



Evaluation of the Healthy Housing Initiative

FINAL REPORT

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Executive Summary

This report provides a thorough evaluation of Catholic Charities USA's (CCUSA) five-year Healthy Housing Initiative (HHI). The HHI program was piloted from January 2020 through December 2024 in response to the worsening homelessness issue in the United States and the desire to see how a CCUSA/Catholic Health system collaboration could help address it. The goals of the HHI program were to (1) house at least 20% of people who experienced chronic homelessness in the five pilot cities (Detroit; St. Louis; Las Vegas; Portland, Ore. and Spokane) based on the U.S. Department of Housing and Urban Development (HUD) 2019 Point in Time (PIT) numbers; (2) decrease the numbers of emergency room visits/hospital stays of those housed by at least 25%; and (3) connect 35% of newly housed persons to primary care and behavioral health services.

The purpose of this evaluation is to examine whether the program reached its three goals and to assess the impact of the employed strategies, while also offering recommendations for best practices going forward. The evaluation further addresses findings relevant to project implementation, service, and program outcomes. For this evaluation, we considered a variety of factors, including:

1. HHI site observations;
2. The up-to-date descriptive results from the baseline survey and the short follow-up surveys conducted via an online survey tool;
3. Differences in various outcome variables (e.g., emergency room visits, hospital stays, and connections to healthcare providers) between the baseline survey and the short follow-up surveys;
4. Results from the qualitative in-depth interviews with the clients, caseworkers, and healthcare providers; and
5. An analysis on cost savings.

Our evaluation employed a mixed-method approach, including quantitative and qualitative analysis. Our evaluation indicated that the HHI program has had a positive impact. For example, the health indicators, including self-rated mental and physical health, as well as incidence of addiction, have improved among clients being housed by the HHI program. The major outcomes of interest, including the number of emergency room (ER) visits and hospital stays, decreased for HHI-housed clients. In addition, the average number of ER visits and hospital stays per person decreased. Our results also indicated that the number of clients with primary care and behavioral health providers increased after being housed.

Qualitatively, interviews with residents underscored the program's transformative impact, highlighting feelings of safety, dignity, and support that come from stable housing and consistent care. Participants described improved relationships with providers, greater engagement with the healthcare system, and renewed hope for long-term recovery and stability. The cost savings analysis estimated \$4.91 million in savings as a result of the reduced ER visits and hospital stays for the 402 surveyed clients during their first six months of housing. Beyond the stated goals, the Healthy Housing Initiative demonstrated that collaborations between service agencies and health systems can improve health, reduce public costs, and help restore humanity to individuals who have been marginalized.

A Message from the President

Dear Friends,

As we wrap up the five-year Healthy Housing Initiative (HHI), there is so much to be thankful for. Not least of all, there is the long-term commitment of the bishops and the work of the five participating Catholic Charities agencies, whose passionate commitment to the well-being of clients facing chronic homelessness in their communities is the fuel that powered this program from day one. We are also appreciative of our evaluation partner, Delaware State University, whose expertise was instrumental in the collection and evaluation of data.

Thanks to the team at Catholic Charities USA—Brian Corbin, Timothy Crawl-Bey, Curtis Johnson, Katherine Moosally, Angelica Reyes, Anthony Sciacca, and Ben Wortham—for tirelessly shepherding this project from inception to completion. And finally, HHI was launched under the leadership of my predecessor, Sister Donna Markham, OP, whose belief in the program helped power it through many challenges, including the Covid-19 pandemic.

The time, money and effort expended by our Catholic Charities agencies—in Detroit, Las Vegas, Portland (Ore.), St. Louis and Spokane—and the collaboration with Catholic hospitals and healthcare partners—Ascension, Common Spirit, Providence, Mercy, and SSM—to provide access to social services, primary medical care, and behavioral and mental health services paid off abundantly for the 792 individuals who found permanent housing as a result of the initiative. That's 113% of the original goal, which also included connecting clients to a primary physician and reducing hospital visits, goals that were achieved, as well. On top of these successes, 970 additional housing units—both permanent supportive housing and other affordable units—have been developed or are under construction by these agencies.

The men, women and children whose lives have been changed for the better by the Healthy Housing Initiative are real people who have received extensive case management services and care for their whole selves, allowing them to build healthier, more fulfilling lives.

These clients are the ones who did the hard work of remaking their circumstances, with the loving care of Catholic Charities staff members, who truly see in them the face of Christ. The Healthy Housing Initiative is an extension of the commitment of the Catholic Charities network to the Gospel mandate of serving our sisters and brothers in need. Its impactful outcomes are a model of what can be achieved through committed engagement and collaboration.

With deep gratitude,



Kerry Alys Robinson
President & CEO

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The Healthy Housing Initiative Project: Background and Overview

The Healthy Housing Initiative (HHI) was conceived by Catholic Charities USA (CCUSA) amid the national homelessness crisis. In 2017, a group of subject matter experts discussed the need to develop high-impact housing solutions across the United States with local Catholic Charities agencies. The objective was to explore a large-scale design to address the integration of housing infrastructure and healthcare. The project would consider investment capital, housing supply, policies relating to health, behavioral health and housing, demographics, and affordability.

CCUSA analyzed existing capacity and infrastructure within their network and submitted a proposal to The Kresge Foundation to underwrite a Health and Housing Innovation Lab, convening a group of regional and national thought leaders from the health and housing sectors. In June 2018, 41 professionals from 16 national/regional organizations and 12 local Catholic Charities agencies met in Chicago for a focused conversation and action planning. The process for the lab included a general presentation and discussion on innovations in health and the role that human services organizations play and three plenary panel discussions on a) housing innovations—what works and what does not, b) housing innovations—theory to practice and c) financing and leveraging of resources.

Through a Health and Housing Innovation Lab, CCUSA developed a five-year pilot program, “The Healthy Housing Initiative (HHI)” designed to combat homelessness. The program ran from January 2020 to December 2024 and was a person-centered, comprehensive approach to combat chronic homelessness through permanent supportive housing and social services. The Catholic Charities agencies also collaborated with Catholic healthcare to provide assistance to people who experienced chronic homelessness. The goals of the HHI program were to (1) house at least 20% of individuals who have experienced chronic homelessness in the pilot cities based on the 2019 Point in Time (PIT) count; (2) decrease emergency room/hospital utilization of those housed by at least 25%; and (3) connect 35% of newly housed persons to primary care and behavioral health services.

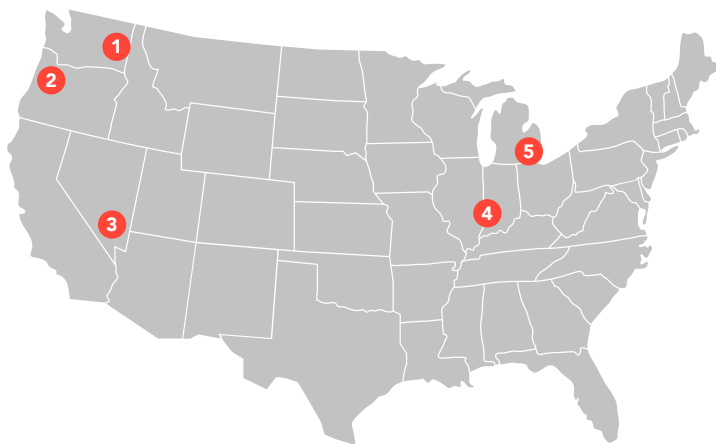


Figure 1. HHI Pilot Catholic Charities agencies

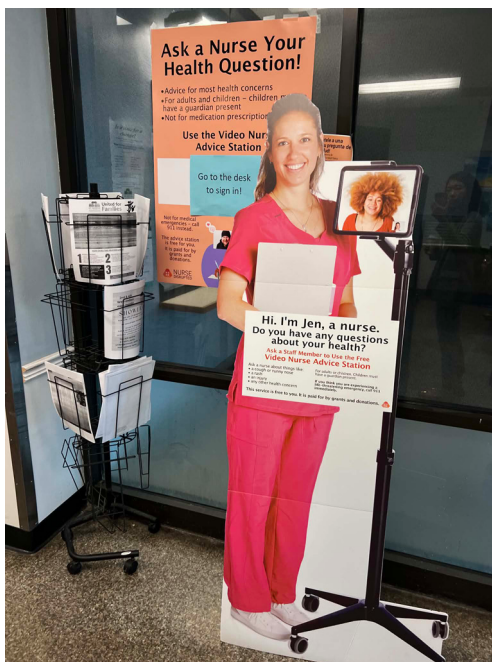
1. Catholic Charities of Eastern Washington
2. Catholic Charities of Oregon
3. Catholic Charities of Southern Nevada
4. Catholic Charities Archdiocese of St. Louis
5. Catholic Charities of Southeast Michigan

In order to participate as an HHI pilot, Catholic Charities agencies had to meet three requirements: the agency needed the full and complete support and commitment of their (arch)bishop to the initiative; the agency should have a partnership with a Catholic health system or other health provider; and the agency should have affordable housing real estate development capacity and integrated health capacity or a realistic plan to attain both. Five Catholic Charities agencies became part of this HHI pilot program. The agencies included Catholic Charities of Southeast Michigan (CCSEM) in Detroit; Catholic Charities of the Archdiocese of St. Louis (CCSTL) in St. Louis; Catholic Charities of Southern Nevada (CCSN) in Las Vegas; Catholic Charities of Oregon (CCO) in Portland; and Catholic Charities Eastern Washington (CCEW) in Spokane. The pilot cities are marked in Figure 1. The Catholic hospitals included Ascension St. John Hospital (which later merged into the Henry Ford Health System and continues the relationship) in Detroit, Mercy Health and Sisters of St. Mary (SSM) Healthcare in St. Louis, Common Spirit Healthcare in Las Vegas, Providence St. Joseph Healthcare in Spokane, and Providence St. Joseph Healthcare in Portland.

The pilot cities provided unique opportunities to assess the effectiveness of the HHI program in diverse settings, as each city has different approaches tailored to their circumstances and populations. The cities differed in terms of geographical location and demographics. In addition, each city possesses a unique history and infrastructure as it relates to addressing homelessness.

Pilot Cities Overview and Site Visits

This section provides a brief overview of the economic and demographic background of the five pilot cities (St. Louis, Detroit, Las Vegas, Spokane, and Portland, Ore.). The overview aims to shed light on the common causes of homelessness in these cities, while also recognizing the differences. For example, some commonalities include a lack of affordable housing, mental health issues, and substance abuse. This section also includes some highlights of the HHI site visits and observations.



St. Louis, Missouri

As the “Gateway to the West,” St. Louis experienced rapid growth both in its economy and population during the early to mid-20th century. However, in recent years, St. Louis has experienced continued population decline. According to the American Community Survey (ACS), conducted by the U.S. Census Bureau, the total population of the city of St. Louis was about 301,000 in 2020, and the population dropped to about 280,000 in 2024. In terms of racial composition, 48% of residents identified as non-Hispanic Whites and 43% non-Hispanic Blacks. The poverty rate in the city was nearly 20%. This number was much higher than the national average (11.1% in 2023).

One major challenge St. Louis has faced is a substantial number of vacant and abandoned homes. Due to a variety of factors including but not limited to population decline, suburbanization, racial segregation, manufacturing job loss, and policy failures, there are an estimated 25,000+

vacant and abandoned properties in St. Louis. The 2019 PIT count reported a total of 1,031 homeless persons in the city (PIT count for chronic homelessness: 235). Black/African American residents have been disproportionately represented, making up nearly 70% of the homeless population.

Organizations such as the St. Patrick Center (a ministry of Catholic Charities of the Archdiocese of St. Louis that has been combatting homelessness since 1983) have been spearheading efforts to provide coordinated housing and supportive services. However, ongoing challenges, such as generational poverty, high eviction rates, and insufficient mental health resources, have continued to hamper progress toward reducing homelessness in the city.

The evaluation team visited St. Louis on October 2 and 3, 2024. St. Patrick Center is the epicenter of services for people experiencing homelessness and those experiencing poverty in downtown St. Louis, serving as the lead agency in the city of St. Louis' continuum of care. In addition to their own impressive array of services, they have been actively working with governmental entities, community-based organizations, scattered site landlords, and healthcare partners to find housing, establish wraparound services, and address the needs of vulnerable populations.

Important highlights of the visit that allowed us to observe the work of the St. Louis site included:

- Meeting with private property owners (landlords) who provided HHI housing to understand their role and perspectives on permanent supportive housing (PSH);
- Meeting with the CEO of the St. Patrick Center, a big supporter of the HHI program, who stated in relation to working to address the homelessness crisis, "How can we bring new ideas to the problem? In the scale of what we are doing here across St. Patrick Center, it is a small piece of what we do, but it has the opportunity to change the game, disrupt, and approach things in different ways. And I think we need more of that. So, it's a wedge. It's a place where we're showing we can do things differently and have great outcomes.";
- Meeting with healthcare partners SSM St. Louis University Hospital and Barnes Jewish Hospital to hear about their work with CCSTL on homelessness and health outcomes, including a Catholic Charities caseworker directly embedded at SSM; and
- Tours of areas where homeless individuals congregated to get a better understanding of the state of homelessness in the city.



Detroit, Michigan

Also known as the "Motor City," Detroit used to be one of the largest and wealthiest cities in the U.S. However, due to a variety of factors, including the decline of the automobile industry, Detroit's population has continued to decline. It has experienced the steepest decline among the largest U.S. cities (65% decrease since 1950). The population in Detroit was estimated to be 639,111 based on the 2020 U.S. Census official count. In terms of racial composition, 77% of residents identified as Black/ African American, 12% as White, and 8% as Latino or Hispanic American. The city has faced decades of economic challenges, resulting in widespread poverty and unemployment. For example, 32% of the residents lived below the poverty line, a number much higher than the national average (11%). In 2023, the median household income was reported as \$38,100, much lower than the national average of \$80,610. Homelessness in Detroit has

been shaped by economic disparities and a lack of affordable housing. Based on the PIT count, 1,965 people experienced homelessness in Detroit in 2019 (PIT count for chronic homelessness: 279).

On October 28 and 29, 2024, the evaluation team visited the site. Key highlights included:

- Touring the Center for the Works of Mercy – which provides case management, a soup kitchen, food pantry, clothing closet, partnerships with a free dental and medical clinic, and programs for the previously incarcerated;
- Visiting a new CCSEM site under construction in a repurposed CVS Pharmacy building;
- Meeting with the director of the Homelessness Advocacy Network of Detroit (HAND);
- Learning about community programs at the Cathedral of the Blessed Sacrament;
- Touring the Solanus Casey Center (a Catholic community partner run by the Capuchin Friars of the Province of St. Joseph) and learning of their prisoner reentry program with a bakery and large, busy soup kitchen down the street;
- Touring an old Catholic school that was being converted to HHI housing units; and
- Visiting Henry Ford St. John Hospital and meeting with the nursing supervisor and director of case management about their healthcare partnerships with CCSEM and concerns about the use of the ER by homeless individuals.



Las Vegas, Nevada

Las Vegas' economy is heavily reliant on tourism and hospitality and was significantly impacted during the pandemic. It has maintained a steady population, with approximately 660,929 residents as of the 2023 American Community Survey estimate. In terms of racial/ethnic background, about 49% of residents identified as White, 12% Black/African American, and 34% Hispanic or Latino. The median household income was \$70,723 in 2023.

The city has faced challenges with homelessness, partly due to the high cost of living and limited affordable housing options. Las Vegas had the lowest number of affordable and available rental units for low-income renters (14 per 100) and one of the highest rates of "cost-burdened" poor renters among U.S. cities: 75% of renters with incomes 80% or less area median income (AMI) levels pay more than 30% of their earnings on rent (National Low Income Housing Coalition, 2020). The PIT

count in Las Vegas was 5,530 in 2019 (PIT count for chronic homelessness: 620). In addition, about 34% of those counted were categorized as chronically homeless. Major factors contributing to homelessness have included unemployment, mental health issues, and substance abuse.

In January 2025, the evaluators visited CCSN in Las Vegas, gleaned valuable insights and information through their experiences, which included:

- An in-depth tour of the campus including the food pantry, Meals on Wheels production line, Housing Navigation Center, community dining facility, and affordable housing units;
- Meeting with Common Spirit and exploring their partnership with CC Southern Nevada;
- Visiting the city-run Courtyard Recuperative Day Center, where homeless individuals can gather freely, store belongings, rest, and meet with service providers if they so choose; and
- A tour of CCSN-owned St. Vincent's apartments with an overview of services and challenges.



Spokane, Washington

The city of Spokane's population has experienced modest growth, reaching approximately 229,000 residents in 2023. The majority of Spokane's population identified as non-Hispanic White (~80%). The non-White population included 2.7% Black/African American, 2.9% Asian, 1.3% American Indian or Alaska Native, 7.8% Hispanic, and nearly 10% who reported being of two or more races. The city's economy has proven to be diverse, with many residents employed in healthcare, education, and manufacturing industries. The median household income was \$65,745 in 2023. The poverty rate was 12.2%.

