significantly more days housed over three years (854 vs. 688 for standard care), with days housed as the primary outcome. However, the available quasi-experimental studies have not consistently examined housing retention or negative exit rates as primary outcomes in the way the RCTs did, and direct comparisons between PSH participants and matched control groups on these measures remain limited in the administrative data literature.

Steps Toward a Causal VSSR Evaluation

The following recommendations outline a potential approach for estimating VSSR's causal impact in a future evaluation:

⁶⁷ Sarah B. Hunter, Adam Scherling, Matthew Cefalu, and Ryan K. McBain, "Just in Reach Pay for Success: Impact Evaluation and Cost Analysis of a Permanent Supportive Housing Program," *RAND Health Quarterly*, Vol. 10, No. 2, 2023.

⁶⁸ Todd P. Gilmer, Elizabeth W. Stefancic, Suzanne Ettner, William G. Manning, and Seija Tsemberis, "Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults with Serious Mental Illness," *Psychiatric Services*, Vol. 63, No. 5, May 2014.

⁶⁹ Lauren R. Grove, Matthew C. Hernandez, and Marisa Elena Domino, "Effects of Permanent Supportive Housing on Healthcare Utilization by Prior Living Setting," *Medical Care Research and Review*, Vol. 80, No. 5, October 2023.

⁷⁰ Ann-Lii Cheng, Peter D. Lam, Michael R. Kasprow, and Robert Rosenheck, "Program Compliance and Client Outcomes in a Randomized Clinical Trial of the Housing and Urban Development–Veterans Affairs Supportive Housing Program," *Psychiatric Services*, Vol. 58, No. 5, May 2007; Maria J. O'Connell, Wesley J. Kasprow, and Robert A. Rosenheck, "Differential Impact of Supported Housing on Selected Subgroups of Homeless Veterans with Substance Abuse Histories," *Psychiatric Services*, Vol. 63, No. 12, May 2012.

Link VSSR enrollment records to VA EHRs.⁷¹ Several veteran-focused studies apply this approach most directly: Nelson et al. (2021, 2022)⁷² and Tsai, Peltzman, and Beydoun (2026)⁷³ link program enrollment files for veteran housing programs to VA EHR data and the VA Corporate Data Warehouse, matching veterans by VA ID or Social Security Number to their utilization records at national scale. For VSSR, the analogous step is working with the VA to establish the same linkage. This linkage would allow measurement of ED visits, ambulance/911 calls, inpatient stays, missed appointments, and health care costs before and after VSSR enrollment.⁷⁴

Construct a comparison group using propensity-matching to support a difference-in-differences design. The most practical approach for VSSR combines propensity score matching with a difference-in-differences framework: First, identify veterans in VA records with similar demographics, health conditions, and housing instability indicators. In 2012, the VA embedded a two-question housing stability screener into its electronic medical record (i.e., the Homelessness Screening Clinical Reminder) that flags patients who are homeless or at risk for homelessness.⁷⁵ Veterans who are not enrolled in VSSR but match on other characteristics can form a matched comparison group; then compare the change in outcomes from pre- to post-enrollment among VSSR participants against the change over the same period among those matched nonparticipants. Researchers in the PSH evaluation literature have applied this combined approach using VA and HMIS data linkages at comparable scale (500+ participants).⁷⁶ The key additional step is identifying a comparison population from within HMIS who share similar characteristics—veteran status, chronic homelessness history, time residing in PSH, and health

⁷¹ Access to VA electronic health record data involves institutional approvals and typically requires partnering with a VA-affiliated investigator. The veteran-specific studies reviewed here were conducted by research teams with VA affiliations. A future evaluation should plan for this process well in advance.

⁷² Richard E. Nelson, Ann Elizabeth Montgomery, Yin Suo, James Cook, Warren Pettey, Adi Gundlapalli, Tom Greene, William Evans, Lillian Gelberg, Stefan G. Kertesz, Jack Tsai, and Thomas H. Byrne, “Temporary Financial Assistance Decreased Health Care Costs for Veterans Experiencing Housing Instability,” *Health Affairs*, Vol. 40, No. 5, May 2021; Richard E. Nelson, Ann Elizabeth Montgomery, Ying Suo, James Cook, Warren Pettey, William Evans, Tom Greene, Lillian Gelberg, Stefan Kertesz, Jack Tsai, and Thomas Byrne, “The Impact of Temporary Housing Assistance Expenditures on Subcategories of Health Care Cost for U.S. Veterans Facing Housing Instability,” *Journal of Health Care for the Poor and Underserved*, Vol. 33, No. 4, November 2022.

⁷³ Jack Tsai, Taylor Peltzman, and Hind A. Beydoun, “Changes in All-Cause, Overdose, and Suicide Mortality Risk in the First 2 Years of Supported Housing, United States, 2017–2021,” *American Journal of Public Health*, Vol. 116, No. 5, 2026.

⁷⁴ One consideration shapes the scope of this approach: Not all VSSR participants are enrolled in VA care, since some veterans are ineligible because of discharge status or service history. VA linkage would therefore cover the subset of participants engaged in VA services, and an evaluation should report what share could be matched. For the remainder, HMIS and HUD program data or Medi-Cal records offer a complementary source.

⁷⁵ Manik Chhabra, Anneliese E. Sorrentino, Meagan Cusack, Melissa E. Dichter, Ann Elizabeth Montgomery, and Gala True, “Screening for Housing Instability: Providers’ Reflections on Addressing a Social Determinant of Health,” *Journal of General Internal Medicine*, Vol. 34, No. 7., July 2019.

⁷⁶ Nelson et al., 2021; Nelson et al., 2022; Tsai, Peltzman, and Beydoun, 2026.

conditions—but who did not receive VSSR services. To reduce contamination, the comparison group should exclude veterans residing at the specific housing sites where VSSR operated. Geography (such as urban/rural status and county-level housing market conditions) could serve as an additional matching variable to account for regional variation in housing stability outcomes. (See recommendations below for important data quality caveats specific to housing exit outcomes.)

Focus the comparative analysis on outcomes with the strongest signals. Based on the literature, the outcomes most likely to show detectable effects are emergency department visits, inpatient hospitalizations, ambulance/911 calls, falls, and housing stability. The RCT literature measured housing retention as a primary outcome: Cheng et al. (2007)⁷⁷ found a significant days-housed advantage for HUD-VASH over three years, but no modern quasi-experimental study using administrative data has replicated this with a matched comparison group at scale.

Plan for multisector data linkage where feasible. The broadest cost-savings findings in the literature came from linking across jail, shelter, Medicaid, EMS, and housing records simultaneously.⁷⁸ For future VSSR sites serving veterans with criminal justice histories or co-occurring behavioral health conditions, a formal data sharing agreement with county jail and Medicaid/Medi-Cal records would enable measurement of health and justice system outcomes across sectors that VA data alone does not capture. This is a longer-term infrastructure investment, but the literature shows that county-level data sharing agreements can support it.

