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- The Demonstration implemented intensive services including case management, transitional jobs, financial literacy training, and relocation counseling.
- Resident engagement increased from 50 to nearly 90 percent.
- Additional costs for the intensive services were modest.

A New Model for Integrating Housing and Services

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Ten years ago the Chicago Housing Authority (CHA), like many housing authorities nationwide, was grappling with how to address the legacy of urban disinvestment: developments that were not functional, clean, or safe; neighborhoods that were physically and socially isolated from the rest of the city; and residents struggling with unemployment, substance abuse, and trauma. The CHA responded to these challenges with an ambitious 10-year Plan for Transformation. The Plan replaced the CHA's notorious high-rise developments with new mixed-income housing, reinvested in and improved its remaining public housing stock, and reversed its long history of dysfunctional internal management (Vale and Graves 2010).

But while the Plan for Transformation addressed the CHA's bricks-and-mortar issues, its Service Connector program, which provided case management and referral services for residents, was less successful. Advocates and resident leaders criticized the Service Connector program for high caseloads and inadequate services. And while Service Connector and the CHA's relocation services evolved over time, and caseloads were gradually reduced, even the improved services could not meet the deep needs of CHA's most vulnerable residents, who had long relied on the CHA's distressed developments as housing of last resort (Popkin 2006). These families faced numerous, complex barriers to their abil-

ity to move toward self-sufficiency or even sustain stable housing, including serious physical and mental health problems, weak (or non-existent) employment histories and limited work skills, very low literacy levels, drug and alcohol abuse, family members' criminal histories, and serious credit problems (Popkin, Cunningham, and Burt 2005; Popkin et al. 2000).

The Chicago Family Case Management Demonstration was created to develop effective strategies for addressing the needs of these hard-to-house families. The Demonstration ran from March 2007 to March 2010, overlapping with the 2009 CHA Panel Study, which tracked a random sample of residents from CHA's Madden/Wells Homes from

“The first part of getting any need met is to recognize what the need is.”

—Heartland Clinical Director

2001 to 2009 (Popkin, Levy, et al. 2010). The Demonstration—a partnership of the Urban Institute, the CHA, Heartland Human Care Services, and Housing Choice Partners—intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families (Popkin et al. 2008). The program provided residents from the CHA’s Dearborn Homes and Madden/Wells developments with intensive case management services, transitional jobs, financial literacy training, and relocation counseling (see text box on page 10).¹

The Urban Institute conducted a rigorous evaluation, including a baseline and follow-up survey, administrative interviews, focus groups with service providers and program administrators, in-depth resident interviews, and analysis of program and administrative data. The evaluation tracked participant outcomes and monitored the collaboration among the service partners. The design allowed for continuous learning and mid-course corrections during implementation.

The Demonstration was remarkably successful in implementing a wraparound service model for vulnerable public housing residents. The lead service provider was able to adapt the service model as residents relocated with vouchers or to mixed-income housing, while sustaining high levels of engagement. Further, participants perceived improvements in service quality and delivery, and providers felt more effective and engaged. The Demonstration also generally improved the quality of coordination and cooperation between service agencies and the CHA. However, the Demonstration was less successful in engaging participants in relocation counseling and, thus, facilitating opportunity moves. The additional costs for the intensive services were relatively modest, suggesting that it would be feasible to take a carefully targeted intensive service model to scale. In this brief, we discuss the implementation of the Demonstration

and our analysis of service costs. The other briefs in the series (see Popkin, Theodos, et al. 2010) describe the outcomes for participants across a range of domains, including employment, health, housing and neighborhoods, and children and youth.

The Chicago Family Case Management Demonstration Service Model

The Demonstration built on and enhanced the CHA’s standard service package (table 1).² CHA Service Connector case managers had high caseloads and were only able to deal with clients who actively sought them out; as a result, the proportion of residents actively engaged in services hovered around 50 percent. The Demonstration allowed Heartland to dramatically lower caseloads to about half the standard load for CHA service providers. Heartland carefully selected its case management team; according to a senior administrator, staff looked for case managers with a unique combination of intuition, empathy, and emotional intelligence. Case managers also received new training in strength-based and change theory models, motivational interviewing, and family-focused case management. At each site, the managers reassigned clients and restructured responsibilities to fit the new model, such as moving active substance users to a case manager with clinical expertise in these issues. With these changes, case managers now had time to conduct outreach to clients who previously had not engaged in services. And, case managers had time to meet more often with all their clients, seeing them weekly, reviewing issues, and attempting to engage other family members.