The city of Spokane and Spokane Valley constitute the Spokane-Spokane Valley Metropolitan Statistical Area (MSA). It is the largest metropolitan area in eastern Washington, where CCEW serves. The population in the

Spokane-Spokane Valley MSA was estimated to be around 605,000 in 2024. In terms of racial/ethnic background, the area is predominantly White, about 86%.

One challenge this area has been facing is the surging opioid and fentanyl crisis, since Spokane lies on a major drug trafficking route. The affordability and availability of fentanyl, combined with economic vulnerabilities, including poverty, insufficient mental health services, and limited treatment infrastructure, have contributed to the growing fentanyl crisis in Spokane (both the city and the MSA). Homelessness in Spokane has been a growing concern. The 2019 PIT count found that 1,309 people faced homelessness in Spokane County (PIT count for chronic homelessness: 255). The city has implemented various actions to address homelessness, such as expanding shelter capacities and providing supportive housing programs. The emergency shelter capacity increased from 1,242 beds in 2023 to 1,381 beds in 2024.

Although demographically the homeless population has been predominantly White in Spokane, racial disparities resembling national trends persist in Spokane's homeless population. For example, African Americans are disproportionately represented in the homeless population in Spokane. African Americans constituted 2% of the population in Spokane, but accounted for 9% of the homeless population, based on the 2019 data. This racial disparity persists in the 2024 PIT data. According to a survey conducted in 2023, common reasons for homelessness in Spokane have included a lack of affordable housing (20%) and drug abuse (12%).

The evaluation team visited Spokane on March 10 and 11, 2025. CCEW has built strong partnerships and created a playbook to help launch respite care programs. They have repurposed old hotels into transitional housing and focused on cost-saving, preventative solutions. Their efforts have eased pressure on hospitals and taxpayers, as shelters and housing have reduced emergency room use and improved outcomes. Highlights of the visit included:

- Touring multiple supportive housing "havens" built as part of HHI, each offering 48 to 75 service-enriched apartments pairing residents with caseworkers and on-site support;
- Interviewing staff members of the Molina Health Clinic, which provided its MyHealth Mobile Unit to enhance access to healthcare for underserved individuals;

- Interviewing the president and CEO of CCEW on the agency's expansion of housing in the face of limited public support, community hostility, and the fentanyl crisis; and
- Tours of Catholic Charities congregate shelters, including the House of Charity, which has respite beds through its partnership with Providence St. Joseph Hospital, which also answered questions submitted later about their working relationship with Catholic Charities.



Portland, Oregon

Portland's population was about 630,498 in 2023. Non-Hispanic Whites accounted for about 68% of the population, followed by Hispanic/Latinos about 11%, Asians about 8%, and Black/African American about 6%. The city's economy has remained strong, with median household income of \$88,792 in 2023. The poverty rate was about 12%. However, Portland has experienced a housing affordability crisis. The housing market remained tight with median home prices reaching \$550,000 in May 2025 (Redfin, 2025). This number was much higher compared to the median price of a home in the U.S., \$441,738 (Redfin, 2025).

Homelessness has been a significant issue in Portland, with visible encampments and public debates over policy responses. Based on the PIT count, Portland had about 4,015 people who experienced homelessness in 2019 (PIT count for chronic homelessness: 2,100). The city has implemented various actions, including increased funding for shelters and supportive housing, as well as shifts in policy to address public safety concerns and drug use. Demographically, the homeless population included a higher proportion of Black and Native American individuals compared to their representation in the general population. Contributing factors to homelessness included mental health challenges, substance abuse, and a shortage of affordable housing.

The HHI program evaluators visited Portland on March 12 and 13, 2025. Highlights and key takeaways included:

- Visiting new PSH sites such as Frances & Clare Place, Beacon at Glisan Landing, and Good Shepherd Village, with each featuring on-site case management and integrated healthcare;
- Gaining a greater understanding of partnerships with Cascadia Healthcare and the Native American Rehabilitation Association;
- Interviewing the quality assurance manager of Catholic Charities of Oregon to understand the housing sites and services provided to residents of these units, particularly those with untreated mental health conditions and chronic health issues; and
- Attending a meeting for a community support strategy session at Good Shepherd Village with its staff, which highlighted the value of integrating housing with social services to improve resident engagement and health outcomes.

Site Visit Summary

Considering the characteristics and backgrounds of the five HHI pilot cities, we discovered similarities and differences in the homelessness crisis across them. For example, all five cities have a limited number of quality, affordable housing units and mental health facilities. As old industrial cities, St. Louis and Detroit have been facing economic decline and decreasing populations. In addition, urban decay and housing vacancy rates have remained high in these two cities. In the book *Homelessness is a Housing Problem*, by Colburn and Aldern (2022), the authors categorized St. Louis and Detroit as facing similar issues and argued that, with the right policies and resources, the vacant/abandoned buildings in these cities could be used to help alleviate homelessness. In Portland, limited affordable housing has contributed to a rapid increase in homelessness. Moreover, Portland and Spokane (both located in the West) have each been suffering from a growing fentanyl crisis. As a tourist city, Las Vegas has faced unique challenges related to gambling, drug use, and associated social problems. We also found that, between 2019 and 2024, the PIT count dropped in Detroit (1,725 PIT count in 2024; a decrease of about 12% compared to 2019), but there was a dramatic increase in the other four cities, as follows: St. Louis (1,235 PIT count in 2024; about 20% increase compared to 2019), Las Vegas (7,906 PIT count in 2024; about 43% increase compared to 2019), Spokane (2,021 PIT count in 2024; about 101% increase compared to 2019), and Portland (7,384 PIT count in 2024; about 84% increase compared to 2019).

The site visits and observations provided the evaluators the opportunity to assess each site's unique approaches to addressing the homelessness problem in their city and to meeting the goals of the HHI program. Table 1 summarizes the unique approaches of and challenges faced by each site. For example, conveniently located in downtown St. Louis, the St. Patrick Center has historical roots in its community. It is well known to the vulnerable and homeless communities of the surrounding area. The caseworkers at the St. Patrick Center routinely meet with unsheltered individuals on the streets and provide them with information and resources. Consistent with the objectives of the HHI program, St. Patrick Center strategically collaborates with private landlords to provide housing in units scattered throughout the city. This strategy helps alleviate the permanent housing shortage. In addition, St. Patrick Center works closely with local hospital systems, including Mercy Health, Barnes-Jewish Hospital, and SSM HealthCare. The healthcare systems in St. Louis also support the permanent housing approach to helping the homeless. For example, caseworkers at St. Patrick Center have access to the hospital's system to track clients' housing and health.

CCSEM in Detroit, on the other hand, faced some barriers, including a funding cut and a shortage of caseworkers. Despite the unexpected difficulties, CCSEM collaborated closely with local churches and religious denominations to provide resources to vulnerable populations. One highlight of the CCSEM site was the conversion of an unused and vacant Catholic school into affordable and permanent supportive housing. This further demonstrated the ability of Catholic Charities' collaboration with Catholic organizations to form a strong, united front for addressing the homelessness crisis.

In summary, the cities of Detroit and St. Louis share a similar history and recent economic decline, including economic shifts, population loss, abandoned properties, and racial segregation. Catholic Charities in these two cities leveraged their unique advantages and adopted different strategies for carrying out the HHI program's objectives.

CCEW in Spokane has housed a large number of clients (N=446), many of whom suffer from mental health and substance abuse issues. During the site visit, many CCEW staff and clients expressed that many residents in Spokane have voiced opposition to building supportive housing. Despite the hurdles, CCEW successfully developed and built multiple apartment buildings to provide affordable and permanent housing. CCEW's housing team has continued working with the city and county at different levels to acquire permits to build more affordable housing. Many caseworkers in the HHI program also have

relevant lived experience, which has afforded them a better understanding of client needs and has allowed them to form closer connections with the clients. Thus, the caseworkers may be especially well-equipped for helping retain clients in their program. However, many clients and caseworkers in Spokane expressed concerns about the shortage of healthcare providers and the long waitlists to be seen by a mental health provider. Many clients mentioned harboring distrust toward the medical system and recounted prior negative experiences with doctors/medical staff.

Portland is known for having a shortage of affordable housing. Fortunately, the Catholic Charities agency in Portland has been able to build supportive housing in more affluent and safer areas. This observation is consistent with the interview finding that many clients felt safe in their housing. But despite having on-site behavioral health coordinators to help connect clients with mental health providers, there is still a long wait to be seen by primary and mental health doctors. In addition, Portland and Spokane are both ravaged by the ever-growing fentanyl crisis, with many clients suffering from fentanyl addiction and mental health issues. The shortage of mental health providers in both cities exacerbated the crisis. Despite these challenges, both Catholic Charities agencies were able to develop and build new units of permanent supportive housing while having caseworkers with experience assist clients in navigating housing and healthcare.

Lastly, CCSN in Las Vegas is located on a large, centralized campus, neighboring other local organizations and shelters that aim to help the homeless. The campus provides a full range of services, from food pantries and dining facilities to affordable housing units. Having multiple services available on campus is especially convenient and unique to the Las Vegas site. In addition, a large team of caseworkers works closely with HHI clients. The evaluators observed that the caseworkers have formed strong supportive relationships and have built an effective rapport with clients. For example, caseworkers were very knowledgeable about their clients' backgrounds and prior struggles.

Table 1. Approaches and challenges to addressing homelessness, by site

Site	Approaches/Advantages	Unique Challenges
CCSTL, St. Louis	Direct work with landlords History and longevity of the St. Patrick Center Collaboration with hospital systems	Many homeless individuals staying in abandoned housing (i.e., squatting) and not utilizing shelters and other services Staggering economic issues
CCSEM, Detroit	Strong connections with other religious denominations Converting surplus church property into housing	Lack of caseworkers and funding cuts in the recent years
CCSN, Las Vegas	Large case management team Centralized campus location with many services	Migration to and from Las Vegas is high, due to Las Vegas being a tourist city. Thus, some clients are difficult to track.
CCEW, Spokane	More PSH units than in other pilot cities Caseworkers with lived experience	Significant substance use issues Conservative and political conflicts Spokane residents hold opposing views on homelessness and substance abuse
CCO, Portland	Sites in more affluent areas, more safety PSH units are new On site behavioral health coordinators	Long wait to get primary care and mental health providers

Literature Review

Homelessness, Health, and Healthcare

The number of people experiencing homelessness in the United States is staggering. Each year, the U.S. Department of Housing and Urban Development (HUD) conducts a PIT count and analyzes the data for national and state changes. In HUD's 2024 PIT count, 771,480 people were identified as homeless nationally, representing an 18% increase over 2023, the most significant jump since HUD began recording these data in 2005 (National Alliance to End Homelessness, 2024). The 2024 PIT count also revealed that the number of people who experienced homelessness increased in the majority of the states, in urban, suburban, and rural areas (HUD, 2024). This increase places a significant burden on healthcare systems, particularly hospitals, which often serve as a safety net for homeless individuals.

Homeless patients often require complex care for chronic illnesses, mental health conditions, and substance use disorders, leading to high costs. For example, emergency department (ED) visits by homeless individuals cost an average of \$3,700 per visit, with frequent users accumulating annual costs of up to \$44,000 (Doran et al., 2019). In addition, homeless patients have longer hospital stays, typically two days more than individuals with stable housing. This may lead to limited availability of beds in hospitals and an increased use of medical resources (Kertesz et al., 2021). Based on data from the National Inpatient Sample (2017–2019), psychiatric and behavioral health issues can account for almost half of all hospital stays for homeless patients, contributing to a nationwide hospital cost of \$9.5 billion annually (Fingar et al., 2023).

It is well-documented that people experiencing homelessness have poorer health outcomes than the general population. According to research conducted by Bedmar et al. (2022), the life expectancy of homeless people can be as much as 30 years shorter than the general population. Around 60 to 80% of homeless individuals experience serious health issues, such as mental illness, substance use disorders, or other concurrent disorders, indicating an urgent need to improve access to healthcare (Bednar et al., 2022). Mental health disorders common among the homeless population include depression, anxiety, and schizophrenia (Fazel et al., 2008), and these disorders often coincide with substance use disorders, which complicates treatment and long-term recovery. In addition, studies have shown that individuals experiencing homelessness suffer disproportionately from chronic illnesses such as diabetes, hypertension, and cardiovascular disease (Baggett et al., 2013). Respiratory infections, skin disorders, and foot problems are also prevalent among the homeless population due to unsanitary living conditions (Kushel et al., 2001). Because of the physical and mental health issues associated with prolonged homelessness, additional problems have become more common among the homeless, including HIV/AIDS, Hepatitis A, and tuberculosis. From a mental health perspective, while mental illness can lead to homelessness, some conditions are caused or worsened by homelessness. Among these are schizophrenia and bipolar disorder. Serious chronic mental illnesses can make it challenging to maintain a stable and "normal" lifestyle (Institute of Medicine, 1988). Stressors inherent with being homeless can also exacerbate health issues. Stressors include harmful weather conditions, violence, and malnutrition. Housing may be the key to mitigating the public health impact of homelessness (Lee, 2021).

The most common way that homeless individuals access healthcare is through emergency room visits. This limits their quality of care, ability to book follow-up visits, and long-term access to medication. In addition, people coming to the emergency room might have to wait for extended periods before they can be seen by a doctor. This could overburden healthcare professionals and the hospital. Reducing emergency room visits for preventable or non-emergency health issues would benefit all involved (Vohra et al., 2022). The CDC estimates the rate of visits to hospital emergency departments by persons experiencing

homelessness increased from an estimated 141 visits per 100 persons per year during 2010/2011 to 310 during 2020/2021, while rates of visitation by non-homeless individuals remained constant over the same period (CDC, 2023). When homeless individuals have stable, long-term housing, they can visit the doctor more regularly and make fewer visits to the emergency room. This could save hospitals and insurers money, while also providing added benefits to the general population.

Several healthcare interventions have been explored in a variety of contexts. A longitudinal study conducted by Koh et al. (2020) investigated the health outcomes for those enrolled in the Boston Health Care for the Homeless Program from 2013 to 2015. The investigators examined healthcare spending through Medicaid for those in the program compared to members of the general population who were also enrolled in Medicaid but not homeless. The average homeless individual demonstrated two to five times higher healthcare and emergency department care spending, even when controlling for health risk scores (Koh et al., 2020). Mortality rates for those experiencing homelessness were 1.5 times higher than those of the general population. Rates of heart disease, HIV/AIDS, and hospital utilization/stays were also substantially higher than those of the general population (Otokiti et al., 2018). Similarly, evidence has shown that mental illness and substance use have profound negative impacts among the homeless.

Approaches to Addressing Homelessness and Health Challenges

Communities have adopted a range of approaches to combat homelessness, reflecting differences in local needs, resources, and policy priorities. Housing First models prioritize rapid placement into permanent, stable housing without preconditions, coupled with voluntary supportive services, and have been shown to be effective for individuals experiencing chronic homelessness. In contrast, treatment-first or transitional housing approaches emphasize sobriety, employment, or program participation before permanent housing is offered, which some communities use for specific subpopulations, such as people in recovery or youth. Many cities also invest in prevention and diversion strategies, including rental assistance, eviction prevention, and mediation, to stop households from entering homelessness in the first place. More recently, systems-level strategies—such as coordinated entry, data-driven targeting through the Homeless Management Information System (HMIS), and cross-sector collaboration among housing, health, and social service agencies—have aimed to improve efficiency and equity in service delivery. Collectively, these approaches underscore the importance of combining housing solutions with long-term structural investments in affordable housing and social supports.

The Housing First (HF) approach was developed in the early 1990s by Dr. Sam Tsemberis in New York City through the Pathways to Housing program; the model has since been implemented internationally and has reshaped the landscape of homelessness interventions (Tsemberis et al., 2004). HF means unconditionally moving those experiencing homelessness into housing and then offering supportive services. HF asserts that housing is a basic human right and serves as a foundation for recovery and well-being. The HF pathway typically includes scattered-site or congregate permanent supportive housing (PSH), paired with voluntary, person-centered support services, such as case management and healthcare (Padgett et al., 2016). Housing First is a policy and practice framework that prioritizes immediate access to permanent housing for people experiencing homelessness, without preconditions such as sobriety, psychiatric treatment, or participation in services. Housing First initiatives have reduced chronic homelessness by 30% and saved healthcare systems between \$2,500 and \$30,000 per person annually (Jacob et al., 2021). This approach not only reduces strain on hospitals but also improves outcomes for vulnerable populations by addressing the root causes of homelessness and health disparities.