Use VSSR’s own exit data as the primary housing stability outcome, and account for known HMIS exit data quality limitations in any comparison. No study in this literature used administrative data to compare housing retention or negative exit rates between PSH participants and a matched comparison group. This gap exists in part because HMIS exit destination data present known quality challenges at scale. Missing exit destination is a recognized and pervasive problem: The California Policy Lab’s evaluation of Los Angeles County homelessness prevention strategies explicitly flagged that “missing project exit data are a common data quality issue throughout the HMIS.”⁷⁹ One contributing factor involves a data entry practice observed in some CoCs: Projects configure their systems to automatically exit clients after a period of inactivity; as the San Luis Obispo HMIS Data Standards document notes, “all system-generated exits will have missing data for the Exit Destination element.”⁸⁰ Because exit destination is the key variable for determining whether a person returned to homelessness, achieved stable

⁷⁷ Cheng et al., 2007.

⁷⁸ Larimer et al., 2009; Hunter et al., 2023.

⁷⁹ California Policy Lab, *Evaluation of Los Angeles County’s Strategies to Expand and Enhance Rapid Re-Housing Services for Multiple Populations*. University of California, 2019. (HMIS exit data quality noted p. 50, fn. 47.)

⁸⁰ Homeless Services Oversight Council, County of San Luis Obispo, *HMIS Data Standards & Data Quality Management Plan*, Version 2.0, undated. (Automated exit and missing exit destination noted p. 12.)

housing, or exited to incarceration, this structural missingness severely limits the usefulness of raw HMIS exit records as a comparison dataset.

VSSR captures exit type, reason, and destination for every enrolled veteran and is a structured, staff-recorded process rather than an automated HMIS event. For future evaluations, these data support two complementary approaches. Within-program, document and report VSSR's negative exit rate (eviction, return to homelessness, incarceration) as a primary funder-facing outcome, comparing it against the 3.6 percent negative exit rate the pilot established. Comparatively, HMIS contains records for veterans who entered PSH through HUD-VASH or CoC vouchers but did not receive VSSR services, making them the most comparable available comparison group. A propensity-matched comparison of housing exit outcomes between VSSR participants and this HMIS-based comparison group is potentially feasible, but any such analysis must explicitly address the exit destination missingness problem, either by restricting to records with nonmissing exit destination and documenting how many records that restriction removes, or by conducting sensitivity analyses that bound the missingness. Given the structural nature of this data quality problem, presenting VSSR's own exit rate benchmarked against published CoC-level statistics may be a more credible near-term approach for funders, and VSSR's structured tracking itself represents a methodologically stronger data source than HMIS alone. Another valuable source for identifying benchmarks is the research literature, particularly RCT studies that have tracked PSH exits among populations similar to VSSR participants—such as older adults with comparable past experiences and length of time in PSH.

Summary

The VSSR program already collects data at the veteran level. The critical gap, which the literature demonstrates is both feasible and necessary to support causal impact claims, is a comparison group. The most achievable near-term step is to work with the VA to link VSSR enrollment records to VA EHR data and identify a propensity-matched comparison group of veterans with similar health profiles and housing instability who did not receive VSSR services. This design, combined with the longitudinal data VSSR already collects, would position future evaluation reports to make the same kind of statistically credible effectiveness arguments that have sustained and expanded HUD-VASH, SSVF, and similar programs.

Chapter 10. Summary and Recommendations

This chapter draws the findings of Chapters 3 through 9 together and sets out recommendations for program administration, sustainability, and future evaluation. Two conclusions run through it. First, the pilot reached the aging, medically complex population it was designed for, and it enrolled more veterans than it set out to serve. Second, participants' measured circumstances improved over their first year in acute health events, emergency and inpatient care, unmet needs for daily living assistance, several health behaviors, group participation, and habitability. Housing stability was the program's strongest result: Just 20 of 560 participants exited to an unstable situation over three years, a negative exit rate of 3.6 percent that showed no upward drift as the cohort aged and grew. These conclusions describe how participants fared during the pilot; because the evaluation was not designed to compare them with veterans who did not receive VSSR services, they cannot establish how much of the change VSSR produced. Chapter 9 sets out a design that would let future evaluations build on this foundation and speak more directly to the program's effects.

Summary of Findings

The program exceeded its enrollment target of 425 veterans. Between June 2023 and May 2026, 560 veterans enrolled across the six sites, and 411 of them reached at least four quarters of enrollment. Staffing grew more multidisciplinary and more consistent across sites over the program's first ten quarters. Peer specialists and service assistants were the most common roles, the number of staff in both roles doubled over the period, and every site employed both from Quarter 7 (December 2024) onward. Mental health specialists and transportation specialists followed. Nurses and occupational therapists appeared mainly in the later quarters and mainly at PATH and U.S.VETS.

Program and Participant Characteristics

The enrolled population matched the pilot's target profile: older, predominantly male, and carrying substantial chronic disease and behavioral health burden, with extensive daily living needs that existing services were not meeting.

- Demographics
 - 79 percent of participants were 56 or older at enrollment.
 - 90 percent identified as men.
 - 41 percent identified as White, non-Hispanic, 33 percent as Black or African American, and 12 percent as Hispanic, Latinx, Chicano, or Spanish origin.
 - 43 percent served in the Army, and all branches of service were represented.

- Health status
 - 31 percent had four or more chronic conditions at enrollment.
 - Depression (38 percent), anxiety (33 percent), PTSD (31 percent), and hypertension (29 percent) were the most frequently reported diagnoses.
 - 36 percent were rated in good or very good health, and 20.5 percent in poor or very poor health.
 - 24 percent had experienced a fall in the three months before enrollment.
- Assistance and unmet needs
 - 11 percent or fewer received any single type of daily living assistance before enrollment, while staff identified substantial unmet need, led by housekeeping (32 percent), companionship or emotional support (25 percent), and grocery shopping or errands (24 percent).
- Health services and behaviors
 - 16 percent had visited or received treatment in a hospital emergency room in the three months before enrollment, and 48 percent had received no outpatient care in that period.
 - 24 percent had missed one or more medical appointments.
 - 15 percent self-managed chronic health symptoms “not well” or “not at all.”
 - Staff reported 51 percent as taking medications as prescribed.
- Social behaviors
 - 36 percent did not participate in any group programs or activities.
 - 65 percent left their apartments daily.
- Habitability concerns
 - Complaints were uncommon across all categories, led by cleanliness (8 percent), clutter (7 percent), and pest infestation (7 percent).

Housing Stability

Through May 2026, 20 of the 560 participants exited to an unstable housing situation, a negative exit rate of 3.6 percent. Negative exits held between one and four per six-month interval across all three program years, showing no upward drift as the cohort aged and grew. Most exits reflected health trajectories rather than housing failure: 82 of the 134 total exits (62 percent) were transitions to a higher level of care or occurred because a veteran passed away, and 32 (24 percent) were moves to another independent living situation. A study of Los Angeles HUD-VASH residents over a comparable period reported a negative exit rate of 15 percent (though under a broader exit definition that included program disengagement and noncompliance alongside eviction and returns to homelessness).⁸¹

⁸¹ Panadero et al., 2025.

