MATHEMATICA Policy Research

REPORT

FINAL REPORT

An Evaluation of SOAR: The Implementation and Outcomes of an Effort to Increase Access to SSI and SSDI

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The authors would like to thank all of these organizations and individuals for their important contributions to the study and to this report. The opinions and conclusions expressed herein are solely those of the authors and do not represent the opinions or policy of any agency of the federal government.

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The Social Security Administration (SSA) disability programs—Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)—provide critical income support for those who meet the eligibility requirements. Accessing SSI or SSDI is challenging for individuals who are homeless or who are at risk of homelessness. Their precarious living situations, the combination of disabilities they often face (which often include mental health or substance abuse problems), and tendency to lack social and familial supports make it difficult for them to successfully complete the SSI or SSDI application process. Staff at SSA field offices and disability examiners charged with assessing an applicant's medical condition may have trouble accumulating necessary information during the eligibility determination process if they are unable to contact the applicant (due to lack of stable address and phone number) or to develop evidence to support the applicant's claim (due to lack of or unknown medical history).

The SSI/SSDI Outreach, Access, and Recovery (SOAR) project, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), aims to improve access to SSI and SSDI among individuals who are homeless or who are at risk of becoming homeless, with a specific focus on individuals with mental illness.[1] Communities that implement SOAR do not receive any funding from SAMHSA to do so; rather, the SOAR Technical Assistance (TA) Center provides states and local communities with free TA intended to help them (1) create systems-level change through promoting collaboration among agencies that serve this population, (2) train professionals to assist individuals through the application process, and (3) sustain and strengthen each of these efforts over time. To implement SOAR, states and local communities must train people who work with the target population to provide the assistance and facilitate relationships among various entities that support the assistance process. Each state implementing SOAR must designate an individual (the state lead) to oversee the implementation effort. Local communities are also encouraged to designate an individual to lead local efforts. State and local SOAR leads determine who to train to provide application assistance and how often to provide training. Training is based on the Stepping Stones to Recovery curriculum, which emphasizes 10 practices as critical for improving the quality of SSI and SSDI applications and facilitating timely determinations.

Evaluation Approach

SAMHSA hired Mathematica Policy Research—under subcontract to Policy Research Associates, Inc., which operates the SOAR TA Center—to conduct an evaluation of SOAR. The goals of the evaluation were to examine the extent to which the SOAR TA has influenced community implementation efforts and examine the outcomes of these efforts. The SOAR intervention was not designed or implemented to facilitate rigorous experimental evaluation of impacts. Rather, Mathematica drew on multiple sources—both qualitative and quantitative—to produce a comprehensive evaluation of SOAR's outputs and outcomes, which included the following:

[1] SOAR uses the same definition of homelessness as SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program: "persons who are homeless or at imminent risk of becoming homeless," (Public Health Services Act, Part C, Section 522 [a][2]).

- **Process analysis,** based on a series of interviews with SOAR stakeholders and observations of SOAR activities for up to three years after the implementation of SOAR in one community in each of 13 states
- **Social network analysis,** based on a survey of key SOAR stakeholders approximately two to three years after implementation of SOAR in one community in each of 13 states
- **Outcomes analysis,** based on (1) management information system data that SOAR trainees collected over a period of two to three years after implementation of SOAR in one community in each of 13 states, and (2) administrative data from SSA's Structured Data Repository (60-0320) and Systems of Records for all adult SSI and SSDI applications initially filed in FY 2010 nationally
- **Exploratory analysis of SOAR's relationship to outcomes**, based on SSA administrative data for adult SSI and SSDI applications initially filed in FY 2010 and a separate file of adult applications initially filed in 2005