Multiple randomized controlled trials and longitudinal studies have demonstrated the effectiveness of HF in reducing chronic homelessness, particularly among individuals with co-occurring mental health and substance use disorders. Tsemberis et al. (2004) found that 88% of HF participants remained housed after five years, compared to significantly lower rates in treatment-first models. A Canadian study, the At Home/Chez Soi project, also showed strong housing retention rates and improvements in quality of life for participants in five cities across the country (Goering and Streiner, 2015). In addition, HF has been associated with improved self-reported health outcomes, increased use of primary care, and decreased reliance on emergency services. Larimer et al. (2009) found that HF significantly reduced hospital and jail visits among chronically homeless individuals with severe alcohol use disorders. Other studies have reported reduced emergency department visits and psychiatric hospitalizations (Rog et al., 2014). However, findings on mental health and substance use outcomes are mixed. Some studies show only modest or no improvements in clinical outcomes unless intensive services are also provided (Padgett et al., 2016). Regarding potential financial benefits, a substantial body of evidence supports the cost-effectiveness of HF. By reducing the use of high-cost public services such as emergency departments, shelters, and jails, HF can offset or even surpass the cost of providing housing and supportive services (Culhane, 2008). The Denver Housing First Collaborative, for example, demonstrated that HF resulted in average cost savings of over \$30,000 per person per year (Perlman & Parvensky, 2006).

Traditional homelessness interventions often follow a “treatment first” or “continuum of care” model, which requires individuals to demonstrate housing readiness through compliance with service plans, sobriety, or mental health stabilization. Treatment-first interventions offer several important benefits, particularly for certain populations and service contexts. By requiring participation in substance use treatment, mental health services, or other structured programs before permanent housing placement, these interventions can provide a highly supportive and supervised environment for individuals who need intensive stabilization. This approach may help participants address acute behavioral health conditions, develop daily living skills, and establish routines that support long-term housing readiness. Treatment-first models can also promote accountability and engagement with services, which some providers view as beneficial for individuals who are motivated for recovery or who prefer structured settings. While not universally effective for all populations, treatment-first approaches can be particularly valuable when aligned with client needs and offered alongside targeted pathways to permanent housing.

As states, localities, and the United States as a whole attempt to address the growing homelessness epidemic in the post-COVID era, debates surrounding potential policies and public health solutions have taken on renewed urgency. Developed from the Housing First model, CCUSA’s HHI program is a timely initiative aimed at addressing the homelessness crisis. The program collaborates with Catholic healthcare providers to provide permanent housing and services to HHI clients (i.e., people who experienced chronic homelessness prior to housing).

Evaluation Goals

The goals of the HHI program were to (1) house at least 20% of individuals who have experienced chronic homelessness based on the 2019 PIT count in Detroit, St. Louis, Las Vegas, Spokane, and Portland (Ore.); (2) decrease emergency room/hospital utilization of those housed by at least 25%; and (3) connect 35% of newly housed persons to primary care and behavioral health services.

The purpose of this evaluation is to assess the success of the HHI program. The report discusses findings related to project implementation, service, and program outcomes. For our evaluation, we considered a variety of factors, including:

1. Site observations;
2. Results from the baseline survey and the short follow-up surveys conducted via an online survey tool;
3. Differences in various outcome variables (ER visits, hospital stays, and connections to healthcare providers) between the baseline survey and the follow-up surveys;
4. Themes from the qualitative in-depth interviews; and
5. An analysis on the cost savings.

Overview of the Methods and Data Collection

This evaluation applies an advanced mixed-method approach including quantitative and qualitative methods. The quantitative method includes statistical analyses of the surveys. The qualitative approach includes multiple in-depth interviews with clients, hospital care providers, caseworkers, and other important stakeholders, in addition to site visits. The integration of quantitative and qualitative methods allows us to comprehensively evaluate the effectiveness of the HHI program.

The Quantitative Methods

The evaluation team developed surveys using an online survey tool, Research Electronic Data Capture (REDCap), to gather data on health and housing experiences among the HHI clients. REDCap is a secure, web-based platform designed for building and managing online surveys and databases. It is widely used in academic and clinical research. REDCap complies with HIPAA and IRB standards. Specifically, three surveys were created, including a baseline survey given to first-time HHI clients, a long follow-up survey given to HHI clients who were already surveyed prior to the implementation of REDCap, and a short follow-up survey given every six months following the initial baseline survey or long follow-up survey. After attending multiple training sessions on HHI survey administration in January and February, caseworkers at all five agencies distributed the surveys to HHI clients beginning February 26, 2024.

We exported data from REDCap to STATA and used the statistical software STATA/SE17.0 to clean the dataset and perform the data analyses. For the quantitative analysis, we employed two approaches to analyze the data. One approach treated data from the baseline survey and the follow-up surveys as cross-sectional. The other approach treated data from the baseline surveyed the first follow-up data as longitudinal panel data. The cross-sectional approach compared results at the time of the baseline survey and the follow-up survey. However, the clients across the datasets were not exactly the same. Specifically, some clients in the baseline survey might not appear in the follow-up survey dataset.

The advantage of the cross-sectional approach is that it allows us to examine and compare the health and housing outcomes between the new clients and the clients being housed for six months, providing a snapshot of the samples.

The longitudinal approach restricted data to clients who were in the baseline survey and the follow-up survey. There are several advantages to the longitudinal approach. For example, it allows the evaluators to follow the same clients over multiple time points, making it possible to observe whether and how their housing and health outcomes improve. This design is especially valuable for providing stronger evidence for causal inferences than cross-sectional data alone. Results from the cross-sectional approach and the longitudinal approach are reported in section VI.

The Qualitative Methods

The qualitative approach was employed to explore the relationship between housing and health outcomes in the five pilot cities. Data was collected through in-depth, semi-structured interviews with: (1) individuals currently in the HHI program; (2) Catholic Charities caseworkers and leaders; and (3) key community and health partners. All interviews and group discussions were audio-recorded with consent and transcribed verbatim. The interviews were analyzed using ATLAS.ti, with an open coding methodology to inductively identify recurring patterns, themes, and categories emerging from participants' narratives.

A qualitative approach offers the opportunity to explore the deeper, contextual dimensions of how stable housing impacts health among people experiencing chronic homelessness. By examining personal narratives, perceptions, and coping mechanisms, qualitative research can illuminate the barriers individuals face in accessing care, their interactions with healthcare systems, and the broader social determinants influencing their health. This contributes to a more holistic understanding of the relationship between stable housing and health through the voices of those directly affected. These interviews also aid in identifying potential areas for policy and service improvement.

ATLAS.ti facilitated the organization, categorization, and interpretation of participants' narratives, allowing for the identification of key themes such as barriers to healthcare access, mental and physical health challenges, and experiences with support services. Open coding allowed for an unrestricted exploration of the data, enabling themes to surface organically rather than being pre-imposed. This approach helped uncover nuanced insights into barriers to healthcare, coping mechanisms, mental and physical health experiences, and the role of support networks. Data were analyzed using thematic analysis and keyword identification, following Braun and Clarke's (2006) six-phase framework:

1. Familiarization with data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Data Analysis and Results

Quantitative Results – A Cross-Sectional Approach

Findings from the Baseline Survey

This section provides an overview of the data collected through the initial baseline survey from the five HHI sites. After removing nine clients from the dataset due to their move-in date taking place prior to January 1, 2020, 402 clients remained in the dataset. Two clients completed the survey in Spanish. The baseline survey was conducted from February 26, 2024, to June 27, 2025.

Figure 2 displays a pie chart indicating the number of clients by agency. Eighteen clients (4.48%) were from CCSEM Detroit, 36 (8.96%) from CCSTL St. Louis, 44 (10.95%) from CCSN Las Vegas, 60 (14.93%) from CCO Portland, and 244 (60.70%) from CCEW Spokane. Regarding sex, 50.25% of clients reported being female (n=202), 48.26% male (n=194), and 1.49% other (n=6).

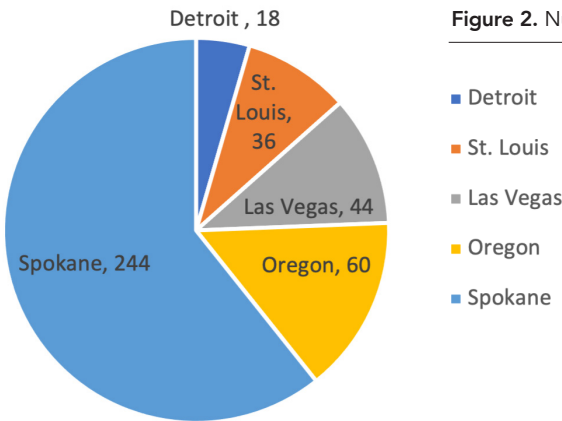


Figure 2. Number of clients in dataset by agency

Figure 3 shows the racial/ethnic composition of the clients. Racial and ethnic categories were mutually exclusive. The majority of clients (62.05%) identified as non-Hispanic White (n=242), 18.97% as non-Hispanic Black (n=74), 5.9% as Native American (n=23), and 6.92% as Hispanic (n=27). Clients who identified as Asian, Pacific Islander, other race, and multiple racial backgrounds accounted for 6.16% of the sample. Additionally, 96.41% of the clients (n=376) reported being native-born Americans. The average age of the housed clients was 48.88 (Standard Deviation=12.49), and the ages ranged from 20 to 83.

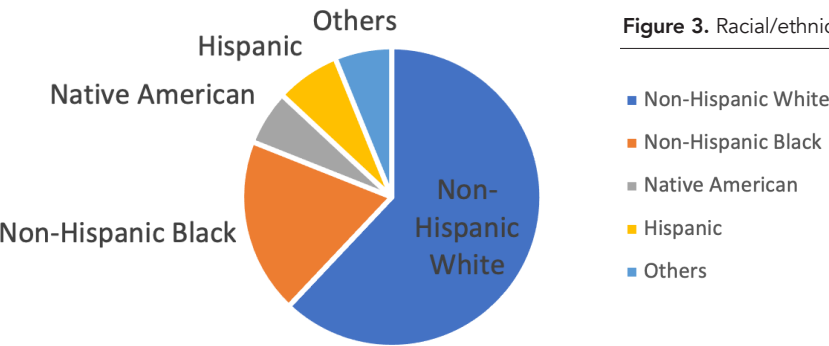
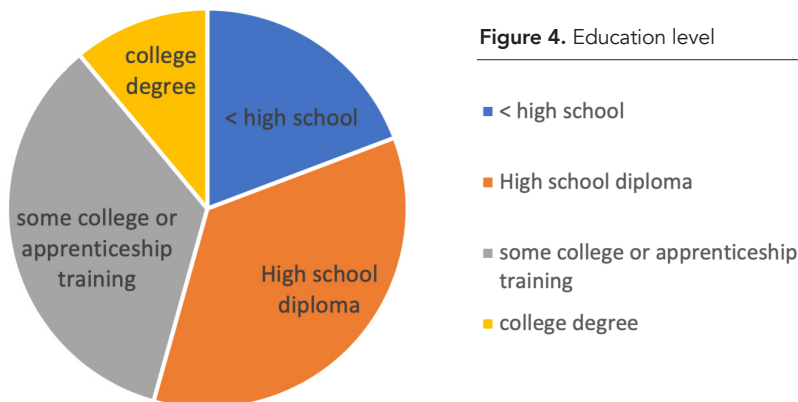
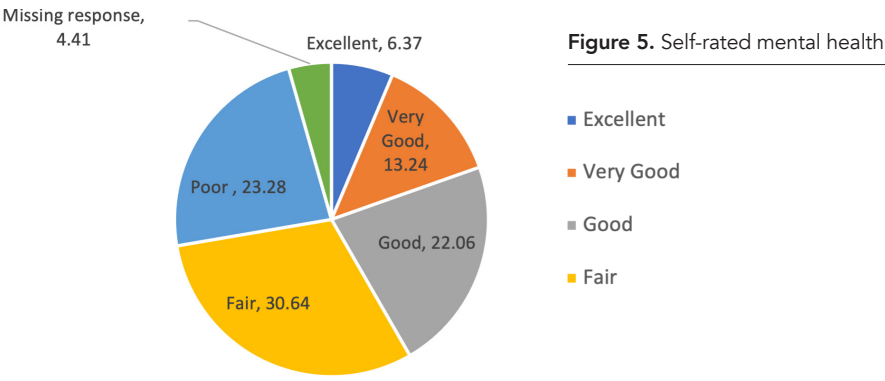


Figure 3. Racial/ethnic composition

Regarding socioeconomic background, 19.23% of the clients reported not having a high school diploma, 35.08% of the clients had a high school diploma, 34.62% had some college or apprenticeship training, and 11.03% had a college degree (see Figure 4). In addition, the majority of clients (n=339, 86.92%) reported that they were not currently employed when completing the survey. The employment rate among the clients was about 11.79%. This number was much lower than the national employment rate (about 60%). Interestingly, 7.69% of the clients in the sample were veterans. This number was lower than homeless individuals at the national level (13%). The majority of clients were not currently married or in a long-term relationship (81.28%). Moreover, 93.85% of clients reported having medical insurance.



In terms of their health background, 12.82% of clients reported they believed they had an alcohol problem. This number was similar to that observed in the previous bi-annual reports and was lower than national estimates (e.g., the Substance Abuse and Mental Health Services Administration estimated that about 38% of the homeless population suffered from alcohol dependency). Regarding drug use, 23.07% of clients reported they believed they had a drug use problem, similar to the national estimate (i.e., 26% of the homeless population in the US).



An important indicator for health is self-rated mental and physical health. Self-rated health has long been established among social scientists to be a valid measure of health status (Wuorela, et al., 2020). In addition, given their background of homelessness, many clients lack a reliable healthcare provider or medical records detailing their general health. Thus, on the survey, clients were asked to answer the following standardized self-rated health question: “In general, would you say your physical health is excellent, very good, good, fair, or poor?” The same template was also used to measure the client’s mental health. In response to these questions, clients reported alarmingly low levels of physical and mental health.

Twelve clients did not report on self-rated mental health and physical health, resulting in a missing response rate of 2.99%. About 53.42% of the clients reported having fair/poor mental health, and about 53.16% reported having fair/poor physical health (see Figures 5 and 6). Among U.S. working-aged adults (aged 18–64), the prevalence of self-reported fair/poor physical health ranged between 31% and 40% (Rhubart and Monnat 2022), significantly lower than figures for the homeless individuals in the sample. According to the 2023 National Health Interview Survey (NHIS), about 13.6% of U.S. adults reported their mental health as “fair” or “poor.” This number was also significantly lower than the number in our sample. However, the self-rated mental and physical health numbers were similar to the national homelessness sample. For example, 40% to 70% of people experiencing homelessness rated their physical health as poor or fair (Hwang, et al., 2010; Kushel, et al., 2001), and over 50% reported serious mental health conditions (Baggett, et al., 2013).

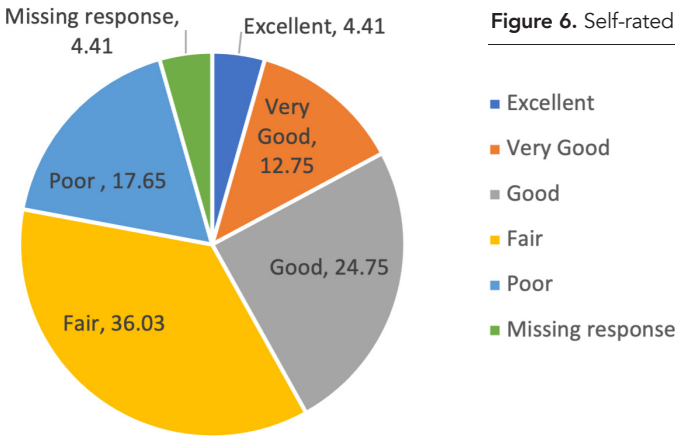


Figure 6. Self-rated physical health

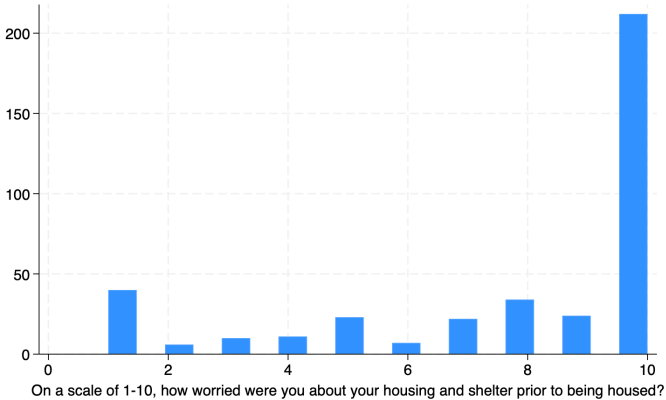
In addition, a substantial number of clients—42.29% (n=170)—reported both physical health and mental health to be fair/poor. This indicated that almost half of the clients suffered from a low level of both mental and physical health when entering the HHI program.

Furthermore, the majority of clients (about 61.44%, n=247) reported having a chronic illness, and 56.22% (226) reported being on medication. It should be noted that many chronic illnesses require medication. A cross tabulation revealed that 29.27% of the clients who had a chronic illness were not currently on medication when filling out the baseline survey.