Another innovation for the Demonstration was ensuring consistency of care over time. Instead of transitioning families to new providers when they moved—with vouchers, to other CHA developments, or to mixed-income units—the same case managers

stayed with the families for the three years of the Demonstration, continuing to make weekly visits in the new location. Essentially, this model means that the service program offered both site-based services and long-term wraparound services for those who left the developments.

Heartland’s intensive service model offered two supplemental services to enhance the case management and help residents improve their life circumstances. The Transitional Jobs (TJ) program, a more intensive version of the model used citywide by CHA’s Opportunity Chicago workforce initiative, was aimed at helping residents with little or no work experience connect to the labor market.³ The program relied on intensive employment and interview training, rapid attachment to the workforce, three months of subsidized employment, and continued counseling and advocacy support for residents throughout the first year of employment. The Demonstration also offered participants the opportunity to participate in Heartland’s Get Paid to Save (GPTS) financial literacy program. GPTS offered training in budgeting and financial management, and it provided a matched savings program: for every dollar a resident saved in a dedicated account, the program provided two dollars. Participants could accumulate up to \$1,000 in this way.

Like Heartland’s intensive case management, HCP’s enhanced relocation services built on CHA’s traditional service model. Under the Relocation Rights Contract—the agreement between the CHA and its resident councils—residents were offered three replacement housing options: a unit in a new, mixed-income development; a Housing Choice Voucher; or a rehabilitated unit in traditional public housing. CHA’s relocation service providers took residents who chose vouchers on tours of low-poverty (less than 23.5 percent poor) and opportunity (less than 23.5 percent poor and less than 30 percent

Table 1. Comparing the Basic CHA Service Model and Demonstration Services

SERVICE FEATURE	CHA SERVICE MODEL AT START OF DEMONSTRATION	DEMONSTRATION SERVICE MODEL
Engagement	50 percent	90 percent
Case manager–to-client ratio	1 case manager for 55 residents	1 case manager for 25 residents
Frequency of contact	Once a month	Two to four visits a month
Contact with household	Leaseholder	Family
Length of time case managers remain with residents, even after they move	3 months	3 years
Financial literacy training and matched savings program	Not available	Available
Clinical and substance abuse services	Referral to substance abuse counseling	On-site licensed clinical social worker; referral to substance abuse counseling
Transitional Jobs program	Not available	Available
Relocation counseling	Traditional relocation services (e.g., neighborhood tours for residents interested in vouchers, help locating apartment listings, assistance negotiating with landlords and the voucher program)	Augmented workshops and “second mover” counseling; traditional relocation services
Case manager training	Limited, varies with service provider	Additional training for case managers and ongoing clinical support groups

African American) neighborhoods. Whether or not residents chose to move to one of these neighborhoods, relocation counselors helped them identify a specific unit and negotiate with landlords and the voucher program; counselors also followed up with residents after the move. HCP’s intensive services included reduced caseloads, increased engagement, and workshops that covered the benefits of opportunity areas, tenant rights and responsibilities, housekeeping, and school choice. Residents received \$20 incentives for participation.

Creative Adaptations

Under the new model, case managers put their energy into outreach, going into the development and knocking on doors. When they did, case managers uncovered one tough problem after another: residents with schizophrenia who had stopped taking their medications and refused to open the door; women with severe depression; mothers at risk for losing custody of their children; grandmothers struggling to care for several grandchildren, some of whom were in trouble with the law; and substance abusers who were so in debt to drug dealers that the dealers had taken over their apartments (see sidebar).