Key Findings

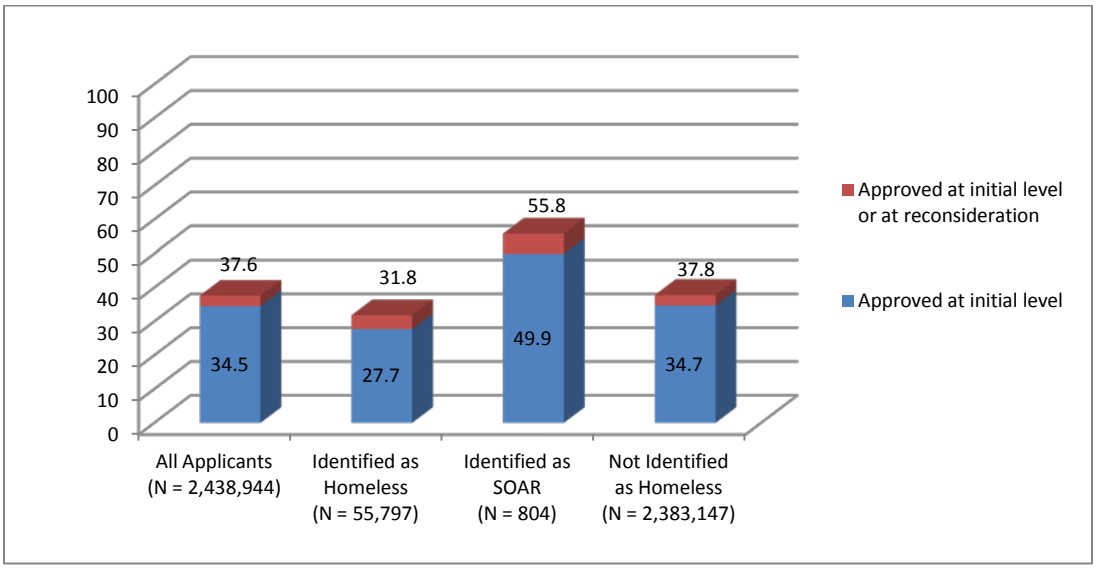
SOAR training is prolific, but most who are trained never complete an SSI or SSDI application using the SOAR process. Of 563 individuals who were trained in SOAR and who work in the 13 evaluation sites, 13 percent completed an application using the SOAR process. Many trained individuals do not complete applications using the SOAR process because they have no direct interaction with the target population (while training is intended for those who work with individuals who are homeless or at risk of homelessness, administrators and others often attend training), they do not have time (a single application can take between 20 and 40 hours to complete), they leave their job before having a chance to provide application assistance (the homeless services workforce generally is characterized by high staff turnover), or they do not feel prepared to apply their skills in practice.

Most professionals who do apply SOAR training in practice help applicants to provide more information to SSA and disability examiners than other applicants. Applications submitted through SOAR are four times as likely to have an authorized representative (who can provide and receive information on an applicant's behalf) as all applications from homeless individuals and more than twice as likely to be submitted with medical evidence to help disability examiners make a determination. They are also slightly less likely to require a consultative exam due to insufficient medical evidence to make a determination. Each of these practices (submitting an application with an authorized representative, with medical evidence, and with enough support to avoid a consultative exam) alone and in combination significantly increases the likelihood of application approval and reduces the time it takes disability examiners to make a determination. Regardless of participation in SOAR or homeless status, the likelihood, on average, that an initial SSI or SSDI will be approved is 66 percent if all three of these practices are used, compared to 26 percent if none of them are used.

SSI/SSDI applications submitted through the SOAR process are approved at a higher rate than other applications. SOAR-trained providers report an average approval rate of two-thirds on initial application and almost three-quarters including approvals made after reconsideration or a hearing. SSA data portray lower approval rates than SOAR-trained

practitioners report, but suggest that applications submitted through the SOAR process are approved at much higher rates than other applications—50 percent at the initial level among SOAR participants compared to 28 percent among all homeless applicants (Figure ES.1). Moreover, analyses of SOAR's relationship to outcomes suggest that SOAR is significantly correlated with higher SSI and SSDI approval rates.