Prior to being housed by HHI, clients were asked to rate their level of worriedness about housing and shelter on a scale of 1 to 10, with 1 being the lowest level and 10 being the highest level. The mean was 7.83, with a standard deviation of 3.10, and the median was 10. In addition, it should be noted that the vast majority of clients (over 200) reported having the highest level of worriedness regarding housing and shelter. Figure 7 illustrates the distribution of worriedness about housing and shelter.

Clients were also asked to rate their level of worriedness in regard to their *health* prior to being housed. Results indicated that the mean rating was 6.11, with a standard deviation of 3.40. The median was 7. Furthermore, the clients were asked to rate their level of worriedness regarding *access to healthcare* prior to being housed. Results showed that the mean rating was 4.07 (SD=3.37) and the median was 3. Results revealed that, among the concerns that our survey measured, clients were most worried about housing and shelter. In addition, only 33.08% of the clients reported that they would often seek medical care or advice for health needs.

Figure 7. Frequency distribution of level of housing/shelter worriedness prior to being housed



The major health outcomes of interest for our evaluation are *the number of ER visits* and *the number of hospital stays*.¹ The baseline survey gathered information on these variables for the six-month period prior to being housed. The majority of clients (52.72%, n=212) reported having visited the ER at least once during the six-month period prior to being housed. Among those who visited the ER (n=212), the average number of ER visits was 4.11 (SD=5.22), and the median was 2. The reported number of ER visits ranged from 1 to 40. The total number of ER visits for the sample was 872. Moreover, 96 clients (23.88%) reported having at least one hospital stay during the six-month period prior to being housed. Among those with hospital stays, the average number of hospital stays was 2.27 (SD=1.89), and the median was 2. The reported number of hospital stays ranged from 1 to 10. The total number of hospital stays in the sample was 218. A cross tabulation revealed that 22% of the clients (n=87) reported at least 1 ER visit and 1 hospital stay six months prior to being housed.

¹The number of hospital stays refers to the count of inpatient admissions and does not reflect the total number of days clients spent in the hospital.

The survey gave clients the opportunity to state the reasons for their ER visits and hospital stays. Common reasons for ER visits included mental health-related problems (e.g., anxiety and stress), injuries resulting from life on the street (e.g., car/bike accident, broken bones, fall, etc.), pain, infections, addiction, and overdose. It should be noted that many clients reported they visited the ER due to homelessness, severe weather, and hunger. These results align with prior research indicating that homeless individuals often use the ER as a shelter or primary care facility (Kushel, et al., 2001), which can potentially put a strain on the healthcare system. Common reasons for hospital stays included infections, mental health-related issues, stroke, and diabetes complications.

Sixty-two percent of clients (n=251) reported that they had a primary care doctor or nurse practitioner prior to being housed. This figure was lower than that of the U.S. general population (77%). Among the clients with a primary care doctor or nurse practitioner (n=251), 61.35% of the clients (n = 154) reported that they had seen their primary care doctor or nurse practitioner in the past six months. Moreover, 30.35% of clients (n=122) reported they had a behavioral health provider prior to being housed. Among the individuals with a behavioral health provider, 78.69% of them (n=96) had seen this provider in the past six months prior to being housed. A cross tabulation revealed that about 25% of the clients (n=99) did not have either a primary care provider or a mental health provider prior to being housed. In addition, over half of the clients (52.23%, n=192) did not visit any primary care provider or mental health provider in the six months prior to being housed.

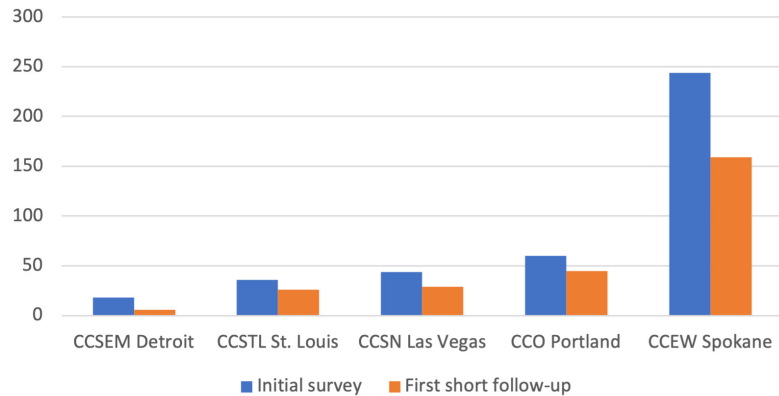
A set of open-ended questions on the survey inquired about clients' reasons for not having a primary care provider or mental health specialist. The survey found that 28.46% (n = 37) of the clients without a primary care provider said the reason was "not having the need to have one"; 24.62% (n=32) reported they "prefer to seek medical care on a case-by-case basis"; 15% (n=19) reported they "haven't found a doctor I like or trust"; and 21.54% (n=28) reported that they "had difficulty accessing healthcare services." Another commonly cited reason was that being homeless and moving to different locations made it difficult to find a doctor. In regard to clients' reasons for not having a mental health specialist, 55% of the clients (n=140) cited the reason of "not having the need to have one"; 9.8% (n=25) reported they "prefer to seek medical care on a case-by-case basis"; 11.76% (n=30) reported they "haven't found a doctor I like or trust"; and 12.16% (n=31) reported that they "had difficulty accessing healthcare services."

It should be noted that a cross tabulation revealed that a substantial number of clients who reported fair/poor mental health on the survey did not have a mental health provider prior to being housed (n=139, 63.47%). Among these clients, 40.46% indicated that they did not feel the need to have a mental health provider. This suggests the urgency of promoting mental health awareness and helping connect clients to mental health providers.

Findings from the First Short Follow-up Survey

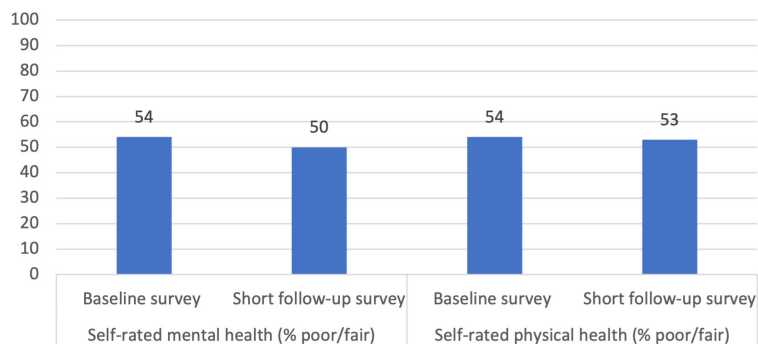
The short follow-up survey was given every six months following the initial baseline survey. There were 265 clients identified in the first short follow-up database. Specifically, six were from CCSEM Detroit, 26 from CCSTL St. Louis, 29 from CCSN Las Vegas, 45 from CCO Portland, and 159 from CCEW Spokane. The comparisons of the first follow-up survey and the initial survey are shown in Figure 8.

Figure 8. Numbers of survey participation



The short follow-up survey collected only time-variant information. Regarding socioeconomic background, 12.44% of the clients reported that they were employed. Almost all clients (98.87%) reported having medical insurance. This number was higher than the number in the baseline survey (93.85%). In terms of clients' health background, 7.17% of the clients in the short follow-up dataset reported they believed they had an alcohol problem, and 16.60% believed they had a problem with drug use. These figures were remarkably lower than those observed in the initial survey (12.82% for alcohol use and 23.07% for drug use, respectively) and lower than national rates for the homeless (38% and 26%, respectively). Clients in the short follow-up dataset have received housing and health services from the HHI program for six months. The decreased rates of drug and alcohol issues in the follow-up dataset might be attributed to the program helping clients seek treatment for addiction.

Figure 9. Self-rated health: Baseline survey vs. short follow-up survey



In terms of self-rated mental and physical health, 49.81% of the clients reported having fair/poor mental health, and 52.83% reported having fair/poor physical health. These figures were slightly lower than those observed for clients in the baseline survey, administered when clients first entered the HHI program (53.92% with fair/poor mental health and 53.68% with fair/poor physical health). These results suggest that receiving care from the HHI program for six months may help improve clients' mental and physical health (see Figure 9). Another important improvement in terms of preventive care is that 84.48% of the short follow-up clients with chronic illnesses reported being on medication. This number was larger than that observed in the baseline survey (56.22%), suggesting that the HHI program may positively influence clients' medication adherence. One possible explanation is that clients who were enrolled in HHI were more likely to be connected to case management services and/or linked to a primary care provider, which could facilitate medication monitoring, prescription refills, and ongoing health guidance. In addition,

stable housing may create a more structured and predictable daily routine, making it easier for clients to consistently take their medications as prescribed. Together, these findings suggest that housing stability, coupled with supportive services, may play an important role in improving health among clients.

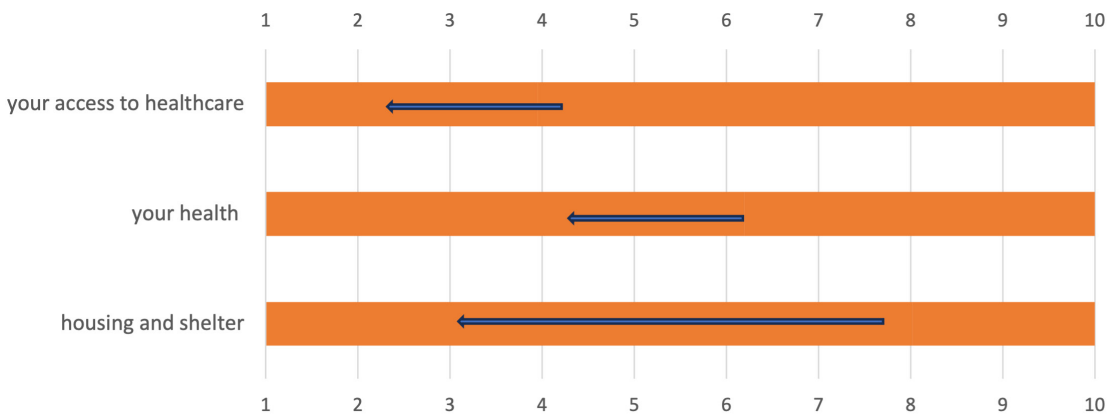
For the short follow-up survey, clients were also asked to rate how worried they were about a variety of variables, including *access to healthcare, their health, and housing and shelter*. Worriedness level for each factor was rated on a scale of 1 to 10, with 1 being the lowest level and 10 being the highest level of worriedness. The mean for worriedness about access to healthcare was 2.39 (SD=2.39) and the median was 1. The mean for worriedness about health was 4.54 (SD=2.95) and the median was 4. The mean for worriedness about housing and shelter was 3.17 (SD=2.89) and the median was 2. It should be emphasized that worriedness about these factors was much lower for clients in the short follow-up survey versus clients in the baseline survey (i.e., clients who just entered the HHI program). Baseline means for worriedness about access to healthcare, their health, and housing/shelter were 4.07, 6.11, and 7.83, respectively. Results are displayed in Table 2 and are further illustrated in Figure 10.

Table 2. Average level of worriedness before and after being housed

<i>Worried about...</i>	<i>Clients just entering the program</i>	<i>Clients 6 months after housing</i>
Access to healthcare	4.07 (SD=3.37)	2.39 (SD=2.39)
Health	6.11 (SD=3.40)	4.54 (SD=2.95)
Housing	7.83 (SD=3.10)	3.17 (SD=2.89)

Note: Range is from 1-10, with 1 being the lowest level and 10 being the highest level.

Figure 10. On a scale of 1 to 10, how worried were you about your housing and shelter prior to being housed?



In terms of the major health outcomes for this evaluation, i.e., ER visits and hospital stays, 31.70% of clients (n=84) reported they had at least one ER visit in the past 6 months. Among the 84 clients who visited the ER, the average number of ER visits was 2.56 (SD=4.53), and the median was 1. The total number of ER visits was 216. These figures represented a dramatic drop in ER visits compared to clients in the baseline survey, when it was reported that 52.72% of clients visited the ER, and the average number of ER visits was 4.11. In terms of hospital stays, 35 clients (13.21%) in the short follow-up survey reported that they had at least one hospital stay during the past six months. For those who had hospital stays, the average number of hospital stays was 1.97 (SD=1.34), and the median was 1. The total number of hospital stays was 69. These figures were much higher in the baseline survey, when it was reported that 23.88% had hospital stays, and the average number was 2.27. Notably, common reasons for visiting the ER for clients in the follow-up dataset included infections, mental health, and diabetes. These reasons were in stark contrast to those given in the baseline survey by clients who often visited the ER for reasons related to homelessness.

At least six months after being housed by CCUSA, 226 clients (85.28%) indicated that they had a primary care doctor or nurse practitioner. Among these clients (n=226), 77.43% reported that they had visited the doctor or the nurse practitioner within the past six months. The majority of the clients visited their doctor for wellness checkups and bloodwork. In addition, 32.08% of the clients (n=85) reported that they had a behavioral health provider, and 90.59% visited their behavioral health provider during the past six months.

Findings from the Second Short Follow-up Survey

A second follow-up survey was conducted by caseworkers six months after the first follow-up survey was conducted. Ninety-three clients were identified in the dataset as completing the second follow-up survey. It should be noted that the number of clients who completed the second follow-up survey does not match the number of clients who remained in the dataset. Due to the timeline of the survey schedule, some HHI clients might not have been housed for one year yet; therefore, they did not complete the second follow-up survey. In addition, many sites reported some attrition, due to clients leaving the program or passing away. Therefore, the dataset for the second short follow-up survey had a smaller number of clients.

Almost all clients (about 99%) reported to have health insurance in the second follow-up survey after one year of being housed by HHI. This number highlights the success of caseworkers' assistance in getting health insurance coverage for HHI clients. Employment rates remained low across the three surveys (around 12%).

In terms of clients' health background, 5.38% of the clients in the short follow-up dataset reported they believed they had an alcohol problem, and 5.38% believed they had a problem with drug use. In addition, 89.86% of the second short follow-up clients with chronic illnesses reported being on medication. Regarding self-rated mental and physical health, 46.24% of the clients reported having fair/poor mental health, and 49.47% reported having fair/poor physical health. The mean for worriedness about access to healthcare was 2.12 (SD=2.28) and the median was 1. The mean for worriedness about health was 4.33 (SD=2.90) and the median was 4. The mean for worriedness about housing and shelter was 3.09 (SD=2.87) and the median was 2². These figures were much lower than those observed for clients in the baseline survey and the first follow-up survey. The results indicated continued improvement in health measures among the HHI clients, compared to when they first entered the program.

² This result is consistent with the clients' interviews. Although worriedness about housing declined dramatically after entering the HHI program, many clients expressed some dissatisfaction with the housing/housing environment, or some uncertainty regarding whether HHI housing will remain available to them in the future.

In terms of the major health outcomes for this evaluation, including ER visits and hospital stays, 31.18% of clients (n=29) reported they had at least one ER visit in the past six months. The average number of ER visits was 1.93 (SD=2.09), and the median was 1. The total number of ER visits was 56. In terms of hospital stays, 8 clients (8.6%) in the second short follow-up survey reported that they had at least one hospital stay during the past six months. For those who had hospital stays, the average number of hospital stays was 1.63 (SD=1.06), and the median was 1. The total number of hospital stays was 13.04.

One year after being housed by CCUSA, 86.02% of the clients indicated that they had a primary care doctor or nurse practitioner. Among these clients, 81.25% reported that they had visited the doctor or the nurse practitioner within the past six months. In addition, 31.18% of the clients reported that they had a behavioral health provider, and 86.21% visited their behavioral health provider during the past six months. Table 3 summarizes the major measures of interest across the three surveys.

Table 3. Results by survey

	Baseline Survey	1st Follow-up (6 months after)	2nd Follow-up (12 months after)
Sample Size	402	265	93
Employed (%)	11.79	12.44	11.90
Have medical insurance (% yes)	93.85	98.87	98.92
On medication with chronic illness (% yes)	56.22	84.84	89.86
Alcohol problem (%)	12.82	7.17	5.38
Drug problem (%)	23.07	16.60	5.38
Fair/poor mental health (%)	53.42	49.81	46.24
Fair/poor physical health (%)	53.16	52.83	49.47
Worried about ...			
Access to healthcare	4.07 (SD=3.37)	2.39 (SD=2.39)	2.12 (SD=2.28)
Health	6.11 (SD=3.40)	4.54 (SD=2.95)	4.33 (SD=2.90)
Housing	7.83 (SD=3.10)	3.17 (SD=2.89)	3.09 (SD=2.87)
ER visits			
Clients with at least 1 ER visit (%)	52.72	31.70	31.18
Mean # (for clients who had ER visit)	4.11 (SD=5.22)	2.56 (SD=4.53)	1.93 (SD=2.09)

Table 3. Results by survey (cont'd.)