Even with a more intensive case management model, participants did not always divulge their problems, nor were they immediately recognizable to case managers. In focus groups, case managers discussed the importance of up-front assessments in revealing untreated trauma among residents. One counselor discussed the connection between undiagnosed trauma and substance abuse in public housing:

People are expected to make rational decisions without the psychological barriers being addressed. Even though this person may act normal, if you don’t do a viable

Serving Families with Deep Challenges

Martin, a 65-year-old man, and his 15-year-old developmentally delayed son, Andrew, relocated from Madden/Wells to a smaller CHA development on the far South Side. Martin grew up in public housing; his family was very close, and he says he had a happy childhood. He dropped out of school after 8th grade because he had to work in his father's trucking business. Martin got married and had his first child when he was 18, and now has six children; he was married for 46 years, but now is divorced. Andrew's mother died in 2006, leaving Martin as his sole caregiver.

Martin has many health problems: he is diabetic, has asthma and congestive heart failure, had lung cancer a few years ago, has a serious drinking problem, and recently began using cocaine again. Even so, Martin says he is very concerned about staying healthy so he can care for his son, so he exercises (he says he has lost 100 pounds) and sees his doctor regularly. He and Andrew get by on Social Security and what Martin makes selling things at the local flea market.

Taking care of Andrew is difficult for Martin. Andrew cannot read or write well, has trouble communicating, and is often picked on at school. Martin worries constantly about Andrew, and often wonders what will happen to Andrew if he dies. Martin's main hope is that he will live long enough to see Andrew graduate from high school and move into an independent living program.

biopsychosocial [assessment] on this individual and ask them probing in-depth questions, you'll never find out this person's issues. They may laugh with you. They may talk with you. They may let you in their house. They may do some other stuff with you. The number one issue we have—the reason that people get high so much in public housing—is trauma. Unaddressed trauma that they never got help for. They continue to use drugs and alcohol as a result because that is their coping sphere.

Heartland quickly realized the need for more intensive, clinical mental health services for participants. A year into the Demonstration, the CHA reconfigured and took direct control of its resident services programs, which had been managed through the Chicago Department of Human Services. Heartland and its other service providers had to negotiate new contracts in 2008; this renegotiation provided Heartland with resources to hire wellness counselors (i.e., clinical case workers) for each site and, eventually, a psychiatrist able to come to each site a few hours a week (Popkin and Getsinger 2010).

While case managers were generally positive about the new service model, their supervisors reported that it was clear from regular staff meetings that they were at risk of becoming overwhelmed by the depth of the problems they were uncovering. The case managers were not trained clinical mental health professionals; through the Demonstration, they faced with situations that even trained clinicians would find extremely challenging. Once Heartland recognized the level of emotional strain placed on case managers, they hired a clinical supervisor to provide ongoing support for case managers in their day-to-day work. The clinical supervisor instituted regular, small-group meetings to review cases and provide support where staff were able to freely vent their concerns and frustrations, work

through challenging cases, obtain support when feeling overwhelmed, and receive ongoing reinforcement of the training they received. CHA's vice president of resident services reiterated the importance of this support system in an interview in December 2009:

The other thing that was really important in terms of case management survival and building was we had put into place a kind of case management consultant on the team that was a part of Heartland staff. But it wasn't someone that directly supervised the case manager. So it was a safe place for case managers to learn, complain, and problem-solve without it directly impacting performance evaluation or review. And that system actually proved to be really valuable.

In addition to ramping up the Demonstration's clinical support, Heartland changed its TJ program to serve a broader range of participants. Initially, TJ staff underestimated the severity of participants' barriers to employment. The coordinator reported that participants were failing to pass the mandatory drug screening, and that many lacked the 9th-grade literacy level required by many jobs. To meet the latter challenge, the TJ coordinator lowered the literacy standards for program entry and developed a pilot program that focused on improving literacy for participants (Parilla and Theodos 2010).

Likewise, the Heartland team refocused its financial literacy initiative when it became clear that it was only reaching families with the least barriers to self-sufficiency. As the GPTS coordinator explained, understanding resident needs when it came to financial literacy and saving was not easy:

One challenge [was determining] what our flexibility is or our ability to be adaptable within the parameters of the program and the parameters of the Demonstration as a

whole. Just being able to adapt things, but adapt in a way that's useful for participants. So, maybe that's something bears further exploration even still. It's what really is useful and what do people really actually want.