Changes in Outcomes

Among the 400 participants who completed at least four quarters and had fourth-quarter data, we compared baseline outcomes with outcomes in the fourth quarter of enrollment. Acute health events, emergency and inpatient care, unmet needs, substance use, and habitability complaints all declined significantly. Self-rated health, medication adherence, and symptom self-management changed little.

- General health status: The share rated in good or very good health rose from 38 to 42 percent. More residents improved than declined. Four in five either improved or held steady, which is notable for a population in which some decline would be expected.
- Acute health events: Falls fell by 59 percent, from 22 to 9 percent, and the share of residents with no acute health events rose by 22 percent, from 74 to 90 percent. Both changes reached statistical significance.
- Assistance and unmet needs: No resident received assistance with activities of daily living at baseline. By the fourth quarter, companionship or emotional support reached 37 percent of residents, housekeeping 26 percent, assistance for medical purposes 22 percent, and grocery shopping or errands 19 percent.
 - Unmet need fell significantly in most categories.
 - Unmet need persisted for housekeeping, which 13 percent of residents still reported in the fourth quarter.
- Health service use: Four declines reached statistical significance:
 - Emergency medical visits fell by 75 percent, from 15 to 4 percent.
 - Outpatient mental health visits fell by 44 percent, from 14 to 8 percent.
 - Inpatient medical visits fell by 36 percent, from 8 to 5 percent.
 - Primary care visits fell by 16 percent, from 42 to 35 percent.
 - Ambulance or 911 calls also fell by 24 percent and specialty care rose by 13 percent, but neither change reached significance.
- Health behaviors: Several measures improved, and others held steady:
 - Missed medical appointments fell by 54 percent, from 22 to 10 percent.
 - The share eating three meals per day rose by 41 percent, from 37 to 53 percent.
 - Alcohol, stimulant, and opioid use each fell 40 percent or more. The share reporting no substance use rose from 50 to 61 percent. Cannabis use fell slightly, a change that did not reach significance.
 - Medication adherence held steady near half of residents (50 to 52 percent), as did self-management of chronic symptoms (51 to 53 percent).
 - Reporting patterns shifted over the year. The share unsure about medication adherence rose from 6 to 17 percent, and the share reporting no medical appointments rose from 9 to 30 percent. Both shifts complicate the interpretation of the adherence and appointment findings.
- Social behaviors: Group participation rose, and patterns of leaving the unit changed.

- Participation in three or more group programs tripled, from 12 to 37 percent, and the share participating in none fell from 50 to 29 percent.
- Daily departures from the unit fell from 71 to 52 percent. (However, about 84 percent of residents were still leaving their units at least three times a week.)
- Habitability: Complaints declined.
 - Cleanliness complaints fell by 53 percent. Hygiene, odor, and pest infestation complaints each fell below the reporting threshold, so we do not report their percentage differences.
- Staff engagement: Discussions with residents expanded substantially.
 - Discussions rose significantly on 10 of 15 topics, led by life skills, peer support, and participation in onsite and offsite activities. Discussions on managing mental health declined.

Associations Between Service Use and Outcomes

Among the 411 participants with four quarters of data, we examined how service use in one quarter related to outcomes in the following quarter. The results do not track a simple benefit story, and they most plausibly reflect how staff target services toward residents with the greatest needs:

- Health outcomes: Residents who received ADL/IADL assistance had lower odds of a good or very good health rating and higher odds of acute care use in the following quarter, with no difference in falls. Residents who took part in discussions on behavior and habitability showed the same pattern.
- Health behaviors: Other general assistance related to higher odds of substance use.
- Habitability and social behaviors: Group program participation related to lower odds of habitability complaints, the only significant association in this set.

Residents' Self-Reported Quality of Life

Veterans completed annual surveys in which they self-reported quality of life, general health, housing quality, housing safety, housing worry, and loneliness. According to our analysis of these surveys,

- All five factors related significantly to quality of life after adjusting for demographics, chronic conditions, and site. Residents in good or very good health showed the strongest association, at roughly 13 times the odds of reporting better quality of life. Residents who felt safe in their housing had roughly five times the odds, those who rated their housing of good quality had roughly four and a half times, and those who did not feel lonely roughly four and a half times. Residents who did not worry about losing their housing had roughly twice the odds, the smallest of the five associations but still highly significant.
- Ratings improved in some domains and held steady in others. Between their first and most recent survey, quality of life improved on average by 13.6 percentage points, general health by 12.8, and housing quality by 10.0, all statistically significant. Housing

worry, housing safety, and loneliness showed no significant net change, although substantial numbers of residents moved in each direction.

- Measured service use related far more weakly to quality of life. Across three veteran annual survey waves and two outcomes, none of the 24 tested associations reached conventional significance. One was marginally significant: residents who left their unit three or more times per week had higher odds of reporting no loneliness at Year 2 (OR = 2.52, $p = .073$). No other association approached significance.

Program Costs in Context

VSSR's enhanced services cost \$17,437 per veteran per year across the six sites, based on \$18.6 million in expenditures through May 2026. Site-level costs ranged from \$12,914 to \$23,245. Adding voucher-linked case management and the housing subsidy brings the total public investment to roughly \$42,800 to \$66,200 per veteran per year in May 2026 dollars.

That total falls below every residential alternative with recent California figures. It runs about 23 to 50 percent below the private assisted living median of \$85,471, between one-quarter and just under one-half the cost of semi-private nursing facility care at \$150,640, and below the net state cost of even the most independent Veterans Home level. Against service-only alternatives, VSSR's services and case management cost of roughly \$22,500 to \$23,300 falls between two California older-adult FSP examples (\$18,757 and \$25,770), sits modestly above a lower-bound ACT benchmark, and equals about one-quarter of the California median for a 44-hour-per-week nonmedical in-home aide (\$94,429).

A caveat is that the figures rest on different pricing bases, including market rates, net public costs, contract rates, grant expenditures, and published research estimates, so they indicate relative magnitude rather than precise equivalents. However, the comparisons do establish that no identified alternative combines VSSR's elements, and that many alternatives ration access in ways VSSR does not. Medi-Cal's Assisted Living Waiver operates in 15 of California's 58 counties and had roughly 18,365 people waitlisted as of December 2025, more than it had enrolled, and the eight Veterans Homes maintain waitlists with no campus in four of the six VSSR counties.

Leadership Interviews

We interviewed leadership at each of the four grantee organizations in spring 2026. All four described the pilot as a valuable and much-needed enhancement to services for aging and high-acuity veterans in PSH.

Consensus centered on which roles mattered most. All four organizations named peer support specialists and service assistants as the most critical roles and the ones they most hope to sustain. Leaders credited peer specialists, many of them veterans themselves, with building trust and rapport quickly, and credited service assistants with resolving habitability problems that would otherwise have put tenancies at risk. Wheelchair-accessible transportation removed a long-standing barrier, since commercial ride services frequently turned veterans away. Group meals,

outings, and social gatherings drew veterans out of their units. Leaders also valued the team model itself, which replaced a single-worker arrangement one leader likened to “one-stop shopping” and which spread workload and reduced burnout.