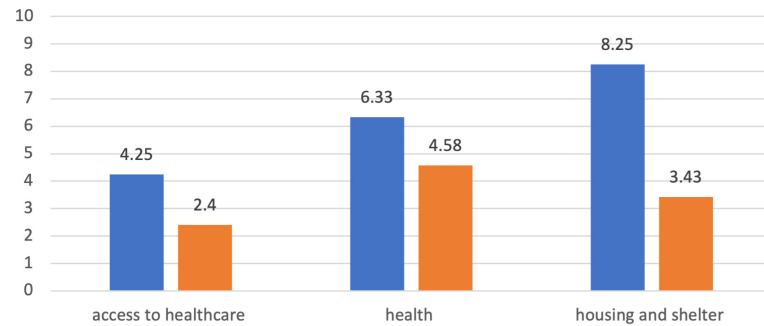
Hospital Stays			
Clients with at least 1 hospital stay (%)	23.88	13.21	8.60
Mean # (for clients who had hospital stay)	2.27 (SD=1.89)	1.97 (SD=1.34)	1.63 (SD=1.06)
Primary Care Provider			
On medication with chronic illness (% yes)	56.22	84.84	89.86
Alcohol problem (%)	12.82	7.17	5.38
Drug problem (%)	23.07	16.60	5.38
Fair/poor mental health (%)	53.42	49.81	46.24
Fair/poor physical health (%)	53.16	52.83	49.47
Worried about ...			
Clients with primary care provider (%)	62.00	85.28	86.02
Clients visiting primary care provider (%)	61.35	77.43	81.25
Behavioral Health Provider			
Clients with behavioral health provider (%)	30.35	32.08	31.18
Clients visiting behavioral health provider (%)	78.69	90.59	86.21

Quantitative Results: The Longitudinal Approach

We used the unique IDs given to each client to link their data across the baseline survey and the first short follow-up survey. Due to the small sample size of the second follow-up survey, we used the first follow-up survey as a benchmark to restrict the longitudinal sample. Clients who participated in only one survey were excluded from analyses. Overall, 193 clients were linked successfully (three clients from CCSEM Detroit, 12 from CCSTL St. Louis, two from CCSN Las Vegas, 142 from CCEW Spokane, and 34 from CCO Portland).

We conducted further analyses to investigate potential changes before versus after housing. Specifically, we examined potential changes in health indicators, including addictions, self-rated mental and physical health, and medication. We also analyzed major outcomes of interest, including whether they had ER visits and hospital stays six months prior to answering the survey, whether they had a primary care/behavioral health provider, and whether they visited their providers. We employed data from the initial survey (before housing) and the six-month follow-up survey (six months after housing). Comparing the data across these two surveys, we were able to test for potential differences in the six-month period before housing versus the six-month period after housing. We did not include data from the 12-month follow-up survey due to the small sample size. We employed paired-samples t-tests and McNemar's tests to determine whether observed differences before versus after housing were statistically significant.

Figure 11. Worried about....



Self-rated Health Measures

Results are displayed in Table 4. Results indicated that more clients reported having health insurance compared to when they first entered the HHI program (98.96% vs. 92.23%). Moreover, the number of clients who reported being on medication while having chronic illness increased dramatically (83.94% vs. 61.11%). In terms of self-reported addictions, measures for both alcohol and drug problems decreased. In addition, the number of clients who reported having fair/poor mental and physical health also decreased compared to when the sample first entered the program. Specifically, the number for fair/poor mental health decreased from 71.88% in the baseline survey to 51.82% in the follow-up survey, and the number went from 66.15% to 54.4% for poor/fair physical health. Also unsurprisingly, reported worriedness levels decreased for housing, access to healthcare, and health (see Figure 11).

Table 4. Results on self-reported health measures from pre- and post-tests

	Baseline Survey	First Follow-up
Sample Size	193	193
Have medical insurance (% yes)	92.23	98.96
On medication with chronic illness (% yes)	61.11	83.94
Alcohol problem (%)	17.71	6.74
Drug problem (%)	32.81	19.69
Fair/poor mental health (%)	71.88	51.82
Fair/poor physical health (%)	66.15	54.40
Worried about		
Access to healthcare	4.25 (SD=3.44)	2.40 (SD=2.49)
Health	6.33 (SD=3.26)	4.58 (SD=2.88)
Housing	8.25 (SD=2.70)	3.43 (SD=3.01)

Table 5 displays the results for the major measures of interest, including ER visits, hospital stays connections to primary care providers, and behavioral health providers. Results from the McNemar's Chi-square tests are reported. Specifically, the McNemar's results indicated that the numbers of ER visits and hospital stays decreased significantly after the clients were housed for six months ($p=0.0000$). In addition, the number of clients who had a primary care provider increased significantly after being housed for six months ($p=0.000$).

Table 5. Results of the major measures from the baseline survey and the follow-up survey

	Baseline	Follow-up	Differences	$\chi^2(1)$
Sample Size	193	193		
ER visits				
# of clients with at least 1 ER visit (%)	114 (59.38%)	62 (32.12%)	-52 (45.61%)	40.89 ($p=0.0000$)
Mean (for clients who had ER visit)	4.18 (SD=5.61)	2.55 (SD=5.14)		
Total number	477	159	-318 (66.66%)	
Hospital Stays				
# of clients with at least 1 hospital stay (%)	57 (26.69%)	23 (11.92%)	-34 (59.65%)	29.35 ($p=0.0000$)
Mean (for clients who had hospital stay)	2.12 (SD=1.76)	1.74 (SD=1.01)		
Total number	121	41	-80 (66.12%)	
Primary Care Provider				
Clients with primary care provider (%)	124 (64.58%)	166 (86.01%)	33.87%	25.81 ($p=0.0000$)
Clients visiting primary care provider (%)	75 (60.48%)	134 (80.72%)		
Behavioral Health Provider				
Clients with behavioral health provider (%)	66 (34.38%)	72 (37.31%)	9.09%	0.06 ($p=0.9063$)
Clients visiting behavioral health provider (%)	52 (78.79%)	64 (88.89%)		

ER Visits

Results indicated that among the 193 clients, the number of clients reported to have at least one ER visit decreased by 46% after being housed for six months. Moreover, the total number of ER visits decreased from 477 to 159, representing a 67% decrease. McNemar's Chi-square analysis revealed that the decrease in ER visits before versus after housing was statistically significant, $X^2(1) = 40.89$, $p = 0.0000$. The average number of ER visits per person decreased from 4.18 to 2.55 (Figure 11).

Hospital Stays

The number of clients with hospital stays decreased by 60% after being housed for six months. The total number of hospital stays also decreased by 66%, from 121 to 41. McNemar's Chi-square analysis revealed that the decrease in hospital stays before versus after housing was statistically significant, $X^2(1) = 29.35$, $p = 0.0000$. In addition, days spent in the hospital per person decreased by 0.38 days on average. The results suggest there was a significant decrease in hospital stays before versus after housing (Figure 12).

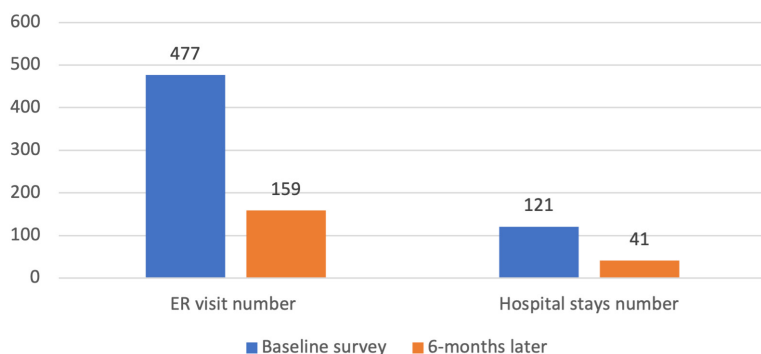
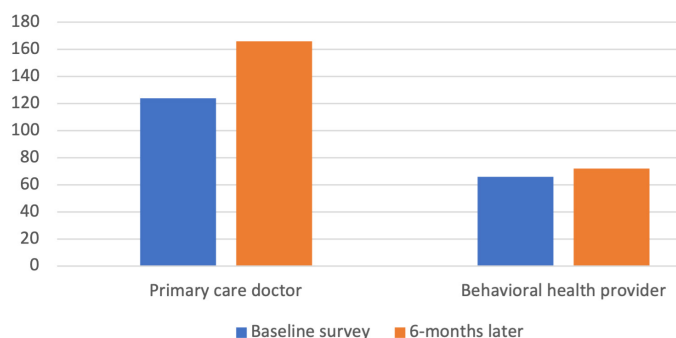


Figure 12. Total numbers of ER visits and hospital stays

Primary Care Providers

Forty-two clients were connected to a primary care doctor after being housed by CCUSA (see Figure 13). This represented a 34% increase before versus after housing. In addition, 59 more clients had seen the doctor in the six-month period after being housed. McNemar's Chi-square analysis confirmed statistical significance for the increase in clients with primary care providers ($X^2(1) = 25.81$, $p = 0.0000$) before versus after housing.

Figure 13. Total numbers of clients being connected to PCD and BPH



Behavioral Health Providers

Six more clients were connected to a behavioral health provider after being housed (see Figure 12), representing a 9% increase. Moreover, 12 more clients had seen a behavioral health provider after being housed. The p level for McNemar's Chi-square analysis was not statistically significant ($p=0.9063$). These results indicated that although there was an increase in the number of clients connected to behavioral health providers after six months in the program, the increase was not statistically significant.

Regarding HHI's goals "to decrease emergency room/hospital utilization of those housed by at least 25%" and "to connect 35% of newly housed persons to primary care and behavioral health services," results indicated that these two goals have been met. For example, after HHI housing, the number of ER visits dropped by 46%, and the number of hospital stays dropped by 60%. In addition, 86% of the clients had a primary care provider and 37% had a behavioral health provider after being housed by HHI.

We further analyzed data on the main outcomes of interest by clients' demographic background, such as sex, age, and race. Table 6 summarizes the results. McNemar's tests were performed to examine whether the changes in the health measures were statistically significant. Results indicated that the number of clients with at least one ER visit and the number of clients with at least one hospital stay decreased dramatically across all demographic groups after being housed by HHI for six months. The drop in ER visits ranged from 35% among males to 59% among clients age 60 and older. McNemar's analysis suggested the decrease in ER visit was statistically significant among all groups. The drop in hospital stays ranged from 41% among clients age 60 and older to 75% among female clients. McNemar's analysis suggested the decreases in hospital stays were statistically significant among all groups, except for non-Hispanic Blacks. In addition, the number of clients with a primary care provider and a behavioral health provider increased across all demographic groups, with the exception of non-Hispanic Whites and behavioral health providers, which decreased by two clients. Specifically, McNemar's analysis suggested that the increases in the number of clients with a primary care provider were statistically significant among all groups.

Regarding HHI's goals "to decrease emergency room/hospital utilization of those housed by at least 25%" and "to connect 35% of newly housed persons to primary care and behavioral health services," results suggested that both goals have been met across the majority of demographic groups. The number of clients connected to behavioral health providers was slightly under the goal of 35% among male clients (33.71%), clients age 60 and older (27.50%), and non-Hispanic White clients (33.82%). This suggests that caseworkers might need to develop tailored strategies to connect specific groups of clients to behavioral health providers. This result corresponded to our qualitative analysis. Some clients expressed hesitancy and distrust of behavioral health providers.

Table 6. Results from the longitudinal analysis by demographic background

Bold indicates significant at p=0.01 level.

	Baseline Survey	First Follow-up	Differences	McNemar's $\chi^2(1)$
Female				
Sample Size	101	101		
# of clients with at least 1 ER visit (%)	59 (58.42%)	36 (35.64%)	-23 (38.98%)	22.35 (p=0.0000)
# of clients with at least 1 hospital stay (%)	36 (35.64%)	9 (8.82)	-27 (75.00%)	24.50 (p=0.0000)
Clients with primary care provider (%)	71 (70.30%)	91 (90.10%)	20 (28.17%)	10.31 (p=0.0013)
Clients with behavioral health provider (%)	38 (37.62%)	41 (40.59%)	3 (7.89%)	0.10 (p=0.7518)
Male				
Sample Size	89	89		
# of clients with at least 1 ER visit (%)	54 (60.67%)	25 (28.09%)	-19 (35.19%)	20.45 (p=0.0000)
# of clients with at least 1 hospital stay (%)	33 (37.08%)	16 (17.98%)	-17 (51.52%)	9.97 (p=0.0016)
Clients with primary care provider (%)	51 (57.3%)	74 (83.15%)	23 (45.10%)	17.29 (p=0.0000)
Clients with behavioral health provider (%)	27 (30.34)	30 (33.71%)	3 (11.11%)	0.29 (p=0.5900)
Age ≥60				
Sample Size	40	40		
# of clients with at least 1 ER visit (%)	24 (60%)	10 (25%)	-14 (58.33%)	10.71 (p=0.0011)
# of clients with at least 1 hospital stay (%)	17 (42.5%)	10 (25%)	-7 (41.18%)	4.57 (p=0.0325)
Clients with primary care provider (%)	26 (65%)	40 (100%)	14 (53.85%)	12 (p=0.0005)
Clients with behavioral health provider (%)	11 (27.50%)	11 (27.50%)	0	0.07 (p=0.7963)
Age <60				
Sample Size	151	151		
# of clients with at least 1 ER visit (%)	90 (59.6%)	52 (34.44%)	-38 (42.22%)	32.01 (p=0.0000)
# of clients with at least 1 hospital stay (%)	52 (34.44%)	16 (10.60%)	-36 (69.23%)	27.00 (p=0.0000)
Clients with primary care provider (%)	97 (64.24%)	126 (83.44%)	29 (29.90%)	16.49 (p=0.0000)
Clients with behavioral health provider (%)	55 (36.42%)	61 (50.40%)	6 (10.91%)	0.64 (p=0.4227)

Table 6. Results from the longitudinal analysis by demographic background (cont'd.)

Bold indicates significant at p=0.01 level.

	Baseline Survey	First Follow-up	Differences	McNemar's $\chi^2(1)$
Non-Hispanic White				
Sample Size	136	136		
# of clients with at least 1 ER visit (%)	76 (55.88%)	39 (28.68%)	-37 (48.68%)	29.35 (p=0.0000)
# of clients with at least 1 hospital stay (%)	44 (32.35%)	13 (9.56%)	-31 (70.45%)	22.35 (p=0.0000)
Clients with primary care provider (%)	88 (64.71%)	119 (87.50%)	31 (35.23%)	23.44 (p=0.0000)
Clients with behavioral health provider (%)	48 (35.29%)	46 (33.82%)	-2 (4.17%)	0.07 (p=0.7855)
Non-Hispanic Black				
Sample Size	20	20		
# of clients with at least 1 ER visit (%)	14 (70.00%)	9 (45.00%)	-5 (35.71%)	5.00 (p=0.0253)
# of clients with at least 1 hospital stay (%)	7 (35.00%)	4 (20.00%)	-3 (42.86%)	1.80 (p=0.1797)
Clients with primary care provider (%)	12 (60.00%)	17 (85.00%)	5 (41.67%)	3.57 (p=0.0588)
Clients with behavioral health provider (%)	9 (45.00%)	13 (65.00%)	4 (44.44%)	2.00 (p=0.1573)

Lastly, we reviewed data regarding the numbers of clients housed by HHI. In total, 792 clients have been housed by the five HHI sites. Based on the 2019 PIT count, 3,489 individuals experienced chronic homelessness in the five cities, as follows: St. Louis (PIT: 235), Detroit (PIT: 279), Las Vegas (PIT: 620), Portland (PIT: 2,100), and Spokane (PIT: 255). One of the HHI goals was to house at least 20% of individuals who have experienced chronic homelessness based on the 2019 PIT count in the five cities. To meet the goal of 20%, the number of clients housed by HHI should be at least 698 ($3489 \times 0.2 = 697.8$). Therefore, the goal of reducing chronic homelessness by 20% has been met ($792 > 698$).

The results from the baseline survey suggested that clients had detrimental health when moving into the HHI sites. For example, the majority of clients rated their mental and physical health as poor/fair. Their reported levels of worriedness about health, healthcare, and housing were high. The majority of the clients had at least one ER visit six months prior to being housed (53%), and many had at least one hospital stay (24%). Results from the follow-up surveys demonstrated that clients' health improved after staying housed for six months or longer. More clients with chronic illnesses reported they were now on medication, almost all clients reported having health insurance, and self-rated health has improved, as well. In addition, the numbers of ER visits and hospital stays dropped dramatically, and more clients were connected to healthcare providers. Furthermore, the longitudinal analysis further confirmed the health benefits of the HHI program. Based on the surveys and different quantitative approaches to analyzing the data (both cross-sectional and longitudinal), results confirmed that all HHI goals have been met, and clients' health has improved after being housed by HHI. A summary of the goals and the quantitative approaches is displayed below in Table 7.