Heartland's response was to increase coordination with case management staff, increase outreach, conduct on-site workshops, and shift the program's focus to credit repair. While there was not sufficient time left in the Demonstration to assess how well this new approach worked, it reflects Heartland's creativity, willingness to strategize, and ability to adapt to new situations.

Many Challenges

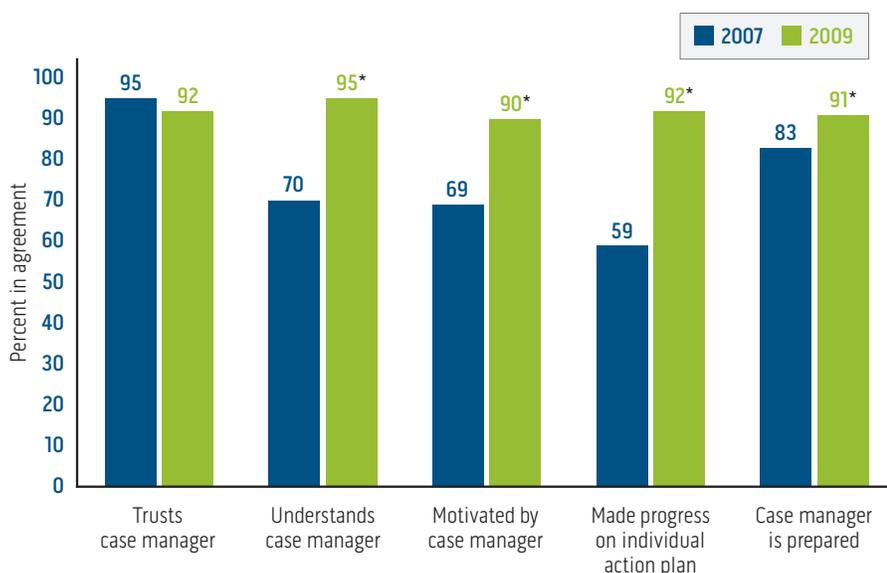
The Demonstration's relocation counseling services encountered numerous challenges that undermined their success, and, despite the enhanced services, few families had relo-

cated to high-opportunity neighborhoods by the 2009 follow-up survey (Theodos and Parilla 2010). First, the intense vulnerability of Demonstration participants prevented many of them from moving to a neighborhood of higher opportunity. Long-term CHA residents had not conducted a housing search in decades, if ever, and many were simply not up to the task. Second, the expedited closure of Madden/Wells limited HCP's work with those families. Relocation counselors reported they did not have sufficient time to adequately educate residents about their full housing and neighborhood choices, given that neighborhood tours, school choice information sessions, and other parts of intensive relocation counseling are time consuming. Third, residents often chose lower-opportunity neighborhoods because of familiarity, proximity to family and friends, or availability of public transit. Finally, the collaboration

between Heartland and HCP did not always work smoothly. Poor communication between the relocation and service providers meant that residents' cases could be dropped with insufficient follow-up.

To increase the number of opportunity moves, HCP proposed incorporating "second mover" counseling, which meant conducting outreach to families who had used their vouchers to move to traditional high-poverty areas to try to encourage them to consider a second move to a low-poverty or opportunity area. However, this component was never fully implemented; CHA assigned HCP to conduct relocation at another CHA development that was slated for closing, which meant HCP's small staff had to shift their focus away from Dearborn and Madden/Wells. Because of these problems, in 2009, only 26 families had moved to a low-poverty area, and just 4 had moved to an opportunity area (Theodos and Parilla 2010).

Figure 1. Residents' Perceptions of Their Case Managers, 2007 and 2009



Sources: 2007 and 2009 Demonstration samples.

* Difference between 2007 and 2009 is significant at the $p < .05$ level.

Successful Engagement with Residents

When the Demonstration began in 2007, engagement levels among residents hovered around 50 percent.⁴ By 2008, these engagement levels had risen to nearly 90 percent and remained at that level until the Demonstration ended in 2010. Case managers met with residents an average of three to four times a month, up from just once a month before the Demonstration. Perhaps most striking was that engagement rates remained high even as case managers began following relocated residents off site. Two years into the Demonstration, participants were living in various settings around the city, including the private market, other traditional public housing developments, and mixed-income housing. To our knowledge, the Demonstration was the first wraparound service model that successfully followed residents after relocation; this achievement represents a major innovation in service provision in a public or assisted housing setting.