Sustainability dominated their forward-looking concerns. The end of pilot funding is the primary barrier for all four organizations, and all made continuation contingent on new funding. Two grantees have developed or are developing sustainability plans, and one is not prioritizing VSSR sustainability because of broader organizational funding pressures. Leaders viewed Medicaid and CalAIM billing as a possible route but flagged administrative and eligibility barriers, and several raised concern about federal cuts. Organizations also asked for clearer and more flexible staffing guidance, more support for data collection and documentation, and additional resources for grief and end-of-life care. Leaders attributed staffing shortages and turnover to the national labor market rather than to the program.

These accounts reflect leaders’ perceptions of program outcomes rather than measured effects, and readers should weigh them alongside the quantitative findings above.

Research Design for Future Impact Evaluation

The analyses in this report are descriptive and pre-post, and they cannot support causal claims because the evaluation included no comparison group. Without one, changes observed during the pilot cannot be separated from what would have happened anyway as participants aged and conditions around them changed. Our review of 16 peer-reviewed studies published between 2007 and 2026, presented in Appendix E, shows that a credible causal design is both feasible and necessary.

The most achievable near-term step is to work with the VA to link VSSR enrollment records to VA EHR data, identify a propensity-matched comparison group of veterans with similar health profiles and housing instability who did not receive VSSR services, and estimate effects using propensity-score matching combined with difference-in-differences. Researchers have applied this approach at comparable scale, with 500 or more participants. The outcomes most likely to show detectable effects (emergency department visits, inpatient hospitalizations, ambulance and 911 calls, missed appointments, and health care costs) are reliably captured in VA EHRs.

Housing stability needs a different approach. The 1990s HUD-VASH randomized trials measured housing retention directly, with days housed as the primary outcome in Cheng et al., and no modern quasi-experimental administrative data study has replicated that with a matched comparison group at scale. HMIS data could in principle close the gap, but exit destination data are systematically missing, a problem to which automated exit practices in some Continuums of Care contribute.⁸² Until that improves, reporting VSSR’s own negative exit rate against published CoC statistics or from RCTs give funders a more credible near-term benchmark.

⁸² California Policy Lab, 2019; Homeless Services Oversight Council, County of San Luis Obispo, undated.

Assessing VSSR Against Its Goals

The pilot set out to help aging and high-acuity veterans age in place, prevent premature exits and isolation, improve health and wellness, and improve site operations. The evidence speaks to each, although not equally:

- **Aging in place** is where the evidence is strongest: a 3.6 percent negative exit rate over three years with no upward drift, and 62 percent of exits reflecting health trajectories rather than housing failure.
- **Preventing acute events and institutional transitions** is supported. Falls fell 59 percent, emergency medical visits 75 percent, and the share with no acute events rose from 74 to 90 percent (the outcomes the PSH literature most consistently finds responsive).
- **Health and wellness** results are mixed. The pilot closed real gaps in unmet daily living needs, missed appointments, and problematic substance use. Staff-rated health status, medication adherence, and symptom self-management held steady over residents' first year. Residents' own ratings of their general health, measured on the annual survey over a longer window, showed net improvement; this difference that may reflect the different reporters, instruments, and time frames rather than a genuine conflict. Neither the quarterly service-use models nor the annual survey found a clear link between specific services and health outcomes.
- **Maintaining and improving quality of life is partly supported.** Residents' own quality-of-life ratings improved on net over their enrollment, and between 57 and 75 percent held steady, depending on the domain. (These findings should be considered in the context of an aging population, where some health decline is expected.)

Overall, VSSR reached its target population, delivered services not previously available at these sites, and did so at a cost below every residential alternative with current California figures.

Recommendations

The findings above point to the following steps:

- **Prioritize peer support and service assistant roles in any continuation or successor program.** All four grantee organizations independently identified these as the highest-value roles and the ones they most hope to sustain, citing peers' ability to build trust quickly with fellow veterans and service assistants' role in resolving the habitability problems that most directly threaten tenancy. The quantitative findings point the same way: Group programming, which these roles make possible, was the only service associated with fewer habitability complaints in the following quarter, and over eight quarters it was also associated with more frequent time outside the unit. Where funding permits only partial continuation, these two roles have the strongest combined support from grantee experience and measured outcomes.
- **Close the remaining unmet need in daily living assistance.** Unmet need fell substantially across most categories over participants' first year, but housekeeping remained the exception, still reported for 13 percent of residents at the end of Year 1—the highest of any category, and the same category that led unmet need at baseline. Meal

preparation and laundry each remained near 7 percent. These are also the needs most directly tied to habitability and to the lease violations grantees described as a leading threat to housing stability, which makes them a practical target for service assistant time.

- **Establish VA and HMIS data linkage and matched comparison group described in Chapter 9.** No other step would do as much to change what a future evaluation can claim. The outcomes most likely to show detectable effects—emergency department visits, inpatient hospitalizations, ambulance and 911 calls, and health care costs—are reliably captured in VA EHRs, and the propensity-matching and difference-in-differences approach has been applied at comparable scale in the published literature. Obtaining HMIS data would allow one to examine whether a veteran uses other non-VA homeless services. Because the VA data linkage requires institutional approvals and partnership with a VA-affiliated investigator, and because it would cover the subset of participants engaged in VA care, this work should begin well before the intended evaluation period.
- **Report VSSR’s negative exit rate against published benchmarks.** Exit destination is systematically missing in some HMIS databases, in part because some CoC configure their systems to exit clients automatically after periods of inactivity, and those system-generated exits carry no destination. VSSR’s own exit tracking, which records type, reason, and destination for every enrolled veteran through a staff-recorded process, is a methodologically stronger source. Benchmarking that rate against published CoC statistics or against exit rates reported in the research literature gives funders a credible near-term measure while the underlying HMIS data quality problem persists.

Appendix A

Enrollment in the VSSR pilot was rolling, so each participant's quarters run from their own enrollment date rather than from a fixed point in program time, and the annual resident survey followed a site visit schedule that did not always align with those quarters. This appendix documents both timelines in support of the methods described in Chapter 2.

Table A.1 maps enrollment cohorts to program quarters. Rows are calendar quarters of the program, columns are enrollment cohorts, and each X marks a quarter in which that cohort was enrolled and under observation. The restricted sample for the outcome analyses in Chapters 4 and 5 comprises the nine cohorts enrolling between June 2023 and August 2025, each with at least four quarters of enrollment by the close of the evaluation period.