Figure ES.1. Initial application decisions among adult SSI and SSDI applicants, by homelessness and SOAR status



Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

Achieving positive application outcomes has less to do with the size of the SOAR effort (that is, the number of people trained) and more to do with trainees' availability to assist with applications. Among the 13 evaluation sites, those with the highest number of approved SSI and SSDI applications submitted through SOAR had staff dedicated solely to conducting SOAR application assistance. In the other sites, staff took on SOAR in addition to their other responsibilities. Additionally, turnover among SOAR trainees was low in the top-performing sites, but moderate to high in the others.

The organizational networking that the SOAR model promotes is successful in increasing communication among entities that play important roles in supporting the application assistance process. On average across the 13 evaluation sites, network density—the total amount of communication present in the network of SOAR stakeholders within a community divided by the total amount of communication possible in that network—increased by nearly one-third (32.9 percent) from before implementation of SOAR to about two years after. Successful application outcomes appear more closely tied to formal opportunities for collaboration (for instance, through regular state- and local-level stakeholder meetings), however, than to the amount of communication (formal or informal) between entities. Communication between stakeholders increased in the 13 evaluation sites across the board, but

sites that conducted formal meetings regularly tended to have more successful application outcomes than those that did not.

Actively engaged leadership facilitates positive application outcomes. Among the 13 evaluation sites, those with the highest number of approved SSI and SSDI applications submitted through SOAR had a leader at the state or local level who was highly engaged in the effort. In the poorest-performing sites, both the state and local leads were minimally engaged.

Because communities do not receive direct funds from SAMHSA to implement SOAR, the effort is susceptible to shifting fiscal, legislative, and political priorities, as well as state and local budgetary constraints. Some communities have addressed this challenge by securing financial resources for the effort (through a program in which SSA reimburses states for general assistance payments made between an applicant's protective filing date and approval date for SSI, through reimbursement from the federal Medicaid agency for uncompensated medical care provided between 90 days retroactive to the SSI or SSDI protective filing date and the approval date, or through grants from federal funding streams). Some also have integrated SOAR into larger efforts to address homelessness (such as SAMHSA's PATH program, the state's 10-year plan to end homelessness, or the Department of Housing and Urban Development's Continuum of Care program).

SOAR may save SSA administrative costs associated with application processing, help states recover general assistance payments, and help medical providers recover uncompensated medical expenditures. Assuming SOAR participants would have eventually applied for SSI or SSDI in the absence of SOAR, the effort has the potential to save SSA costs related to consultative exams, acquisition of medical evidence, and labor associated with reconsiderations and hearings. A lower bound estimate of savings from the reduction in consultative exams attributed to SOAR, for example, ranges from $800,000 to $2.8 million nationally. In several evaluation states, the estimated amount of general assistance payments states could have recovered from SSA or medical expenditures providers could have recovered from the Medicaid agency for applicants who were approved for SSI with assistance from SOAR could support an annual salary for one or more part- or full-time SOAR positions.

Conclusion

Findings from this evaluation suggest that providing application assistance using the SOAR intervention shows substantial promise for helping individuals with disabilities who are either experiencing homelessness or who are at risk of homelessness to access SSI or SSDI, and that the strategic planning process promotes systems-level collaboration toward that end. The current model of promulgating training to provide this application assistance, however, appears to be an inefficient use of resources. Taken together, the findings demonstrate the challenge of a model that (1) provides no funding for implementation; (2) presents broad, rather than targeted, training to a workforce characterized by high workloads and high turnover; and, (3) focuses on a narrow, difficult-to-reach population.