Very High Marks for Case Managers

In 2007, Demonstration participants rated their case managers very highly. Even after starting out high, these figures rose significantly by 2009 (figure 1). The increases reflect both that engagement increased and that participants viewed the higher engagement as productive, not an intrusion or burden. The vast majority of participants said that their case manager was easy to talk to and to understand; nearly all said that they felt motivated and encouraged by their case managers, were more likely to attend meetings with their case manager, and felt these meetings were productive.

These high marks for case managers reflect Heartland's investment in its staff and, consequently, case managers' investment in the Demonstration model. At the end of the Demonstration, the clinical director said she felt that because case managers were seeing clients more regularly, they were more invested in their clients, and thus there was less staff turnover. Likewise, one site manager stated,

We are like family to them. Good and bad. The good is that they allow us to celebrate their successes. Bad is that they sometimes feel like you may be too close, so case managers definitely need to know when to back up and let their resident to grow within the space they have and come back to us.

Participants' Service Use Varied Considerably

The Demonstration created and implemented a wraparound service model that produced motivated case managers and satisfied clients. However, while engagement was generally high, how participants used the services varied considerably.⁵ Between March 2007 and September 2009, the 287 heads of household in our sample engaged in 3,163 services, approximately 11 services per head of household. But just half of household heads accounted for over 75 percent of total service use; the top quarter

accounted for nearly 50 percent of all services, and the top tenth accounted for 25 percent.

Generally, our sample experienced gains in employment (Parilla and Theodos 2010) and declines in fear and anxiety (Popkin and Getsinger 2010). Participants also moved to better housing in safer neighborhoods that are still highly poor and segregated (Theodos and Parilla 2010). Because our study lacked an adequate comparison or control group, we are unable to assess the impact of services on these participant outcomes. But we can examine how different types of participants used the services. We developed a typology based on head-of-household baseline characteristics that categorizes the Demonstration participants into three groups: "strivers," younger residents who mostly have high school degrees and are connected to the labor force; "aging and distressed," who suffer from high rates of mental and physical illness, lack high school degrees, and have little work experience; and "high risk," younger residents already showing high rates of chronic illness and labor force disconnection (Theodos et al. 2010).

Virtually all participants (87 percent) used housing counseling services. Beyond that, strivers used primarily employment and child-related services, while participants from the two higher-need groups also used physical and mental health services. Most strivers reported participating in employment-related services (72 percent); the figure for the high-risk group was slightly lower (66 percent). In contrast, less than half (46 percent) of the aging and distressed group reported participating in these services. Additionally, 12 percent of strivers reported using physical health services, compared with 33 percent of high-risk and 43 percent of aging and distressed participants. Likewise, just 7 percent of strivers engaged in mental health services (i.e., independent counseling, group counseling, assessments), compared with 20 percent of high-risk and 32 percent of aging and distressed participants. Finally,

not surprisingly, only a small proportion (4 percent) of aging and distressed households used child-related services such as summer and after-school programs, compared with about 40 percent of striving and high-risk families.⁶

Additional Costs of Intensive Services Were Relatively Modest

While the Demonstration produced high engagement levels and promising outcomes (Popkin, Theodos, et al. 2010), if the costs of the services were prohibitive, it would not be feasible to take this intensive model to scale. Because we did not have an adequate control or comparison group, we were unable to do a full cost-benefit or cost-effectiveness analysis.⁷ We were, however, able to analyze per referral and per person costs, providing us with valuable information to better understand the costs of specific services, and how these household-level costs translate into the full-scale cost of the Demonstration. We used a bottom-up approach to estimating costs. This method calculates costs based on the unit of service, using data on internal and external program costs.⁸

To estimate service use, we used the CHA's administrative database, which tracks the type and number of referral for each household in its system, including all services that Heartland referred residents to through the Service Connector program, which ran through 2008, and the retooled FamilyWorks model, which replaced Service Connector. Heartland provided data on internal program costs, including data on staff salaries (fully loaded) and service duration for case managers, program supervisors, the wellness (clinical) team, the assets team, the employment team, and administrative support. For estimating external costs, Heartland provided information on where clients were referred and the title of the person providing the service, along with the estimated duration of service provision. HCP also provided information on the costs of relocation counseling.