Table A.1. Program Year-Quarters and Corresponding Enrollment Periods for the Restricted Sample

Program Year	Program Quarter (Time Period)	Enrolled in								
		Jun–Aug 2023	Sep–Nov 2023	Dec 2023–Feb 2024	Mar–May 2024	Jun–Aug 2024	Sep–Nov 2024	Dec–Feb 2025	Mar–May 2025	Jun–Aug 2025
1	1 (Jun–Aug 2023)	X								
	2 (Sep–Nov 2023)	X	X							
	3 (Dec 2023–Feb 2024)	X	X	X						
	4 (Mar–May 2024)	X	X	X	X					
2	1 (Jun–Aug 2024)		X	X	X	X				
	2 (Sep–Nov 2024)			X	X	X	X			
	3 (Dec–Feb 2025)				X	X	X	X		
	4 (Mar–May 2025)					X	X	X	X	
3	1 (Jun–Aug 2025)						X	X	X	X
	2 (Sept–Nov 2025)							X	X	X
	3 (Dec–Feb 2026)								X	X
	4 (Mar–May 2026)									X

NOTE: Program-level quarters represent calendar time based on the overall program timeline. Participant-level enrollment quarters are defined relative to each individual's enrollment start. For the restricted sample in this report, the start of enrollment occurs during Y1Q1, Y1Q2, Y1Q3, Y1Q4, Y2Q1, Y2Q2, Y2Q3, Y2Q4, and Y3Q1.

Table A.2 gives annual survey dates by site, along with the quarterly assessment immediately preceding each survey. Those assessments supplied the independent variables for the analyses in Chapter 6. Because survey dates follow the site visit schedule, the matching assessment is the fourth quarter of the corresponding program year at most sites but not all: Nation's Finest–

Sonoma completed its Year 2 survey before its Y2Q4 assessment, and the Swords to Plowshares sites had fall visits, which placed their Year 1 and Year 2 surveys in the first quarter of the following program year.

Table A.2. Annual Survey Administration Dates and Corresponding Quarterly Assessment, by Site

Site (Code)	Y1 Survey Date(s)	Y1 Quarterly Assessment Used	Y2 Survey Date(s)	Y2 Quarterly Assessment Used	Year 3 Survey Date(s)	Y3 Quarterly Assessment Used
U.S.VETS–Inland Empire	7/11–7/12/2024	Y1Q4	6/10–6/11/2025	Y2Q4	Mid-June 2026	Y3Q4
U.S.VETS–Los Angeles	7/8–7/10/2024	Y1Q4	6/9–6/13/2025	Y2Q4	Mid-June 2026	Y3Q4
Nation’s Finest–Mather	8/7–8/8/2024	Y1Q4	6/17/2025	Y2Q4	Mid-June 2026	Y3Q4
Nation’s Finest–Sonoma	8/6/2024	Y1Q4	5/13–5/14/2025	Y2Q3	Mid-June 2026	Y3Q4
PATH	7/30–7/31/2024	Y1Q4	7/16/2025	Y2Q4	Mid-June 2026	Y3Q4
Swords to Plowshares (E)-Edwin M. Lee Apartments	9/25/2024	Y2Q1	10/27/2025	Y3Q1	Mid-June 2026	Y3Q4
Swords to Plowshares sites	9/25–10/16/2024	Y2Q1	10/27–10/29/2025	Y3Q1	Mid-June 2026	Y3Q4

Appendix B. Comparison of Full-Year Sample to All Other Participants

Table B.1 presents descriptive statistics by comparing two groups of program participants. The first group includes those who were enrolled in the program for at least a full year and appeared in the quarterly data for four consecutive quarters; these individuals were included in our sample examining changes in outcomes over time ($n = 411$). The second group consists of those who had missing quarterly data or were enrolled for less than a full year ($n = 149$).

Table B.1. Characteristics of Full-Year Sample and All Other Participants

Variable	Enrolled for at Least Four Quarters ($N = 411$)	All Other Enrollees ($N = 149$)	Percentage Point Difference
Site			
Nation's Finest–Mather	24.0%	14.4%	–9.6**
Nation's Finest–Sonoma	8.5%	9.4%	+0.9
PATH	12.3%	11.9%	–0.4
Swords to Plowshares	26.5%	40.6%	+14.1**
U.S.VETS–Inland Empire	13.8%	8.1%	–5.6*
U.S.VETS–West Los Angeles	15.0%	15.6%	+0.6
Time residing at site			
<1 year	25.5%	36.3%	+10.8*
1–2 years	20.3%	22.5%	+2.2
3–4 years	21.5%	18.1%	–3.4
5 or more years	32.8%	22.5%	–10.3*
Age			
26–45	6.0%	11.3%	+5.3
46–55	9.0%	9.4%	+0.4
56–65	37.3%	36.3%	–1.0
66–75	33.3%	28.8%	–4.5
76–100	9.5%	10.0%	+0.5
Nor available	5.0%	<10	–
Gender			
Woman	9.3%	<10	–
Man	89.3%	93.1%	+3.9
Not available	<10	<10	–

Variable	Enrolled for at Least Four Quarters (N = 411)	All Other Enrollees (N = 149)	Percentage Point Difference
Race/ethnicity			
White (non-Hispanic, Latinx, Chicano, or Spanish Origin)	43.5%	35.6%	-7.9
Black or African American	33.5%	30.0%	-3.5
Hispanic, Latinx, Chicano, or Spanish origin	9.8%	16.3%	+6.5*
Multiple	3.8%	<10	-
Branch			
Army	43.0%	41.9%	-1.1
Navy	22.3%	25.0%	+2.8
Marine Corps	14.8%	13.1%	+1.6
Air Force	9.3%	12.5%	+3.3
General health status at program enrollment			
Good/very good	36.8%	33.8%	-3.0
Fair	39.8%	40.0%	+0.3
Poor/very poor	19.0%	24.4%	+5.4
Number of conditions			
0	18.0%	15.0%	-3.0
1-3	53.3%	48.1%	-1.1
4-6	26.8%	31.3%	+4.5
7-9	<10	<10	-
Frequency of conditions			
Depression	34.8%	46.9%	+12.1**
Anxiety	29.3%	43.1%	+13.9**
Hypertension	28.8%	28.1%	-0.6
PTSD	28.5%	38.8%	+10.3*
Arthritis	23.8%	25.0%	+1.3
Diabetes	18.0%	17.5%	-0.5
Substance use disorder	16.5%	28.1%	+11.6**
Heart disease	17.0%	12.5%	-4.5
Respiratory	10.5%	11.3%	+0.8
Asthma	8.3%	9.4%	+1.1
Disability	4.5%	<10	-
Chronic kidney disease	3.0%	<10	-
Dementia	<10	<10	-

NOTE: Sample size of 560 participants enrolled between June 2023 and May 2026. To protect anonymity of enrollees, variables with fewer than 10 respondents are reported as a count of <10. * = $p < 0.05$, ** = $p < 0.01$.

Appendix C

Table C.1 reports the counts underlying Figure 6.1 in Chapter 6. Chapter 2 describes how residents were paired across surveys and how each domain was dichotomized.