Table 7. Goals and approaches

✓ **The goal is met.**

	Cross-Sectional Approach	Longitudinal Approach
Goal 2a: Decrease the numbers of emergency room visits of those housed by at least 25%	✓	✓
Goal 2b: Decrease the numbers of hospital stays of those housed by at least 25%	✓	✓
Goal 3a: Connect 35% of newly housed persons to primary care services	✓	✓
Goal 3b: Connect 35% of newly housed persons to behavioral health services		✓

Results by Site

The quantitative results regarding the numbers of ER visits and hospital stays for each site are presented in Table 8. Results showed a decrease in hospital usage and an increase in healthcare provider connections across the five HHI sites. Specifically, in St. Louis, the percentage of clients with at least one ER visit dropped substantially, from 97.22% pre-HHI to 46.15% six months post-HHI. Among those who visited the ER, the mean number of visits decreased from 9.66 to 6.83. Hospitalizations followed a similar pattern, with the percentage of clients with at least one hospital stay falling from 52.78% to 19.23% and the mean number of hospital stays decreasing from 3.16 to 2.40. Connections to primary care increased sharply (41.46% to 73.08%), while behavioral health provider engagement remained stable (55.56% to 57.70%).

In Detroit, ER utilization changed little in terms of prevalence (31.25% to 33.33%), although the mean number of ER visits decreased from 1.80 to 1. No hospitalizations were reported at either timepoint. Primary care connection increased dramatically from 31.25% to 100%, and behavioral health engagement rose from 12.50% to 33.33%. It should be noted that the number of clients housed by the HHI program in Detroit was relatively small due to the delay in the opening of HHI housing and the agency not directly placing clients in housing with other providers. Many HHI clients in Detroit moved into permanent supportive housing after the data collection deadline. This might influence the results due to the small sample size.

In Las Vegas, the percentage of clients with at least one ER visit decreased from 32.5% to 17.24%, and the mean number of ER visits declined slightly (1.31 to 1.00). The percentage of clients with at least one hospital stay also decreased from 17.07% to 3.45%, and the average number of hospital stays dropped from 2.29 to 1.00. The percentage of clients connected to a primary care provider remained high (92.68% pre-HHI; 89.66% post-HHI). However, the percentage of clients connected to behavioral health providers was low (4.88% to 3.45%).

Spokane also showed dramatic decreases in ER and hospital usage among their clients. For example, the percentage of clients with at least one ER visit dropped from 52.54% to 25.79%, accompanied by a decrease in the mean number of visits (3.06 to 1.83). The number of clients with at least one hospital stay also declined from 22.88% to 11.32%, with a slight decrease in mean stays (1.85 to 1.67). The percentage of clients connected to a primary care provider increased substantially (61.86% to 87.42%), whereas behavioral health engagement remained consistent (33.47% to 33.96%).

Lastly, in Portland, the percentage of clients with at least one ER visit decreased slightly (58.33% to 53.33%), and the mean number of ER visits fell from 2.97 to 2.13. In addition, the percentage of clients with at least one hospital stay declined marginally from 26.67% to 24.44%, and the mean number of stays decreased from 2.63 to 2.36. Connections to primary care and behavioral health providers remained relatively stable over time. For instance, 80% of the clients were connected to a primary care provider after being housed by HHI, compared to 78% before moving in; around 31% of the clients were connected to a behavioral health provider before and after being housed by HHI.

It is worth noting that many HHI sites faced unexpected challenges, including delays in the opening of PSH units, the COVID-19 pandemic, funding cuts, turnover of caseworkers and staff, and a shortage of healthcare providers, especially mental and behavioral care providers. Despite these challenges, across most HHI sites, clients demonstrated lower rates of ER visits and hospital stays after being housed by HHI. Improvements in primary care provider connections were evident in nearly all sites.

Table 8. Results by each site

	Pre-HHI	Post-HHI
St. Louis		
# of clients with at least 1 ER visit (%)	97.22	46.15
Mean (for clients who had ER visit)	9.66	6.83
# of clients with at least 1 hospital stay (%)	52.78	19.23
Mean (for clients who had hospital stay)	3.16	2.40
Clients with primary care provider (%)	41.46	73.08
Clients with behavioral health provider (%)	55.56	57.70
Detroit		
# of clients with at least 1 ER visit (%)	31.25	33.33
Mean (for clients who had ER visit)	1.80	1.00
# of clients with at least 1 hospital stay (%)	0	0
Mean (for clients who had hospital stay)	NA	NA
Clients with primary care provider (%)	31.25	100
Clients with behavioral health provider (%)	12.50	33.33
Las Vegas		
# of clients with at least 1 ER visit (%)	32.5	17.24
Mean (for clients who had ER visit)	1.31	1.00
# of clients with at least 1 hospital stay (%)	17.07	3.45
Mean (for clients who had hospital stay)	2.29	1.00
Clients with primary care provider (%)	92.68	89.66
Clients with behavioral health provider (%)	4.88	3.45

Table 8. Results by each site (cont'd.)

	Pre-HHI	Post-HHI
Spokane		
# of clients with at least 1 ER visit (%)	52.54	25.79
Mean (for clients who had ER visit)	3.06	1.83
# of clients with at least 1 hospital stay (%)	22.88	11.32
Mean (for clients who had hospital stay)	1.85	1.67
Clients with primary care provider (%)	61.86	87.42
Clients with behavioral health provider (%)	33.47	33.96
Portland		
# of clients with at least 1 ER visit (%)	58.33	53.33
Mean (for clients who had ER visit) 2.97	2.13	
# of clients with at least 1 hospital stay (%)	26.67	24.44
Mean (for clients who had hospital stay)	2.63	2.36
Clients with primary care provider (%)	78.33	80.00
Clients with behavioral health provider (%)	31.67	31.11

The following section provides results from the qualitative analysis. Taken together with the quantitative results, the qualitative analysis hopes to provide a more complete and comprehensive picture of the influence of the HHI program on improving clients' health and reducing unnecessary ER and hospital usage.

Qualitative Results

During site visits and follow-up virtual sessions, the evaluators conducted 27 interviews with HHI clients and 13 focus groups with Catholic Charities caseworkers, leaders, and related community and health organizations/partners. All transcripts were organized and analyzed, and a variety of codes were generated to identify recurring themes and summarize the sentences and terms instead of using a pre-existing codebook. The codes were refined and grouped according to their themes to link them to the evaluation goals and project outcomes (see Table 9). The codes to analyze the transcripts included "drugs/substance use"; "fentanyl"; "healthcare system interaction/doctors"; "law enforcement interaction/safety/policy"; "mental health" and "permanent supportive housing/HHI." From these codes, the evaluators were able to identify and analyze how codes and themes related to each other through co-occurrence tables, network diagrams, and frequency word clouds to be able to visualize relationships. The most common occurring themes relevant to this project are explored next and displayed in Table 10.

Table 9. Codes and example key quotes

Term/Code*	Application	Key Quote Exemplifying
Drugs/substance use	Clients or caseworkers mention these terms and relate them to the lived experience of homeless/formerly homeless individuals.	<i>"There's definitely more people that are using than that are not so I would say maybe 60, 70% of the people in our building."</i>
Fentanyl	Clients or caseworkers mention this term and relate it to homeless/formerly homeless and the impact of its use.	<i>"The proliferation of fentanyl in particular has made things a lot more challenging..."</i>
Healthcare system interaction/ doctors	Clients or caseworkers often mention this term and relate it to their experiences and feelings toward the healthcare system, including doctors and hospitals.	<i>"...when you're homeless, you don't go to the doctor and you can't take care of yourself...so a lot of them are just afraid to know how bad a shape they are, and they've been traumatized by medical people."</i>
Law enforcement interaction/ safety/police	Clients or caseworkers mention these terms and relate them to homeless/formerly homeless individuals and/or permanent supportive housing living environment.	<i>"Well, and when they do file reports, they're discounted by the police department."</i>
Mental health	Clients or caseworkers mention this term and relate it to homeless/formerly homeless individuals and their mental health and/or mental illness.	<i>"I ended up going into the mental health hospital. Stayed there for, let's see, I was probably in there about six weeks."</i>
Healthy Housing Initiative (HHI)/ permanent supportive housing	Clients or caseworkers mention this term and relate it to the work of Catholic Charities and HHI.	<i>"So it's just, you know, really making sure that everybody, as these people, move in, they know who they are, they know what they need, and that everybody comes to the table as a partner and not as property management and case management like really being a partner..."</i>

***Other terms coded:** building access, caseloads, Catholic Charities, community, affordable housing, food pantries, governmental interaction), living conditions, population served, staff background. All of these had a limited number of occurrences/mentions. After the ones detailed above, the most frequently occurring terms were affordable housing, community, and Catholic Charities.

Table 10. Codes and frequency

Term/Code*	Frequency (times mentioned)	Ranking as a major theme
Mental health	208	1
Healthcare system interaction/doctors	129	2
Law enforcement interaction/safety/ police	117	3
Drug/substance use	104	4**
Fentanyl	72	5**
Healthy Housing Initiative/PSH (permanent supportive housing)	39	6

** When references to drugs/substance use are combined with references fentanyl, they become the second most mentioned topic.

Substance Use and the Emergence of Fentanyl

In recent years, the landscape of substance use has been profoundly altered by the emergence of fentanyl. This powerful synthetic opioid is up to 50 times stronger than heroin and 100 times stronger than morphine. Initially developed for pain management in medical settings, illicitly manufactured fentanyl has increasingly infiltrated the unregulated drug supply, leading to a public health crisis marked by a dramatic rise in overdose deaths. In the words of a caseworker:

The proliferation of fentanyl in particular has made things a lot more challenging...the comorbidity rate of substance use and mental health is like some 75, 80%. I would say it's probably higher now, and even more impactful because of things like fentanyl and how much that affects one's physical health and mental health, just on a different level than with other substances like heroin and other benzos and things of that nature [that] have been issues for many, many years, but even more similar. So that's one change that is ... a little bit more recent.

The connection between substance use and fentanyl is complex and deeply concerning. For many individuals who use substances — particularly opioids such as heroin, prescription painkillers, or non-opioid drugs like cocaine and methamphetamine — fentanyl is often consumed unknowingly. It is frequently mixed into other substances to increase potency or profit, without the user's knowledge. As a result, individuals may ingest a lethal dose without realizing they are using fentanyl at all. It has become a leading driver of overdose deaths in the United States, with marginalized and vulnerable populations disproportionately affected, including people experiencing homelessness, individuals with co-occurring mental health conditions, and those without access to harm reduction or treatment services. Here is a sample quote from an agency leader:

[W]e have a huge issue with fentanyl. And like I said, it's the apex predator of drugs. I've never seen a drug do to people [what fentanyl does]... We want to say yes to everybody. But the reality is, fentanyl is a whole different thing. We already now have Narcan that we use to [revive clients]. Now we have to Narcan two or three times. That's new in the last year or two.

Mental Health

The relationship between mental health and homelessness is deeply interconnected and mutually reinforcing, forming a cycle that is difficult to break. For many individuals, mental health challenges are both a cause and a consequence of homelessness. Conditions such as depression, bipolar disorder, post-traumatic stress disorder (PTSD), and schizophrenia can significantly impair a person's ability to maintain employment, relationships, and stable housing. In the absence of accessible, affordable mental health care, individuals may find themselves unable to cope and ultimately pushed to the margins of society, where housing becomes precarious or is lost altogether.

At the same time, the experience of homelessness can severely impact a person's mental health. The constant stress of survival, navigating unsafe environments, lacking privacy or rest, and enduring stigma can exacerbate existing mental illness or contribute to the development of new mental health issues. A client spoke to the vicious cycle of homelessness and mental health challenges:

I ended up going into the mental health hospital. Stayed there for, let's see, I was probably in there about six weeks. [I]t brought up a lot of PTSD for me, a lot of trauma, triggered a lot of stuff for me, so to stay in the hospital was probably the best thing for me, because I needed a safe place to be.

These challenges are often compounded by systemic barriers: limited access to care, long waitlists for mental health services, criminalization of homelessness, and a lack of supportive housing options. Individuals with dual diagnoses—those facing both mental illness and substance use—face even greater difficulty accessing coordinated care, despite being among the most vulnerable. Evidence-based models, such as Housing First, the HHI approach that includes stable housing without preconditions, combined with voluntary mental health and social support, have successfully improved mental health outcomes and reduced hospitalizations. All of the housing through HHI at the five sites was low barrier, meaning that those with mental health and substance use disorders were accepted for housing, and seeking treatment was not a mandatory step in the process.

That said, connecting to mental health providers has been challenging. As the quantitative results show, there was a slight increase in the number of clients connected to mental health/behavioral health providers after six months of housing (a 9% increase). This number does not constitute a statistically significant increase. The evaluators learned through their qualitative interviews with caseworkers that limited mental health resources (e.g., a shortage of mental health providers), long wait times, and judgments from previous healthcare providers made it more difficult to connect clients with mental health providers. A sample quote from a caseworker:

There's kind of long wait times in healthcare. These folks are now in permanent stable housing, and so they are like, I get to meet all my needs, but it's like, hold on, we gotta schedule it out. And they are like four or five months waitlists or whatever. Mental health [provider] is honestly very difficult to find at this point. Even for me working for a mental health service provider, we haven't accepted new clients for intake since 2023. The system is backed up and there is a shortage of providers.

Catholic healthcare partners recognized the importance of providing mental health and addiction services to clients in supportive housing. A sample quote from a community health partner:

I really love supportive housing. I think it's one of the biggest and most important things with tackling the homelessness crisis we are dealing with in this region and across the United States. And so I really love that we are able to partner with Catholic Charities to be able to serve folks that are dealing with some of the most traumatic experiences that one can deal with.

Law Enforcement Interaction

For individuals experiencing homelessness, encounters with law enforcement are often not about protection or assistance, but about punishment, displacement, and fear. These interactions, rooted in systemic inequities and outdated policies, frequently reinforce the cycle of homelessness. One caseworker explains:

Well, and when they do file reports, they're discounted by the police department. They're not treated with the same sort of respect or gravity that you know, if we were making a report of a similar nature, you know, our experience would be much different.

The enforcement-driven responses are not only ineffective but also harmful. A criminal record can create further barriers to employment, housing, and access to services, deepening the marginalization that led to homelessness in the first place. For individuals already grappling with trauma, mental illness, or substance use, interactions with police can escalate distress and result in violence, arrest, or involuntary hospitalization. Rather than providing meaningful support, law enforcement is too often used as the front line of response to homelessness. *"It's like we're kind of singled out... feel targeted in this neighborhood,"* explained a client. This dynamic put both officers and unhoused individuals in difficult and unsafe positions, straining

police resources while doing little to improve long-term outcomes. People experiencing homelessness frequently report that these interactions leave them feeling targeted, dehumanized, and invisible. Constant displacement, often referred to as “sweeps,” not only destroys personal belongings and medications but also severs connections to outreach workers and services, disrupting any fragile progress toward stability. All five pilot sites for HHI, even while accounting for differences in location and services, reported adverse interactions with law enforcement, mostly from caseworkers relaying things clients experienced while homeless before moving to permanent supportive housing, although a few clients mentioned it as well.

Safety

Safety is a basic human need, but for people experiencing homelessness, it is often a daily struggle. Without the security of a locked door, stable shelter, or a protected community, unhoused individuals live with constant vulnerability. Those who are homeless face disproportionate risks of violence, exploitation, and health emergencies. Sleeping outdoors or in unsafe shelters exposes individuals, especially women, LGBTQ+ people, seniors, and youth, to physical assault, theft, sexual violence, and harassment. For example, one client shared their experience:

It was really hard to live on the street. Some guy tried to kill us one morning. It was 5:30 in the morning. We are back in our Jeep, and I wake up to my husband with his hand over my mouth. He's whispering in my ear not to move. There's somebody outside with a gun.

Beyond interpersonal violence, safety is compromised by the lack of access to basic needs: clean drinking water, sanitation, medical care, and weather protection. Exposure to extreme heat, cold, or infectious disease can quickly become life-threatening. Many of the places where people go to seek safety, like shelters, are not always safe themselves. Overcrowding, strict entry requirements, lack of privacy, and histories of trauma can make some shelters inaccessible or dangerous for many individuals. Sometimes, people choose the streets over shelters because it feels safer. For many, HHI represented the first safe space they had experienced in years. Clients spoke of being able to “lock the door and finally sleep,” emphasizing the importance of physical security in healing from trauma. Yet safety was not universally felt, and some participants expressed concerns about interpersonal conflict in adjacent units, rampant substance use, and dangerous visitors. Caseworkers and staff echoed these concerns and detailed their experiences of feeling unsafe and not having adequate and responsive local law enforcement or security officers. For example:

You hear things [the neighbor] says to people, he's really destructive. He's broken stuff [in the] building on purpose. He's still here. He doesn't get evicted. We filed grievance after grievance after grievance for a couple years, and nothing ever got done about it.