Table 2. Referrals, Total Costs, and Unit Costs of Selected Demonstration Services

REFERRAL TYPE	TOTAL COST FOR REFERRAL CATEGORY	TOTAL REFERRALS	AVERAGE PER PERSON COST FOR REFERRAL CATEGORY
Employment	\$1,304,947	794	\$1,644
Housing services	\$564,199	653	\$864
Mental/physical health services	\$126,729	233	\$544
Substance abuse	\$119,010	74	\$1,608
Education	\$116,354	169	\$688
Child care/children/family	\$60,660	375	\$162
Financial education/assets	\$37,851	106	\$357
Public assistance meetings	\$22,191	25	\$888
Basic needs	\$20,068	227	\$88

Source: Urban Institute analysis of CHA administrative data.

To estimate external staff salaries, we used the Occupation Employment Survey, which provides average salaries by job type.

Costs vary tremendously across the different types of referrals, and much of what drives the costs are the intensity or duration of the service (table 2). Employment and substance abuse services are the most costly: Transitional Jobs includes a wage subsidy and frequent meeting with staff for several weeks.⁹ In-patient substance abuse treatment programs are time and staff intensive, and, therefore, very costly.

To estimate the total cost of Demonstration services, we multiplied the cost per referral by the number of people referred to that service. Because the CHA administrative data is referral data and does not track receipt of service, we created two total estimates; one that assumes all people who are referred receive that service, and a second that uses an estimated take-up rate to account for service no-shows. Heartland site managers provided

us with the estimated take-up rates for each service. Because this approach to estimating cost requires several assumptions and estimates, it is a range rather than an exact figure.

The estimated program service cost total, with no-shows taken into account, is roughly \$2.1 million. The average cost for the 287 respondents in our 2009 follow-up sample is about \$2,900 a year, about \$900 more than the standard CHA service package. Our estimates include HCP's relocation services costs, as well as the TJ wage subsidy. When we assume that residents fully attended services, the total cost is roughly \$2.6 million, or \$3,600 annually per household. The CHA's service provider costs account for the largest share of the services, roughly two-thirds of the total, while external providers account for the remaining third. The Demonstration's costs are relatively modest compared with other intensive service programs. For example, the costs of a housing-first anti-homelessness pro-

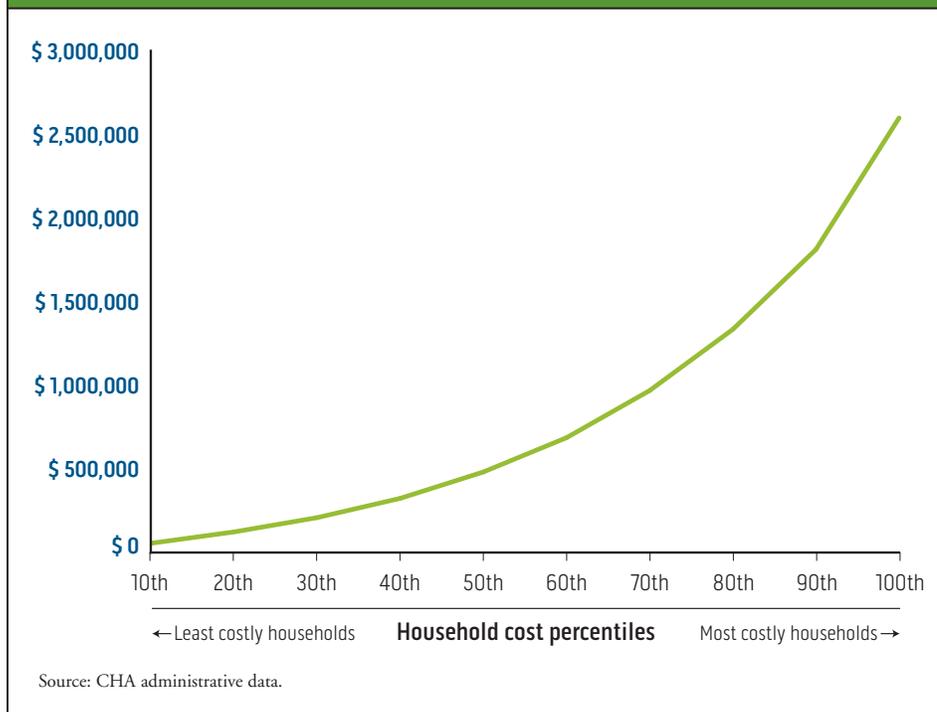
gram can be around \$3,700 per individual a year (Gilmer, Manning, and Ettner 2009).