Table C.1. Individual-Level Trajectories from First to Most Recent Annual Survey

Domain	<i>n</i>	Stable (negative) %	Improved %	Worsened %	Stable (positive) %	Net (pp)	McNemar <i>p</i>
Quality of Life	243	24.7	23.9	10.3	41.2	+13.6	0.0004**
General Health	242	28.1	22.7	9.9	39.3	+12.8	0.0006**
Housing Quality	120	13.3	17.5	7.5	61.7	+10.0	0.0428*
Housing Worry	238	26.9	23.5	19.3	30.3	+4.2	0.3729
Housing Safety	236	17.8	16.1	16.5	49.6	-0.4	1.0000
Loneliness	238	27.3	16.0	15.5	41.2	+0.5	1.0000

NOTE: These are the underlying figures for Figure 6.1 in Chapter 6. “Stable (negative)” = remained in the lower category at both surveys; “Stable (positive)” = remained in the higher category. “Net” = % improved minus % worsened (percentage points). For all domains except housing quality, the first survey is the baseline survey conducted around the time of enrollment. Because an error in the baseline response options rendered the housing quality item unusable (see Chapter 2), the housing quality row pairs each resident’s Year 1 survey with their most recent survey, giving that domain a smaller sample and a shorter average follow-up interval than the others. McNemar’s exact *p* tests whether more residents changed in one direction than the other (among those who changed at all). * *p* < 0.05; ** *p* < 0.001.

Appendix D. Leader Interviews Protocol and Codebook

VSSR Site Leadership Interview Protocol

INTERVIEW DATE:

Site:

Facilitator:

Start Time:

End Time:

Process Notes (optional; this can include any details about the interview itself, logistical challenges like connectivity or distractions):

[Notes are in brackets and/or CAPS, do not read]

INTERVIEW QUESTIONS:

What is your primary professional role at your organization and how long have you served in this role?

As earlier mentioned, we are interested in learning about your organization's experiences and plans regarding the Veterans Support to Self- Reliance (or VSSR) pilot. How long have you been overseeing the delivery of the Pilot?

[NOTE: Grants were awarded in 3/23; determine whether respondent had oversight since its inception and throughout its implementation]

[IF RELEVANT] Were you involved in the planning of the pilot before it was awarded, including grant writing?

- If so, can you discuss your organization's rationale for applying for the award?
- How did you determine which staffing/roles to include? [PILOT PLANNING/ ORGANIZATION MISSION/ALIGNMENT]
- To what extent do you think the Pilot was needed [TENSION FOR CHANGE]

What do you think of the VSSR pilot for the veterans you serve? Do you think it's a good fit? [INNOVATION FIT]

Our records indicate that the VSSR pilot helped your organization support the following staff positions [LIST STAFF POSITIONS SUPPORTED IN BUDGET REPORTS FOR THIS SITE, e.g., a mental health specialist, a transportation specialist, a pilot specialist, 2 peer support specialists, part-time occupational therapist, a part-time nurse]. Is this accurate? [PROGRAM STAFFING]

How valuable were these staff and the services they provided to helping veterans age in place relative to services your organization provided prior to the Pilot? [RELATIVE ADVANTAGE]

Were there other resources, beyond staffing, that this grant provided to improve services to veterans ? [PROGRAM NONSTAFFING RESOURCES; RELATIVE ADVANTAGE]

Did you document within your agency, the average annual cost per participant that the VSSR pilot supported that you can share? [PROGRAM COSTS]

If you could change the VSSR pilot program, what would you change?

Did you have all the resources you needed to implement the Pilot as planned? If not, what was missing and why? [ACCESSIBLE RESOURCES]

Is your organization supportive of continuing VSSR pilot staffing and activities after the Pilot ends? Why or why not? [LEADERSHIP SUPPORT]

What VSSR pilot activities or staffing do you plan to continue after the pilot ends?
[SUSTAINABILITY PLANNING]

Can you describe any strategic planning your organization is doing to continue any of the VSSR services after the grant ends? [STRATEGIC PLANNING]

What source of funding do you plan to use to continue any VSSR activities after the grant ends?
[PLEASE ENSURE THAT FUNDING ASSOCIATED WITH EACH PLANNED VSSR
ACTIVITY IS DISCUSSED] [FUNDING]

Do you think the cost of running the VSSR pilot will make it hard for your organization to keep the program going in the future? Why or why not? [FUNDING]

Are there any policies within your organization or at the county, state or federal level that will help support the delivery of VSSR activities after the grant ends? [POLICY SUPPORT]

Are there any policies that will interfere with the delivery of VSSR activities after the grant ends?

What barriers have you encountered in planning for sustainability? [BARRIERS]

Have you been able to overcome any of those barriers and how so? [SUSTAINABILITY STRATEGIES]

In the past 6 months, how have you or others at your organization disseminated information about your VSSR pilot? By disseminated, we mean things like presentations, writing articles, media coverage, teaching, blogging, tweeting, e.g [DISSEMINATION/MARKETING]

POTENTIAL FOLLOW-UP QUESTIONS:

Are there others at your organization that you think it would be helpful to speak with? If so, can you share with us their contact information?

Leadership Interview Codebook

ID	Parent ID	Depth	Title	Description
1		0	Pilot Planning	
2	1	1	Organization mission/program alignment	Organization's rationale for apply for grant award; perception of need for the pilot
3	1	1	Staff Planning	How organization determined staffing/roles to include
4		0	Pilot Perceptions	
5	4	1	Innovation fit	Program "fit" or alignment/match for the veterans the organization serves
6	4	1	Relative advantage-staffing	Pilot staff supported by the grant help veterans age in place relative to the services previously provided by organization
7	4	1	Relative advantage-nonstaffing resources	Other resources, other than staffing, provided by grant to improve services to veterans enrolled in Pilot
8	4	1	Program costs	Organization's documentation of pilot program costs
9	4	1	Program improvements	What could change to enhance the program
10	4	1	Accessible Resources	Whether organization had all the resources to implement the Pilot as planned
11		0	Sustainability efforts	
12	11	1	Leadership support	Is the organization supportive of continuing pilot activities or staffing after pilot/grant ends?
13	11	1	Sustainability planning	Is the organization planning to continue the pilot activities or staffing after the grant ends
14	11	1	Strategic Planning	Strategic planning activities to continue pilot activities after grant ends
15	11	1	Funding sources	Funding sources to continue pilot activities
16	11	1	Funding barriers	Will costs challenge pilot continuation
17	11	1	Policy support	Whether any county, state or federal policies will help or hinder support to continue pilot after grant ends
18	11	1	Sustainability barriers and strategies	Any barriers encountered in sustainability planning and strategies to overcome them
19	11	1	Dissemination and marketing efforts	Any recent efforts to disseminate information about pilot

Appendix E. Administrative Data Evidence Tables for PSH Impact Evaluation

This appendix presents the studies included in the structured review summarized in Chapter 9. Table E.1 covers eight veteran-specific studies using VA administrative data and/or HMIS. Table E.2 covers eight nonveteran PSH and Housing First studies using Medicaid, county administrative, and HMIS data. Together these 16 studies form the basis for the evaluation design recommendations in Chapter 9.