I. THE SOAR EVALUATION: CONTEXT, OBJECTIVES, AND METHODS

The Social Security Administration (SSA) disability programs—Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)—provide critical income support for those who meet the eligibility requirements. For individuals or families who are homeless or who are at risk of homelessness, receiving SSI or SSDI is often an important first step in improving their life circumstances. SSI and SSDI benefits provide financial resources for housing and facilitates access to Medicaid or Medicare, which enables beneficiaries to obtain critical medical and mental health services. SSI and SSDI recipients typically have access to employment assistance programs offered through vocational rehabilitation agencies or alternative providers as well as the SSA Ticket to Work program.

Accessing SSI or SSDI is challenging for individuals who are homeless or who are at risk of homelessness (Dennis et al. 2011). Their precarious living situations, the combination of disabilities they often face (which often include mental health or substance abuse problems), and tendency to lack social and familial supports make it difficult for them to successfully complete the SSI or SSDI application process. Program staff may have trouble accumulating necessary information during the eligibility determination process if they are unable to contact the applicant (due to lack of stable address and phone number) or to develop evidence to support the applicant's claim (due to lack of or unknown medical history).

The SSI/SSDI Outreach, Access, and Recovery (SOAR) project, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), aims to improve access to SSI and SSDI benefits for individuals who are homeless or who are at risk of being homeless, with a specific focus on individuals with mental illness. One main aspect of SOAR is the provision of technical assistance (TA) for states and localities, social service providers, and advocates for the homeless to collaborate on policies and procedures that will help individuals in the target population obtain SSI or SSDI. A second important aspect of SOAR is training staff who work with homeless or at risk individuals in Stepping Stones to Recovery, a curriculum designed explicitly to relay the skills and information they need to support homeless individuals through the SSI or SSDI application process.

To determine whether and how SOAR is improving access to SSI and SSDI among individuals who are experiencing homelessness or who are at risk of homelessness, SAMHSA hired Mathematica Policy Research—under subcontract to Policy Research Associates Inc., which operates the SOAR TA Center—to conduct an evaluation of SOAR beginning in October 2010. This report summarizes the findings from the evaluation. Most prominent among the findings is that when trainees have the time to provide application assistance using concepts from SOAR, they achieve better application outcomes for their clients. But, the current training model does not seem to be an efficient use of resources, as most who are trained never apply SOAR in practice. The remainder of this introductory chapter describes the policy context, objectives, and components of the SOAR TA, as well as the research objectives and methodology.

A. Background and need for SOAR

Eligibility for SSI and SSDI is contingent upon having a medical condition that meets SSA's definition of disability. To be eligible for SSI, individuals must pass an income and resource test

and be deemed disabled. To be eligible for SSDI, individuals must have worked in jobs covered by Social Security and also be deemed disabled.[2] Adults are deemed disabled if they have a medically determinable physical or mental impairment that (1) prevents them from performing substantial gainful activity (generally, earning over $1,070 per month in 2014 for non-blind applicants) and that (2) has lasted or is expected to last at least 12 continuous months or to result in death.[3] Impairments that qualify individuals for SSI or SSDI are common among individuals who are homeless or at risk of homelessness. Research suggests that at least 46 percent of the population has one or more chronic physical health conditions (Burt et al. 1999; O'Toole et al. 2007; Zlotnick and Zerger 2009), about 25 percent of sheltered persons who are homeless have a severe mental illness (HUD 2011), and as many as 67 percent of homeless people have received a mental health diagnosis during their lifetimes (United States Conference of Mayors 2004; Goering et al. 2002; North et al. 2004).

Eligibility is determined jointly by two entities: (1) SSA field offices and (2) each state's federally funded Disability Determination Service (DDS).[4] Individuals submit applications to local SSA field offices, which are responsible for verifying nonmedical eligibility requirements such as age, employment, recent earnings, and income. Field offices then send applications to the relevant state DDS where disability examiners decide whether applicants meet SSA's definition of disability. DDS examiners generally do not meet with applicants and must instead rely exclusively on written documentation to make determinations of disability. Documentation includes medical evidence submitted with the application or that DDS collects directly from treatment providers. If an applicant receives a denial from DDS on the initial application, in most states he or she may request that DDS reconsider the decision. (Ten states do not have reconsideration.) If the reconsideration results in a denial or the applicant lives in a state without reconsideration, the applicant may request a hearing to appeal the decision.