The cost per participant varies considerably. Unsurprisingly, higher average engagement leads to higher average per person costs. Just 10 percent of participants account for over 30 percent of the total cost of the Demonstration; 20 percent account for nearly 50 percent of the total cost; and 50 percent account for over 80 percent of the total costs (figure 2). On the other hand, some residents are minimally engaged and cost very little. For instance, the least-costly 20 percent accounted for only 5 percent of the total Demonstration costs.

Service Model Targets High-Risk Participants

Taken together, our analysis of service use and costs suggests that participants who fall into the high-risk group were the most likely to take up a range of services and, thus, the

Figure 2. Total Demonstration Costs, by Decile



most costly to serve. Substantial proportions of this group used every category of service—housing, employment, physical and mental health, and child-related—while strivers tended to use only housing, employment, and child services, and the aging and distressed tended to use only housing and health-related services. Yet, as argued elsewhere (Theodos et al. 2010), the high-risk group is likely the most appropriate target for an intensive service model: these adults are high need and young enough to benefit from employment programs, and most have children in their households. Although we are not able to do a full-cost benefit analysis here, our results suggest that this type of service investment is a promising strategy for effectively serving the needs of these extremely vulnerable families. While costly in the short run, the payoff may be substantial, especially if it helps stabilize their situations enough to

avoid eviction or involvement in the child welfare or criminal justice systems.

Implications for Policy

The Chicago Family Case Management Demonstration has produced a successful model for providing wraparound services to residents in public and assisted housing settings. The lead service provider quickly achieved high levels of engagement, then adapted the basic service model as case managers learned more about resident needs. Case managers received additional training and support, and their improved performance was reflected in participants’ improved perceptions of service quality and effectiveness. However, despite efforts to enhance relocation counseling, the Demonstration was less successful in helping participants to move to lower-poverty areas that might offer them and their children greater opportunity. The other briefs in our

series (see Popkin, Theodos, et al. 2010) detail participant outcomes, including gains in employment and health, improvements in housing and neighborhood conditions, and reductions in fear and anxiety. The average costs for the intensive services were relatively modest (about \$2,900 a year, or \$900 more than the standard CHA service package, which does not include programs like TJ and GPTS), although costs varied considerably by level of need and service take-up. Still, the overall lesson of the Demonstration is that it would be feasible to take a carefully targeted, intensive service model to scale, and that doing so might pay off by stabilizing some of the most vulnerable public housing families.

- **It is possible to effectively combine housing and services to serve vulnerable families.** The Demonstration showed that it is feasible to partner wraparound services with a voucher. Most housing and services packages are place based, with the services provided on site in a specific development. The Demonstration showed that it was possible, at reasonable cost, to adapt this model to serve families who have moved to the private market with a voucher but still need assistance.
- **Housing authorities must be willing to take risks and experiment with service provision.** The key factors behind the success of the Demonstration were a housing authority committed to resident services, effective service providers willing to collaborate and participate in evaluation and performance monitoring, and a model that enabled continuous learning and adaptation. The CHA has already integrated lessons from the Demonstration into its larger resident services program and is seeking opportunities to test new ideas, such as incorporating services for youth into an intensive model. Other housing authorities could benefit from being equally willing to

experiment and test novel approaches for serving their most vulnerable households.