Table E.1. Veteran-Specific PSH and Temporary Housing Support Programs: Studies Using Administrative Data and Comparison Group Designs (2007–2026)

Study	Program/Service	Intervention	Population	Outcomes Measured	Administrative Data Sources	Research Design	Results
Cheng et al. 2007	HUD-VASH	HUD-VASH (Section 8 housing vouchers + intensive case management) vs. intensive case management only or standard VA care	460 homeless veterans (predominantly male); 4 sites; data 1992-1995	Days housed (primary) - nights in own/family/friend's housing in past 90 days; days intoxicated; housing quality (secondary)	VA administrative data; RCT tracking data	3-arm RCT Reanalysis addressing differential attrition; multiple imputation for missing data	3-year cumulative days housed: HUD-VASH 854 days vs. CM-only 739 vs. standard care 688; HUD-VASH significantly superior to both. Fewer days intoxicated ($p = 0.018$) for HUD-VASH vs. controls.
O'Connell et al., 2012	HUD-VASH	Section 8 vouchers + case management vs. case management alone or standard VA care	259 male homeless veterans with SUD histories; data 1992-1995	Housing outcomes (days housed; same metric as Cheng 2007) by subgroup; socioclinical outcomes by subgroup	VA administrative data; RCT tracking data	3-arm RCT Subgroup analysis by race, diagnosis, substance use status; reanalysis of same 1992-1995 data as Cheng 2007	Better housing outcomes (days housed) for Caucasian veterans, veterans who had a co-occurring psychiatric diagnosis, and active substance users - but no significant housing advantage in the full sample. No significant full-sample effect on socio-clinical outcomes.
Tsai, Peltzman, and Beydoun 2026	HUD-VASH	PSH voucher placement vs. no PSH enrollment among homeless veterans	60,888 HUD-VASH participants matched to homeless veterans not in HUD-VASH; VA data 2017-2021	All-cause mortality; overdose mortality	VA Corporate Data Warehouse (EHR, mortality records, program enrollment)	Propensity score matching (1:1) Retrospective cohort; 6, 12, 24-month follow-up	Mixed: Lower all-cause mortality at 6 months for HUD-VASH group (HR 0.88, 95% CI 0.79-0.98); effect reversed to statistically higher risk by 24 months for HUD-VASH group (HR 1.05, 95% CI 1.00-1.10). Overdose mortality ~2x higher in HUD-VASH throughout follow-up (HRs 1.79-2.29). No significant suicide mortality difference at any time point.

Study	Program/ Service	Intervention	Population	Outcomes Measured	Administrative Data Sources	Research Design	Results
Khatana et al., 2026 ^a	HUD-VASH	Early PSH placement (within 1 month) vs. delayed placement (6+ months) among veterans with cardiovascular disease	970 veterans with cardiovascular disease receiving HUD-VASH vouchers; 2016-2019	Cardiovascular ED visits; cardiovascular hospitalizations	VA administrative data linked to HUD-VASH voucher records	Difference-in-differences Early-housed ($n = 845$) vs. delayed-housed ($n = 125$)	-9.1 pp reduction in cardiovascular ED visit/hospitalization probability (95% CI -17.7 to -0.5; $p = 0.04$) among early placement group. Wide CI limits precision.
Nelson et al., 2021	SSVF	Temporary financial assistance component of SSVF rapid re-housing	Veterans receiving SSVF temporary financial assistance vs. SSVF nonrecipients; national VA data	Total VA health care costs per quarter	VA administrative data; SSVF enrollment records	Matched comparison + DiD SSVF TFA recipients vs. SSVF TFA nonrecipients	Total health care costs averaged \$352 less per quarter among TFA recipients than among nonrecipients. Magnitude of decrease was larger for those in the SSVF rapid re-housing component relative to the homelessness prevention component.
Nelson et al., 2026	SSVF	SSVF program enrollment (any component) vs. no enrollment (housing instable in VA records)	26,649 SSVF enrollees vs. 666,734 non-enrollees; national; Oct 2015-Dec 2018	Inpatient costs (3-year); outpatient costs (3-year); total VA health care costs	VA EHRs linked to HMIS	Inverse probability of treatment weighting (IPTW) Target trial emulation; 693,383 patient-trials	SSVF associated with Inpatient costs -\$10,020 (95% CI -\$13,644 to -\$6,396); Outpatient costs +\$7,534 (95% CI \$6,767-\$8,302). Net shift from inpatient to outpatient care with SSVF enrollment.
Nelson et al., 2022	SSVF	SSVF rapid re-housing temporary financial assistance (TFA)	Veterans enrolled in SSVF; national; Oct 2015-Sep 2018	Inpatient MH costs; outpatient MH costs; outpatient SUD costs; ED costs; residential BH costs	VA administrative data linked to SSVF enrollment records	Multivariable difference-in-differences DiD; natural comparison group (non-TFA SSVF enrollees within the same program); cost subcategory analysis	Per-quarter reductions: Inpatient MH -\$258 ($p < .001$); Outpatient MH -\$28 ($p < .001$); Outpatient SUD -\$25 ($p < .001$); ED costs -\$11 ($p = .003$); Residential BH -\$181 ($p < .001$).

Study	Program/ Service	Intervention	Population	Outcomes Measured	Administrative Data Sources	Research Design	Results
Yoo et al., 2026	SSVF	SSVF enrollment; rural vs. urban differences in program effect	Veterans with housing instability (ICD- 10 Z59.x codes); rural and urban; national VA data	Inpatient length of stay; inpatient costs; outpatient visits/costs; ED utilization; total costs	VA Corporate Data Warehouse + HMIS + VA PSSG Enroller File (rurality)	Difference-in- difference-in- differences (DDD) IPTW; triple interaction (treatment x time x rurality)	Triple interaction (SSVF × time × rurality) nonsignificant for inpatient, outpatient, and total VA cost outcomes. Significant rural-urban divergence for ED utilization and costs across most post-enrollment quarters: urban veterans had small post- enrollment ED reductions while rural veterans showed no significant ED change; overall magnitude small.

NOTE: Studies are ordered chronologically. BH = behavioral health; CM = case management. DiD = difference-in-differences. IPTW = inverse probability of treatment weighting. MH = mental health; SSVF = Supportive Services for Veteran Families; SUD = substance use disorder; TFA = temporary financial assistance.

^a Sameed Khatana, Ahmed M., Jingmei Wu, Peter W. Groeneveld, Victoria J. Reina, Jack Tsai, and Eric T. Roberts, "Permanent Supportive Housing and Cardiovascular Outcomes Among Veterans Experiencing Homelessness," *Journal of General Internal Medicine*, published online March 6, 2026.