Two key challenges can limit access to SSI or SSDI for individuals who are experiencing homelessness or who are at risk of homelessness. First, individuals who are experiencing homelessness or who are at risk of homelessness often have personal barriers that limit their ability to file a complete and high quality application. To submit medical evidence with their application, applicants must have knowledge of their recent treatment history and spend time and effort contacting their providers to obtain their records, often at a financial cost. In fact, many adults who are homeless have no usual source of medical care and lack trusting relationships with providers who can document their disability for the application (O'Toole et al. 2004; Zima et al. 1996; Bird et al. 2002). This often reflects the homeless community's distrust of health and social service professionals (Bhui et al. 2006). The perceived stigma associated with homelessness and mental health problems also may prevent these individuals from seeking professional help (Bird et al. 2002). In addition, physical and mental health problems may limit cognitive functioning and impair an individual's ability to make decisions, provide accurate

[2] Individuals may also receive benefits as a disabled adult child based on a parent's job record.

[3] See http://www.socialsecurity.gov/oact/cola/sga.html. A different definition exists for children.

[4] The names of the federally funded state agencies that support SSA in making disability determinations vary from state to state. Many states use Disability Determination Services, but some use other names. For example, Florida officials call their agency the Division of Disability Determinations while Indiana officials call their agency the Disability Determination Bureau. For ease of exposition, we use the term DDS to describe all such state agencies. A detailed list of agencies is available at http://www.ssa.gov/disability/professionals/procontacts.htm.

information, and keep appointments during the eligibility determination process (Macnee and Forrest 1997). In practice, it is often family members and friends who provide information for the application and support in getting to and from appointments. Yet, individuals who are homeless frequently function within strained social networks (Meadows-Oliver 2005) and lack family supports. In addition, as many as 23 percent of individuals who are homeless have been incarcerated and 34 percent report legal troubles while homeless (Kushel et al. 2005; Goering et al. 2002). These individuals may be particularly disconnected from social networks (though jails or prisons may serve as a valuable source of medical evidence).

Second, SSA and DDS staffs face several logistical challenges in processing applications from individuals who are homeless or who are at risk of becoming homeless. Without an address or phone number for the applicant, SSA and DDS staffs may not be able to contact the applicant to request necessary information or to provide notification of a decision. For DDS staff to collect medical evidence, contact information for treatment providers must be submitted in the SSI or SSDI application and treatment providers must respond to requests for information with documentation that is adequate to permit a medical determination of disability. Some treatment providers lack experience with SSA's medical criteria for determining disability and may not provide the information needed for a determination. Lack of sufficient information to document a disability may require DDS staff to request the applicant to undergo a consultative examination with an SSA-contracted medical provider. Even if DDS staff has contact information to notify the applicant of the appointment, and even if the applicant keeps the appointment, in one short session the consultative exam provider may not obtain a complete picture of the individual's condition and functioning. The need for a consultative exam or problems collecting or remedying other missing or inadequate information in the application can delay the claim adjudication process or result in a denial.

Federal, state, and other agencies also incur costs when SSI and SSDI applicants have disabilities that qualify them for benefits, but the applications lack the quality or necessary documentation for a favorable determination. DDS pays a fee for each consultative exam (fees vary by state and type of exam) as well as medical evidence collected from treatment providers. Applications denied at the initial level may be submitted for reconsideration and then a hearing, requiring additional labor on the part of DDS examiners and SSA staff. In most states, individuals receiving SSI are automatically enrolled in Medicaid. In all states, individuals who have received SSDI for two years are automatically enrolled in Medicare. But medical providers may incur costs for treatment provided to homeless individuals who are uninsured before SSI or SSDI approval. (Providers may later recoup costs incurred between 90 days retroactive to the SSI or SSDI protective filing date and the approval date.[5]) Similarly, states with General Assistance programs may be providing cash benefits to homeless individuals that could otherwise be paid with federal funding through the SSI or SSDI programs. (States may later recoup the financial assistance that was provided through these state income support programs between the SSI or SSDI protective filing date and the approval date.)