Healthcare System and Doctors

For individuals experiencing homelessness, accessing healthcare is often a journey marked by mistrust, stigma, and systemic neglect. While medical care should be a source of healing and support, many unhoused individuals report that the healthcare system is instead a place where they feel judged, dismissed, and dehumanized.

One of the most common barriers seems to be prejudice against the unhoused. People without stable housing are frequently met with assumptions that they are drug-seeking, non-compliant, or undeserving of care. These explicit or implicit biases can lead to rushed examinations, denied services, or refusal to treat underlying health issues. A recurring theme in participant narratives was negative experiences with the healthcare system. Stories of being ignored, judged, or denied care due to their appearance, housing status, or substance use were common. A caseworker explained:

Traversing the medical system... can also be a very traumatizing experience for folks, not only in terms of like physical health, but mental health, as well as sexual health and gender identity. Going to a doctor can be traumatizing.... Even with physical health, you don't always get the greatest news...I know for me personally, some of my clients are a little more hesitant to go to doctors.

Additionally, the healthcare system is often ill-equipped to meet the needs of people living in poverty and crisis. Medical appointments may require identification, insurance, or fixed addresses. Missed appointments (often due to unstable conditions or lack of transportation) can result in being discharged from care altogether. Emergency departments may become the only available point of access, and patients are released back to the street without follow-up care or safe housing, perpetuating cycles of illness and re-hospitalization.

The problem is not individual doctors or nurses, many of whom want to help, but a healthcare system not designed to serve people in poverty or extreme vulnerability. Fragmented services, lack of coordination with housing and social supports, and structural racism all contribute to a system that too often fails the very people who need care the most.

Many individuals interviewed for the HHI project reported varying levels of distrust, experiences of discrimination, or other negative experiences with the healthcare system. This is echoed by a client: *"It depends on the workers, though, but most of the hospitals...you know, this is a self inflicted misery, dude... you're using or it's not....not important."* Caseworkers backed up these experiences and often relayed that the clients had very different experiences if they, the caseworkers, were in the room with them. In talking with some of the healthcare systems and hospitals associated with Catholic Charities, some Catholic hospital systems, but not all, understand the criticisms but paint their services and approaches in the best light, which unintentionally reinforces the experiences of the clients/patients. Although these experiences led many to delay care or avoid seeking help altogether, through Catholic Charities' case management and advocacy, some residents have successfully re-engaged with health providers, like one client who expressed:

[I am] doing way better [than] normally when I would feel like I'm doing better. I would stop my services, like counseling and seeing my doctor or my meds. But I haven't. I haven't been seeing things or hearing things as much since I've been in my own place, good and they have an awesome program where they take people to their medical appointments.

Stable Housing

For individuals experiencing chronic homelessness, the path to stability is often blocked by more than just the absence of shelter. Mental illness, substance use, physical disabilities, trauma, and systemic barriers to care all create a cycle that is nearly impossible to escape without comprehensive support. This is where HHI becomes transformative, not just as a housing intervention, but as a lifesaving, dignity-restoring solution. Evidence of the benefits of HHI are perfectly encapsulated by this statement from a client:

I'll tell you what I can identify now, on the two things that speak volumes. I don't do meth and I don't drink. A lot of things are good. A lot of things are good. They're getting better. They continue to move forward. Things that do happen, that, you know, I had a, you know, personal things that happen, or whatever, they still hit, they still hurt. But I'm not, you know, they don't cripple me. I'm strong enough to be able to deal with them. I'm not drinking, not doing dope, and that gives me a better playing field in my brain to figure things out. And that right there has brought me change.

The Healthy Housing Initiative combines affordable, permanent housing with services tailored to the needs of the individual. These services may include case management, food bank events, mental health care, substance use treatment, life skills training, and health and employment resources connections. According to one caseworker, the HHI program made a substantial difference:

So it's just, you know, really making sure that everybody, as these people, move in, they know who they are, they know what they need, and that everybody comes to the table as a partner and not as property management and case management like really being a partner and Catholic Charities from the top really is the glue that creates that. We have a lot of PSH properties. We have a lot of partners who have PSH. And this, by far, is like the A+ setup from design to partnering with us, and how we partner with them, and then the presence that they have at the property is really, really a big part of that.

The impact is profound and well-documented. Research shows that PSH reduces chronic homelessness by offering long-term housing solutions rather than temporary fixes (National Alliance to End Homelessness, 2017). Also shown in the quantitative results, the HHI program has improved clients' physical and mental health by providing a stable environment where clients can access consistent care. The HHI program has also lowered clients' ER visits and hospital stays, resulting in cost savings for hospitals.

The qualitative findings from CCUSA's HHI program affirmed that housing is not the end of the story; it is the beginning. It provided the stability necessary to confront substance use, manage mental health, build a sense of safety, and began to repair broken trust in institutions such as healthcare. This was echoed by a caseworker:

Homeless services is the hardest task, because people have, unfortunately, I think, the least amount of compassion for those that they see. You know, there's the misperception, misconception that, oh, well, they want to be that way. They must have done something bad to be where they are. And so it's a hard ask, you know, and that's even the development department here in Catholic Charities, tends to kind of focus on food programs, meals, on meals and food for seniors, you know, because that's something people can relate to.

While significant progress has been made, the analysis highlighted key areas for growth, including more robust mental health and substance use services, trauma-informed community practices, and continued advocacy to combat safety issues. Rankings of the top themes by site varied from the aggregate and reflected the specific challenges of each location (see Table 11).

Table 11. Qualitative themes by site

	St. Louis	Detroit	Las Vegas	Spokane	Portland
Drugs/Fentanyl/Substance Use	4	4	3	1	3
Mental health	1	3	2	3	1
Safety	6	6	6	4	6
Police/Law Enforcement	3	5	5	6	5
Healthcare/Doctor	2	2	1	2	2
PSH/Permanent Supportive Housing	5	1	4	5	4

Mental health was the most frequently recurring theme in St. Louis from the interviews and meetings with caseworkers and staff. In the St. Louis region, mental health was a major concern among people experiencing homelessness because behavioral-health resources are insufficient, and many unhoused individuals faced overlapping challenges that increased their risk for mental illness yet hindered access to services.

In Detroit, the top theme was permanent supportive housing. The emphasis on PSH has emerged as a central theme in the city's homeless-response strategy because PSH programs in Detroit have shown strong outcomes. For example, the Michigan Chronicle noted that PSH units in the city contributed to a measurable reduction in chronic homelessness. Also, the city and its Homeless Action Network of Detroit (HAND) lead agency explicitly prioritized PSH in funding allocations and service design, recognizing that housing stability is foundational to addressing other issues.

For the unhoused of Las Vegas, the top theme was healthcare and doctors. In Southern Nevada, individuals experiencing homelessness and low-income residents faced significant barriers to healthcare access, which were compounded by a broader physician shortage in the state. Statewide data show that Nevada ranks near the bottom for physicians per capita ranking 45th for active physicians per 100,000 residents and 48th for primary-care physicians. Together, these factors mean that vulnerable populations in Las Vegas often face long wait times and difficulties finding a provider, and they sometimes rely on emergency rooms for primary care. Additionally, many providers do not accept Medicaid or low-income patients because reimbursement rates are low, paperwork is onerous, and patient-no-show rates are higher, so those with Medicaid or no insurance have difficulty getting care.

In Spokane, fentanyl has become a dominant contributor to overdose deaths and intersects heavily with homelessness. Over 78% of overdose deaths in 2024 involved fentanyl. Among the homeless population, more than half reported addiction issues. In downtown Spokane, large-scale visible use, including smoking fentanyl in public spaces, is noted near homeless encampments and service areas. The mixing of fentanyl with stimulants such as methamphetamine further complicates the risk landscape for people experiencing homelessness. Thus, drug use and fentanyl were the most recurring themes in the interviews.

Similarly to St. Louis, mental health was the most common theme in interviews in Portland. Many people experiencing homelessness in Portland have untreated or severe mental health disorders. One outreach group, Portland Street Medicine, estimates that about 40% of unsheltered individuals report a serious mental health condition, and 80% report a disability. The combination of unstable housing, trauma from living on the streets, lack of behavioral health providers, and high prevalence of substance use all contribute to significant mental health concerns for Portland's homeless population.

An Analysis of Cost Savings

One dynamic that CCUSA sought to examine in the evaluation was potential cost savings achieved as a result of the services provided to clients. Our longitudinal results suggested that the number of clients who reported at least one ER visit decreased by 46% after being housed by HHI for the first six months, and the average number of ER visits among clients who had reported at least one ER visit decreased by 1.63. In the baseline dataset (N=402), 212 clients reported that they had at least one ER visit six months prior to being housed. Plugging in the results from the longitudinal analysis, in the first six months after being housed, the number of clients who had at least one ER visit should drop to 115 [$212 \times (1 - 0.46) = 115$], and the average number of ER visits among clients who had at least one visit should decrease from 4.11 to 2.48 ($4.11 - 1.63 = 2.48$).

Therefore, it is estimated that after the first six months of being housed, the total number of ER visits should be roughly 286, representing a **decrease of 585 in total ER visits**. Based on the Homeless Management Information System (HMIS) case notes, the cost per ER visit ranged from \$750 to \$3,000, with the average being \$2,000. Based on this estimate, the cost savings for ER visits alone during the first six-month period after being housed is around **\$1.17 million** for a total of 402 clients.

Regarding hospital stays, our results suggested that the number of clients who reported having at least one hospital stay decreased by 60% after being housed by HHI after the first six months, and the average number of hospital stays among clients who had reported to have at least one hospital stay decreased by 0.38. In the baseline dataset (N=402), 96 clients reported that they had at least one hospital stay six months prior to being housed. Based on the trends observed for those who completed the baseline and follow-up surveys, we conducted further analysis to estimate the changes in hospital stays for all respondents, including both those who completed and those who did not complete the follow-up survey. The results from the longitudinal analysis suggested that, six months after being housed, the number of clients who had at least one hospital stay would drop to 39 [$96 \times (1 - 0.6) = 39$], and the average number of hospital stays among clients who had at least one stay would decrease from 2.27 to 1.89.

Similarly, when considering all 402 clients, it is estimated that after six months of housing, the total number of hospital stays would be roughly 74 [$39 \times (2.27 - 0.38) = 74$], a sharp **decrease from the 218 total hospital stays observed in the baseline survey**. According to one report (Karpenko, et al., 2025), the median length of hospital stay was **seven days** among the unhoused population. Based on HMIS case notes, the average cost per hospital stay was \$3,000. Thus, using the decreased number of hospital stays (n=144) times the median length of hospital stay (seven days) multiplied by \$3,000 would result in a total estimated savings of **\$3.02 million** for hospital stays alone during the first six-month period for the 402 clients.

Therefore, the drop in ER visits and hospital stays would result in an estimated savings of **\$4.91 million per 402 new clients** in the first six months of housing, or \$12,214 per client. The collaborative investment between Catholic Charities and hospitals also strengthens the local continuum of care and builds trust with underserved populations. As a result, this partnership model improves lives and makes economic sense. Every dollar spent on HHI is offset by multiple dollars saved in public health, safety, and social service systems. In essence, housing is healthcare, and by investing in HHI, Catholic Charities and hospital systems together demonstrate a compassionate and cost-effective approach to breaking the cycle of homelessness.

Summary and Recommendations

The current evaluation employed a mixed-method approach including a cross-sectional and longitudinal design for the quantitative analysis, as well as in-depth interviews for the qualitative analysis. The results have indicated that the HHI program has met all three program goals. In addition, it had an overall positive impact on clients and their communities. Clients have also reported the significance of housing and social services in combatting homelessness. Moreover, our results have demonstrated enduring health benefits for long-term HHI clients (i.e., clients who have stayed with HHI for more than six months).

In terms of the **three major program goals**, the evaluation has indicated that:

1. A total of 792 clients have been housed by the five HHI sites despite the unexpected COVID-19 pandemic, which may have introduced unique challenges to each site. The actual number of clients housed by all sites exceeded the cumulative targeted number of 698 (calculated as 20% of PIT counts in 2019). Therefore, the goal of housing at least 20% of those who have experienced chronic homelessness has been met;
2. The number of ER visits dropped by 46% and the number of hospital stays dropped by 60% after clients were housed by HHI for six months. Results from the cross-sectional approach were consistent with these findings. Therefore, the goal of reducing emergency room/hospital utilization of housed clients by at least 25% has been met; and
3. A full 86% of the clients had a primary care provider and 37% had a behavioral health provider after being housed by HHI. Therefore, the goal of connecting at least 35% of newly housed persons to primary care and behavioral health services has been met.

In terms of the reported **health benefits of the HHI program**, our evaluation has found the following:

1. Health indicators, including medication compliance and self-rated physical and mental health, have improved dramatically after clients were housed by HHI for at least six months;
2. Average worriedness about housing, health, and access to healthcare were dramatically lower for clients after six months of being housed; and
3. The cross-sectional analysis revealed benefits of being in the HHI program after being housed for a long period of time. For example, health indicators continue to improve, as shown by the second follow-up survey.

In terms of **financial and community benefits of the HHI Program**, our evaluation indicated the following:

1. The drop in ER visits and hospital stays would result in an estimated savings of \$4.9 million for the 402 surveyed clients over the first six months of being housed;
2. In interviews, clients and caseworkers emphasized the benefits of the HHI program and the importance of housing and social services in combatting homelessness; and
3. Health benefits may vary depending on clients' demographic background. For example, while the number of clients connected to behavioral health providers met the program goal of 35% for clients overall, it was slightly under the goal for male clients (33.71%), clients aged 60 and older (27.50%), and non-Hispanic White clients (33.82%). This further suggested that caseworkers might need to develop tailored strategies to connect specific groups of clients to behavioral health providers.

Catholic Charities USA is uniquely positioned to lead a national movement addressing homelessness by expanding its Healthy Housing Initiative (HHI). By leveraging the success of HHI as a model, CCUSA can advance the development of more permanent supportive housing solutions that provide stable shelter and integrate critical wraparound services. These include fostering stronger partnerships with hospital systems and community organizations to improve health outcomes, enhancing access to mental health and substance use disorder services, and promoting better, more compassionate interactions between law enforcement and individuals experiencing homelessness. Together, these strategies can create a holistic, person-centered approach that addresses the complex needs of the most vulnerable and drives systemic change nationwide. The following are our recommendations based on the evaluation report.

1. Expanding the Healthy Housing Initiative to other Catholic Charities agencies across states might represent an effective solution to one of the most pressing social issues of our time. CCUSA is uniquely positioned for this expansion due to its extensive national Catholic network, deep community roots, and trusted relationships with the people it serves. By growing HHI nationwide, CCUSA can create a unified, mission-driven response to homelessness that integrates housing stability with holistic health and human services in communities large and small.
2. Expand the number of Permanent Supportive Housing (PSH) units available; invest in sustainable funding streams for wraparound services that meet the diverse needs of individuals and families; and strengthen cross-sector partnerships to create seamless pathways from homelessness to housing.
3. Develop and solidify relationships with hospital systems. CCUSA should collaborate with hospitals to devise innovative approaches to combat homelessness. For example, agencies and health partners could find ways to integrate on-site mental health services and increase substance use disorder (SUD) services and treatment options.
4. Work with health insurance companies to cultivate mutually beneficial programs (such as HHI) that both help the homeless and reduce insurance claims for unnecessary or preventable ER visits and hospital stays.
5. Employ strategies for finding available behavioral health providers (including virtual doctors) and collaborate with behavioral health systems to reduce the wait times for clients to be seen.
6. Continue working with clients who express distrust in the medical system and get them connected to primary care providers.
7. Create tailored strategies for developing and maintaining HHI at each CC agency. For example, the evaluation results demonstrated the unique advantages and challenges of each city, and the health outcomes of clients varied. Therefore, each agency participating in HHI should develop tailored strategies for helping the clients of their city.
8. Continue to promote workshops and encourage HHI agencies to share best practices among fellow agencies.
9. Continue to track clients' data and outcomes, if agencies are able to do so.

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Glossary

ACS: American Community Survey is an annual demographics survey conducted by the U.S. Census Bureau.

ATLAS.ti: ATLAS.ti is a computer-assisted qualitative data analysis software that facilitates analysis of qualitative data for qualitative research, quantitative research, and mixed methods research.

Baseline Survey: The HHI Baseline Survey is given to new HHI clients. It contains information on self-rated health, demographic and social background, and hospital/healthcare experience for the six months prior to being housed.

CCEW: Catholic Charities Eastern Washington (Spokane)

CCSEM: Catholic Charities of Southeast Michigan (Detroit)

CCSN: Catholic Charities of Southern Nevada (Las Vegas)

CCSTL: Catholic Charities of the Archdiocese of St. Louis

CCO: Catholic Charities of Oregon (Portland)

Chronic Homelessness: The federal definition of chronic homelessness describes the experience of those who have been homeless while struggling with a serious mental illness, substance use disorder, or physical disability. These individuals live in impermanent and inhabitable places, and have been unhoused for at least a year, or have had four episodes over the last three years.