Table E.2. Non-Veteran PSH and Housing First Programs: Studies Using Administrative Data and Comparison Group Designs (2009–2023)

Study	Program/Service	Intervention	Population	Outcomes Measured	Administrative Data Sources	Research Design	Results
Larimer et al., 2009	1811 Eastlake Housing First, Seattle	Immediate PSH placement with no sobriety requirements vs. waitlist	95 chronically homeless adults with severe alcohol problems; Seattle, WA	Total multisector service costs; jail/incarceration; use of shelters and sobering facilities; hospital and EMS use; detox and SUD treatment	Linked: jail records, shelter/sobering center records, hospital records, EMS records, Medicaid claims, publicly funded detox/treatment records	Waitlist control Quasi-experimental; 95 housed vs. 39 waitlist controls; 6-month follow-up	53% reduction in total service costs vs. waitlist (rate ratio 0.47; 95% CI 0.25-0.88). Savings primarily driven by billed medical services (hospital/Medicaid; 76.6% of between-group cost offset); also lower jail, shelter, and sobering center use.
Gilmer et al., 2014	FSP, California	Intensive wraparound services + housing support vs. routine county-administered mental health care	10,231 adults with serious mental illness enrolled in CA FSP; Medi-Cal data 2004-2010	Mental health outpatient visits; mental health costs; total service costs	California Medi-Cal (Medicaid) claims; public mental health services records	Propensity score matching + DiD 10,231 FSP vs. 10,231 matched controls with SMI; intent-to-treat pre-post design	\$12,056 higher total annual costs in FSP vs. matched controls; reflects greater service engagement. County variation: inpatient cost declines in San Diego (–\$2,828, $p < .05$) and Los Angeles (–\$1,166, $p < .05$) counties; overall inpatient DiD nonsignificant.
Gilmer, 2016 ^a	PSH for transition-age youth with SMI, California	PSH enrollment for youth with SMI vs. standard public MH services	Transition-age youth (18-24) with serious mental illness; CA public MH services 2004-2010	Total health service costs; inpatient utilization; outpatient utilization	California public mental health services administrative data; Medi-Cal claims	Propensity score matching + DiD Contemporaneous matched controls; higher vs. lower fidelity sub-analysis	\$13,337 higher total health service costs vs. matched controls. Higher-fidelity programs had greater inpatient declines offset by outpatient increases. Reflects greater service access.
Lim et al., 2018 ^b	NY/NY III Supportive Housing, New York City	PSH placement for homeless families vs. continued housing instability	926 adults heading homeless families eligible for the NYC NY/NY III initiative; 2007-2012	Housing stability (2-year); preventable ED visits	NYC Medicaid records linked to shelter and housing administrative data	Marginal structural modeling 300 PSH-placed vs. 626 not-placed; addresses time-varying confounding	87% of PSH-placed achieved housing stability within 2 years (descriptive). Preventable ED visit rate ratio 0.60 (95% CI 0.38-0.96), a 40% relative reduction.

Study	Program/Service	Intervention	Population	Outcomes Measured	Administrative Data Sources	Research Design	Results
Hollander et al., 2021	PSH, Pennsylvania (54 counties)	PSH entry vs. continued housing instability among Medicaid enrollees	1,226 homeless adults entering PSH vs. 970 matched housing-unstable Medicaid enrollees; PA 2011–2016	Total Medicaid spending/month; residential BH spending; inpatient non-BH spending; ED visits per 100 person-months; inpatient stays per 100 person-months	Pennsylvania Medicaid claims linked to PSH program records and HMIS (54 counties; Philadelphia excluded)	Difference-in-differences Propensity-matched housing-unstable Medicaid enrollees; 3-year follow-up	At 3 years: –\$145/month total Medicaid spending ($p = 0.046$); –\$89/month inpatient non-BH; –4.7 ED visits/100 person-months ($p = 0.010$); –1.6 inpatient stays/100 person-months ($p < .001$).
DeLia et al., 2021	PSH, New Jersey	PSH placement vs. no PSH enrollment among Medicaid-enrolled homeless adults	1,442 PSH-placed vs. 6,064 propensity-matched Medicaid enrollees experiencing homelessness; NJ	ED visits; ED-associated spending; total cost of care; pharmacy spending	NJ Medicaid Management Information System (MMIS) linked to HMIS; 6 quarters pre/post	Difference-in-differences Propensity score matching; 6 quarters pre/post housing placement	PSH associated with –14.3% ED visits ($p < .001$); –25.2% ED-associated spending ($p < .001$). No significant total cost reduction across groups, increased pharmacy spending offset acute care savings.
Grove et al., 2023	PSH, North Carolina	PSH enrollment vs. no PSH, stratified by prior living setting (institutional vs. community)	NC Medicaid enrollees with disabilities entering PSH 2014-2018	Hospitalizations; ED visits; primary care visits	NC Medicaid claims linked to PSH program records	Propensity score weighting (ATT) Stratified by prior setting; 12-month follow-up	Institutional-entry: more hospitalizations and ED visits. Community-entry: no significant differences. Prior setting is a critical moderator of PSH effects.
Hunter et al., 2023	Just in Reach Pay for Success (JIR PFS), LA County	PSH placement for chronically homeless adults with justice involvement and behavioral health needs	336 PSH-placed individuals vs. 672 propensity-matched individuals eligible but not enrolled; LA County	Jail days; jail service costs; mental health service use	LA County administrative records: jail records, county mental health records, homeless services records	Before-after + propensity-matched comparison group Year 1 and Year 2 post-placement outcomes	PSH group had ~24 fewer jail days in Year 1 (~\$16,891 savings/participant). Year 2 reduction (12 days) not statistically significant. Mental health and other service use increased post-placement.

NOTE: Studies are ordered chronologically. DiD = difference-in-differences. ATT = average treatment effect on the treated. MMIS = Medicaid Management Information System. SMI = serious mental illness. NY/NY III = New York/New York III Supportive Housing Initiative. JIR PFS = Just in Reach Pay for Success. EMS = emergency medical services.

^a Todd P. Gilmer, “Permanent Supportive Housing for Transition-Age Youth with Serious Mental Illness,” *Psychiatric Services*, Vol. 67, No. 3, March 2016.

^b and Preventable Health Care among Homeless Families,” *Health Services Research*, Vol. 53, No. 5, October 2018.

Abbreviations

ACT	Assertive Community Treatment
ADL	activity of daily living
BHSA	Behavioral Health Services Act
CalVet	California Department of Veteran Affairs
CI	confidence interval
CoC	continuum of care
CPI-U	Consumer Price Index for All Urban Consumers
EHR	electronic health record
FMR	Fair Market Rent
FSP	Full Service Partnership
HMIS	Homeless Management Information System
HUD	U.S. Department of Housing and Urban Development
HUD-VASH	U.S. Department of Housing and Urban Development–Veterans Affairs Supportive Housing
IADL	instrumental activity of daily living
OR	odds ratio
PATH	People Assisting the Homeless
PHA	public housing authority
PSH	permanent supportive housing
PTSD	posttraumatic stress disorder
RCT	randomized controlled trial
SD	standard deviation
UCLA	University of California, Los Angeles
VA	U.S. Department of Veterans Affairs
VAGLA	Veterans Affairs of Greater Los Angeles
VSSR	Veterans Support to Self-Reliance

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