- **Targeting high-risk families may have long-term payoffs.** High-risk families—those grappling with mental and physical health challenges and disconnection from the labor market, while struggling to raise their children—are the heaviest consumers of intensive services. Stabilizing these extremely needy households may have long-term payoffs for both their own well-being and reduced costs for development

management. Developing an assessment tool that successfully identifies these high-need households is critical so service providers can target services more efficiently and effectively (Theodos et al. 2010).

- **Performance measurement and evaluation should be part of any service model.** Even without a comprehensive evaluation, housing authorities and service providers can develop performance measurement systems that allow them to track performance. There are now several database systems for social

service providers that enable them to track clients across different providers. Regular coordination, meeting, and review is critical to ensuring that service models stay on track and that providers are able to learn from experience and make mid-course corrections and adaptations to make their services more effective. Database systems not only should help providers gauge such outputs as resident participation, but also must collect data on resident outcomes, which allow agencies to assess the impact of service interventions on residents' well-being. ■

Notes

1. Seven households were interviewed for both the CHA Panel Study and the Demonstration research.
2. This brief draws on material from Popkin et al. (2008) and Theodos et al. (2010).
3. For an overview of the Opportunity Chicago initiative, see Opportunity Chicago (2010).
4. A household was considered engaged if it had a FamilyWorks individual action plan and was meeting with its case manager.
5. To determine overall service use, variability in service use, and what services were used most frequently, we use the unit of the service (as defined as meetings, classes, counseling sessions, etc.). Some services are ongoing commitments (housing counseling, mental health counseling, job search assistance, etc.) whereas others are one-time commitments (TJ, GPTS, GED courses, etc.).
6. These differences were significant at the 5 percent level.
7. We attempted to construct a comparison group using CHA's administrative data but were unable to do so because of the limitations of that dataset, including the lack of information on key outcomes of interest.
8. In some cases, Heartland staff and outside organizations both provide a service. In those cases, we estimated the proportion of the service provided internally and externally, then created a weight that reflects these estimates. We used the weights to sum across the providers to give us one estimate per referral type.

9. The average cost of TJ for one client is \$3,400. The wage subsidy accounts for roughly 85 percent of the cost of the service.

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Chicago Family Case Management Demonstration

The Chicago Family Case Management Demonstration was a partnership of the Urban Institute, the Chicago Housing Authority (CHA), Heartland Human Care Services, and Housing Choice Partners, intended to test the feasibility of providing wraparound supportive services for vulnerable public housing families. The demonstration ran from March 2007 to March 2010, targeting approximately 475 households from the CHA's Dearborn Homes and Madden/Wells developments with intensive case-management services, transitional jobs, financial literacy training, and relocation counseling.

The Urban Institute evaluated the Chicago Family Case Management demonstration to inform implementation and track outcomes for participants over time. In spring 2007, we conducted a baseline resident survey ($n = 331$, response rate 77 percent). The survey asked about a range of domains, including housing and neighborhood conditions, service use, mental and physical health, employment and economic hardship, and children's health and behavior. We conducted a follow-up survey ($n = 287$, response rate 90 percent) in summer 2009, approximately two years after the rollout of the demonstration. The largest source of attrition between 2007 and 2009 was mortality; we were able to locate, if not survey, nearly all original sample members.

To complement the survey, Urban Institute staff conducted 30 qualitative in-depth interviews (21 adults and 9 adolescents) with participants in summer 2008. We also gathered information from CHA administrative records and case manager reports, including whether residents chose to engage in the demonstration services, whether participants were referred for additional services, and their relocation history. In addition, we assembled secondary data on neighborhood poverty, unemployment, crime, race and other characteristics that we received from the Metro Chicago Information Center. Finally, we conducted a process study to assess the efficacy and cost of the demonstration's implementation. We conducted in-depth qualitative interviews with case managers, project staff, relocation providers, and CHA administrators, monitored service implementation weekly, and met regularly with Heartland and Housing Choice Partners leadership and CHA staff. We also thoroughly analyzed the costs associated with the intensive services.

The principal investigator for the Chicago Family Case Management Demonstration is Susan J. Popkin, Ph.D., director of the Urban Institute's Program on Neighborhoods and Youth Development. Funding for the demonstration was provided by the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the Rockefeller Foundation, the Partnership for New Communities, JPMorgan Chase, and the Chicago Housing Authority.

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