HHI: Catholic Charities' Healthy Housing Initiative is a five-year pilot program combining housing and health services in five cities to address chronic homelessness and improve health outcomes.

HMIS: The Homeless Management Information System is a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families at risk of and experiencing homelessness.

HUD: The U.S. Department of Housing and Urban Development.

Long Follow-up Survey: The survey was designed for clients in the EXCEL dataset. It collects similar information to the Baseline Survey and the Short Follow-up Survey.

McNemar's Chi-square: McNemar's test (also known as the paired or matched chi-square) provides a way of testing the hypotheses in quantitative research.

PIT Count: The HUD Point-in-Time Count is a count of the people experiencing homelessness in a single night.

PSH: Permanent Supportive Housing is long-term, affordable housing with voluntary wraparound supportive services for people experiencing homelessness or housing instability.

REDCap: Research Electronic Data Capture (REDCap) is a secure, HIPAA-compliant web application specifically geared to support online and offline data collection and data management for research.

Short Follow-up Survey: The HHI short follow-up survey is given to clients six months after they complete the Baseline Survey. The second short follow-up survey is given to clients 12 months after they complete the Baseline Survey. It contains only time-variant questions.

Supplement (EXCEL datasets):

Findings from the HHI datasets

The five pilot agencies collected major outcome measures using EXCEL, including ER visits, hospital stays, whether clients had primary care providers, and whether clients had behavioral health providers. This data was collected before the evaluation project began. The evaluation team acquired the EXCEL datasheets and analyzed the data. The results from the EXCEL datasheets are presented in this section.

Overview

This section provides an overview of the data collected in the five HHI datasets. There were 154 clients total in the dataset. Figure 14 displays a pie chart indicating the number of clients by agency. Eleven were from CCSEM Detroit, 45 from CCSTL St. Louis, 49 from CCSN Las Vegas, 16 from CCO Portland (Oregon), and 33 from CCEW Spokane. Figure 15 indicates the sample size for each survey. The vast majority of clients (144 clients; 94%) participated in the six-month follow-up survey, while 75 clients (49%) participated in the 12-month follow-up survey.

Gender was reported for 108 clients. Among those clients, 43% reported being female (N=46) and 57% reported being male (N=62). The remaining 46 clients did not report their gender (30 were from St. Louis and 16 were from Oregon).

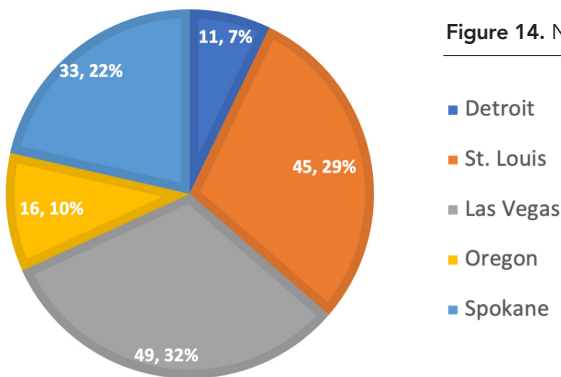


Figure 14. Number of clients by agency

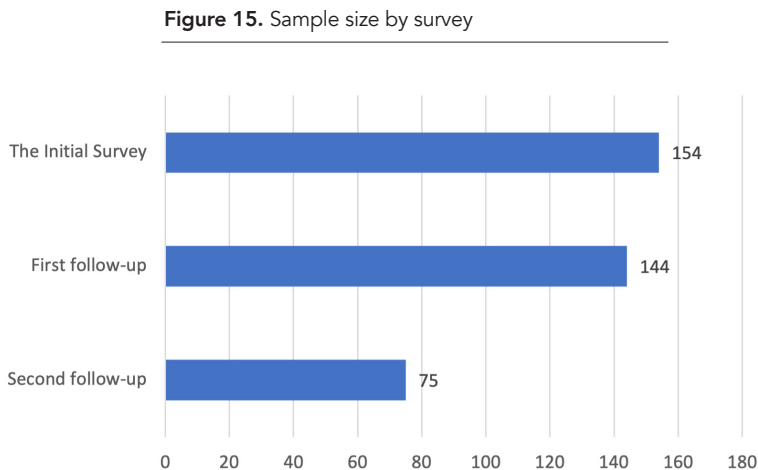


Figure 15. Sample size by survey

Figure 16. Racial composition

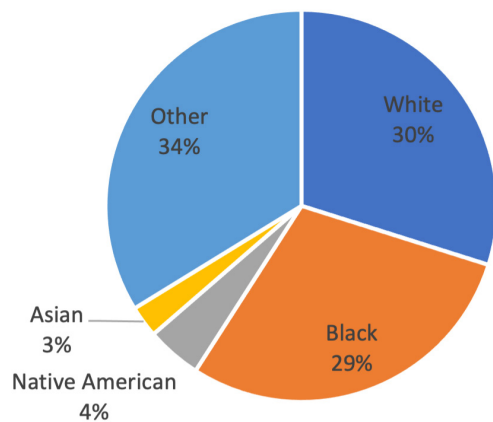


Figure 16 shows the racial composition of the clients. About one-third of clients (30%) identified as White (N=46), 29.2% as Black (N=45), 4.5% as Native American (N=7), 2.6% as Asian (N=4), and 34% as Other (N=52). It should be noted that many of the clients who reported “Other” as their racial background also indicated a Hispanic ethnicity. This is consistent with prior demographic and social science reports in which individuals with a Hispanic or Latin American background were more likely to report “Other” as their racial identity. The average age of the housed clients was 54.18 (SD=13.00), and the ages ranged from 23 to 86.

Survey 1 was conducted when the client received housing through CCUSA. The survey gathered information pertaining to the six-month period prior to being housed. Regarding data in the ER/Hospital/PCP Questionnaire, 114 clients (76%) reported that they had *at least one ER visit* during the six-month period before being housed. For those who visited the ER, the average number of ER visits was 9.1 (SD=14.38), and the median was 2. The total number of ER visits was 1,037. Eighty-seven clients (57.62%) reported that they had *at least one hospital stay* during the six-month period prior to being housed. For those who had hospital stays, the average number of hospital stays was 2.09 (SD=2.48), and the median was 1. The total number of hospital stays was 182.

Sixty-three clients (40.91%) reported that they had a *primary care doctor or nurse practitioner* before being housed. Among these clients, 38 of them (61%) reported that they had seen their primary care doctor or nurse practitioner in the past six months. Regarding *behavioral health providers*, only 8 clients (5.19%) reported having one, and only 5 clients had seen this provider in the six-month period prior to being housed.

Survey 2 was conducted six months *after* the client received housing through CCUSA. Data items pertain to this six-month period after being

housed. There were 144 clients who participated in this follow-up survey. About half (80 clients; 55.6%) reported that they had *at least one ER visit* within the six-month period after being housed. The average number of ER visits among the 80 clients within this six-month period was 5.28 (SD=9.14), and the median was 2. The total number of ER visits was 426. This figure represents a dramatic drop in ER visits, as it is less than half the number reported in the six months prior to being housed (i.e., 1,037 ER visits before housing versus 426 ER visits after housing). In terms of hospital stays, 49 clients (34%) reported that they had *at least one hospital stay* six months after being housed. For those who had hospital stays, the average number of hospital stays was 1.57 (SD=1.17), and the median was 1. The total number of hospital stays was 77 (also remarkably lower than the total hospital stays prior to being housed, which was 182).

Six months after being housed by CCUSA, 80 clients (55.6%) indicated that they had a *primary care doctor or nurse practitioner*. Among these clients, 72% reported that they had visited the doctor or the nurse practitioner within the six-month period after being housed. In addition, 12.5% of the clients (n=18) reported that they had a *behavioral health provider*, and 83% (n=15) visited their behavioral health provider in the six months after being housed.

Survey 3

Seventy-five clients participated in an additional follow-up survey (Survey 3), which was conducted 12 months after being housed and asked questions about the previous six months. In this survey, 31 clients (41.33%) reported at least one ER visit, which represents a remarkable decrease compared to the figures in previous surveys (see Table 12). For the clients who visited the ER, the average number of ER visits within the past six months was 7.45 (SD=13.91), and the median number was 2. In addition, only 19 clients (25.33%) reported at least one hospital stay within the previous six months. For the clients who had hospital stays, the average number of hospital stays was 1.53 (SD=0.84), and the median was 1. The total number of hospital stays was 29. Some survey items, including whether the client had a doctor or behavioral health provider, had high missing response rates (61% and 63%). In addition, many clients who participated in Surveys 1 and 2 did not participate in Survey 3. Therefore, data from Survey 3 were not included in further analyses.

Table 12. Pre- and post-survey data

	Survey 1	Survey 2	Survey 3
Sample Size	154	144	75
ER visits			
# of clients with at least 1 ER visit (%)	114 (76%)	80 (55.6%)	31 (41.33%)
Total number	1037	426	186
Mean (for clients who had ER visit)	9.1 (SD=14.38)	5.28 (SD=9.14)	7.45 (SD=13.91)
Median (for clients who had ER visit)	2	2	2
Hospital Stays			
# of clients with at least 1 hospital stay (%)	87 (57.62%)	49 (34%)	19 (25.33%)
Total number	182	77	29
Mean (for clients who had hospital stay)	2.09 (SD=2.48)	1.57 (SD=1.17)	1.53 (SD=0.84)
Median (for clients who had hospital stay)	1	1	1
Primary Care Provider			
# of clients with primary care provider (%)	63 (40.91%)	80 (55.56%)	N/A
# of clients visiting primary care provider (%)	38 (61%)	57 (72.15)	N/A
Behavioral Health Provider			
# of clients with behavioral health provider (%)	8 (5.19%)	18 (12.5%)	N/A
# of clients visiting behavioral health provider (%)	5 (62.5)	15 (83%)	N/A

Further Analysis

We conducted further analyses to investigate potential changes before versus after housing. Specifically, we examined potential changes in ER visits, hospital stays, having a primary care/behavioral health provider, and visiting their providers. We employed data from the initial survey (Survey 1, before housing) and the six-month follow-up survey (Survey 2, after housing). Comparing the data across these two surveys, we were able to test for potential differences in the six-month period *before* housing versus the six-month period *after* housing. We did not include data from the 12-month follow-up survey due to there being too many missing values. We employed paired-samples t-tests and chi-square analyses to determine whether observed differences before versus after housing were statistically significant.

Table 13 displays the results of our analyses. There were 144 clients who participated in both Surveys 1 and 2. Clients who participated in only one survey were excluded from analyses.

Figure 17. Number of clients had ER visit or had hospital stays

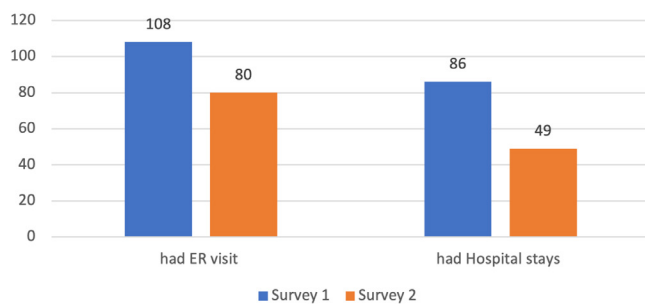
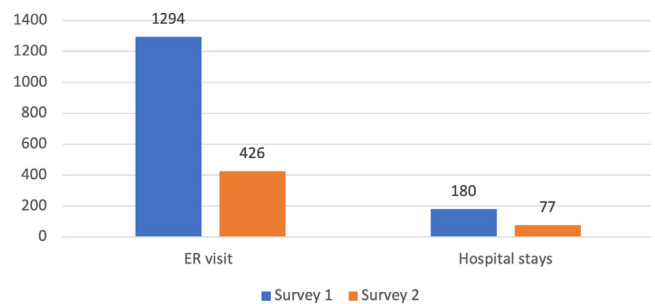


Figure 18. Total number of ER visits and hospital stays



ER Visits

Results indicated that the number of people who had visited the ER decreased by 26% after being housed for six months (see Figure 17). Moreover, the total number of ER visits decreased from 1,294 to 426, representing a 67% decrease (see Figure 18). Chi-square analysis revealed that the decrease in ER visits before versus after housing was statistically significant, $\chi^2(1) = 12.01$, $p = 0.0005$. The average number of ER visits per person decreased by 4.3 times, and a paired-samples t-test determined that this decrease in individual visits was also significant ($p = 0.000$). Taken together, the results suggest there was a significant decrease in ER visits before versus after housing.

Hospital Stays

The number of clients with hospital stays decreased by 43% after being housed for six months. The total number of hospital stays also decreased by 57% (from 180 to 77). Chi-square analysis revealed that the decrease in hospital stays before versus after housing was statistically significant, $\chi^2(1) = 19.09$, $p < 0.0001$. In addition, days spent in the hospital per person decreased by 0.73 days on average. A subsequent paired-samples t-test revealed that the drop in hospital stays per person was statistically significant ($p = 0.000$). The results suggest there was a significant decrease in hospital stays before versus after housing.

Primary Care Providers

Twenty-three more clients were connected to a primary care doctor after being housed by CCUSA (see Figure 19). This represented a 40% increase before versus after housing. In addition, 23 more clients had seen the doctor in the six-month period after being housed, representing a 67% increase. Chi-square analyses confirmed statistical significance for the increase in clients with primary care providers ($X^2(1) = 7.365$, $p = 0.0067$) and primary care visits ($X^2(1) = 8.498$, $p = 0.0036$) before versus after housing.

Behavioral Health Providers

Eleven more clients were connected to a behavioral health provider after being housed (see Figure 19), a 1.5x increase compared to before housing. Moreover, 11 more clients had seen a behavioral health provider after being housed, representing a 2.7x increase. Chi-square analyses confirmed statistical significance for the increase in clients with behavioral health providers ($X^2(1) = 5.300$, $p = 0.0213$) and behavioral health visits ($X^2(1) = 6.818$, $p = 0.0090$) before versus after housing.

Figure 19. Total number of clients being connected to PCD and BHP

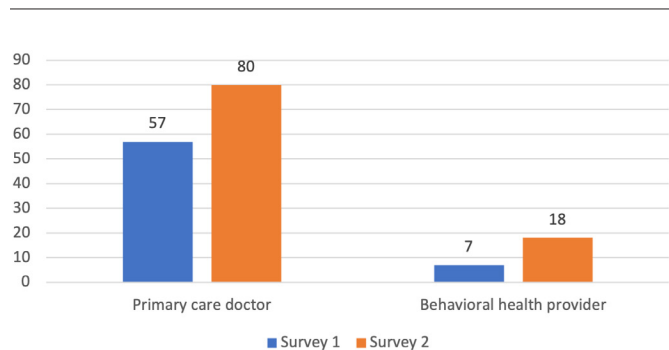


Table 13. Statistical analysis of pre- and post-survey data

	Survey 1	Survey 2	Differences	Significance Test
Sample Size	144	144		
ER visits				
# of clients with at least 1 visit (%)	108 (75%)	80 (55.6%)	-28 (25.93%)	$X^2(1) = 12.01$ ($p = 0.0005$)
Total number	1294	426	-868 (67.08%)	$4.26 \text{ Pr}(T > t)$ $= 0.0000$
Mean	7.21 (SD=13.42)	2.95 (SD=7.33)		
Hospital Stays				
# of clients with at least 1 stay (%)	86 (59.73%)	49 (34%)	-37 (43.02%)	$X^2(1) = 19.09$ ($p < 0.0001$)
Total number	180	77	-103 (57.22%)	$0.73 \text{ Pr}(T > t)$ $= 0.0000$
Mean	1.26 (SD=2.18)	0.52 (SD=1.01)		

Table 13, cont'd.

	Survey 1	Survey 2	Differences	Significance Test
Primary Care Providers				
# of clients with primary care provider (%)	57 (39.89%)	80 (55.56%)	23 (40.35%)	X2 (1) = 7.365 (p = 0.0067)
# of clients visiting primary care provider (%)	34 (59.65%)	57 (72.15%)	23 (67.65%)	X2 (1) = 8.498 (p = 0.0036)
Behavioral Health Providers				
# of clients with behavioral health provider (%)	7 (4.86%)	18 (12.5%)	11 (157.12%)	X2 (1) = 5.300 (p = 0.0213)
# of clients visiting behavioral health provider (%)	4 (57.14%)	15 (83%)	11 (275%)	X2 (1) = 6.818 (p = 0.0090)



Last year, Catholic Charities agencies nationwide served more than 16 million of our at-risk neighbors — people without homes, those who are unemployed or underemployed, children who are hungry or malnourished, elderly persons who are isolated, vulnerable migrants and refugees on the move, families recovering from natural disasters, pregnant women and new mothers in need, and persons with disabilities who have inadequate care.

The membership of CCUSA is made up of 170 diocesan Catholic Charities agencies. Each falls under the auspices of its local bishop/archbishop and serves the needs of the community in which it is located.