[5] Individuals with amyotrophic lateral sclerosis (ALS) or end-stage renal disease are eligible for Medicare immediately upon SSDI eligibility.

B. The history and objectives of SOAR TA

SOAR is designed to enhance the quality of SSI and SSDI applications submitted by individuals who are homeless or who are at risk of becoming homeless and to increase the efficiency of the eligibility determination process so that eligible individuals receive benefits as swiftly as possible. SOAR's immediate goals are to increase the likelihood of approval among eligible applicants and to reduce application processing time by (1) creating systems-level change through promoting collaboration among agencies that serve this population, (2) training professionals to assist individuals through the application process, and (3) sustaining and strengthening each of these efforts over time. SOAR-trained professionals provide application assistance at no financial cost to the applicant, distinguishing SOAR from the application assistance offered by other third parties who typically charge a fee for their services.

Communities that implement SOAR do not receive any funding from SAMHSA to do so; rather, states and local communities receive free TA from SAMHSA's SOAR TA Center (http://www.prainc.com/soar).[6] SOAR TA has occurred incrementally. States were selected to receive SOAR TA based on proposals that were received in response to calls for applications, which were issued by SAMHSA through the SOAR TA Center. Initially, only states participating in the Federal Interagency Policy Academies on Homelessness, sponsored by the Health Resources Services Administration (HRSA), were invited to apply, but the effort expanded to other states over time.[7] Although SAMHSA has been the primary funder of all SOAR TA, HRSA and the U.S. Department of Housing and Urban Development (HUD) have each contributed at various stages. Figure I.1 summarizes the rollout of SOAR TA. As of June 2012, all states and the District of Columbia had received some federally funded SOAR TA.

As states were selected to receive TA, the SOAR TA Center worked individually with each to provide the following three essential, and sequential, services:

1. **Strategic planning.** The SOAR TA Center assists states and communities in bringing agency stakeholders together to develop an action plan for implementing SOAR. In each state or local community, up to 30 stakeholders participate in a professionally facilitated forum intended to lay the groundwork. Stakeholders include state mental health agencies, vocational rehabilitation agencies, public assistance agencies, and substance abuse agencies; local community mental health providers and homeless assistance providers; local SSA field offices; the state DDS; criminal justice institutions; public hospitals and clinics; and a variety of other service providers that assist individuals who are homeless. The goals of the forum are (1) to foster an understanding of how the disability application process currently works in the state and local community, (2) to develop a process for the submission and processing of SSI and SSDI applications from homeless individuals that will address their barriers and to establish stakeholder roles and responsibilities in that process, and (3) to

[6] Although SAMHSA does not provide direct support to states for SOAR, grantees are permitted to use SAMHSA funds from the Cooperative Agreements to Benefit Homeless Individuals (CABHI) grants and Projects for Assistance in Transition from Homelessness (PATH) program to support their SOAR efforts.

[7] The Policy Academies on Homelessness, funded by the U.S. Department of Health and Human Services and HUD, was designed to help state and local policymakers address the issues of chronic homelessness and the needs of families with children experiencing homelessness.

develop an action plan for ongoing implementation. Each state implementing SOAR must designate an individual (the state lead) to oversee the implementation effort. Local communities are also encouraged to designate an individual to lead local efforts.

2. **Train-the-trainer program.** After participating stakeholders have developed a strategic action plan, they may send representatives to attend a four-day training program, based on the Stepping Stones to Recovery curriculum. The curriculum is designed to increase knowledge of the disability application process by providing information and tools needed to effectively guide applicants through the process. The four-day training also offers instruction on how to train others. After completing the intensive training, these representatives are expected to return to their states and train other state and local program staffs that serve individuals who are homeless or who are at risk of becoming homeless. Only training provided by individuals who complete the train-the-trainer program is considered official SOAR training. In-state trainers receive ongoing assistance from the SOAR TA Center as they plan their initial training sessions, as well as feedback after the training sessions on content and their training techniques (based on observations by the Center).

3. **Ongoing TA and monitoring.** Each state receives ongoing TA and monitoring of action plan implementation following its initial development. This entails telephone consultation as well as site visits to observe and provide feedback on SOAR activities and to provide follow-up training and strategic planning sessions. In addition, the SOAR TA Center offers frequent webinars on assorted topics related to SOAR, publishes a periodic newsletter, and hosts a website with TA materials and tools for use by SOAR leads, trainers, trainees, and other stakeholders.

Figure I.1. Map of SOAR TA Rollout in the United States

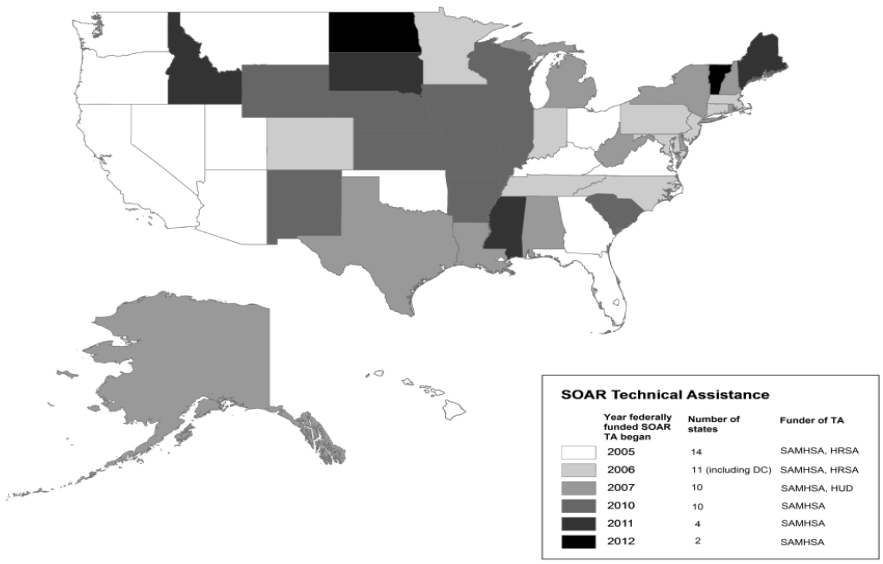


Figure I.2 provides a logic model illustrating these activities and their potential outputs and outcomes. Some of the relationships in the model are less linear and more reciprocal than depicted. The inputs (the TA activities that the SOAR TA Center provides to introduce SOAR into a community and facilitate its implementation) are intended to result in two key observable outputs. In the logic model, outputs reflect community efforts to implement SOAR and are what enable SOAR to achieve intended outcomes. These outputs include (1) the proliferation of training to use the SOAR model and (2) the establishment of interagency relationships and collaboration. In turn, outputs may lead to short-term and eventually long-term outcomes. Short-term examples include increased applications among homeless individuals (or those at risk of homelessness) for SSI and SSDI, higher application approval rates, and shorter application processing time. Long-term examples include increased income and improved quality of life for applicants and cost-efficiencies for other stakeholders—for example, state entities may realize cost savings as they recoup General Assistance funds from SSA, medical providers may realize savings as they recoup uncompensated state Medicaid expenditures from the Centers for Medicare and Medicaid Services for those patients who are approved for SSI, and SSA may reduce administrative costs related to application processing as DDS staff are able to make application decisions more quickly (assuming that SOAR participants would have eventually applied for SSI or SSDI in the absence of SOAR).

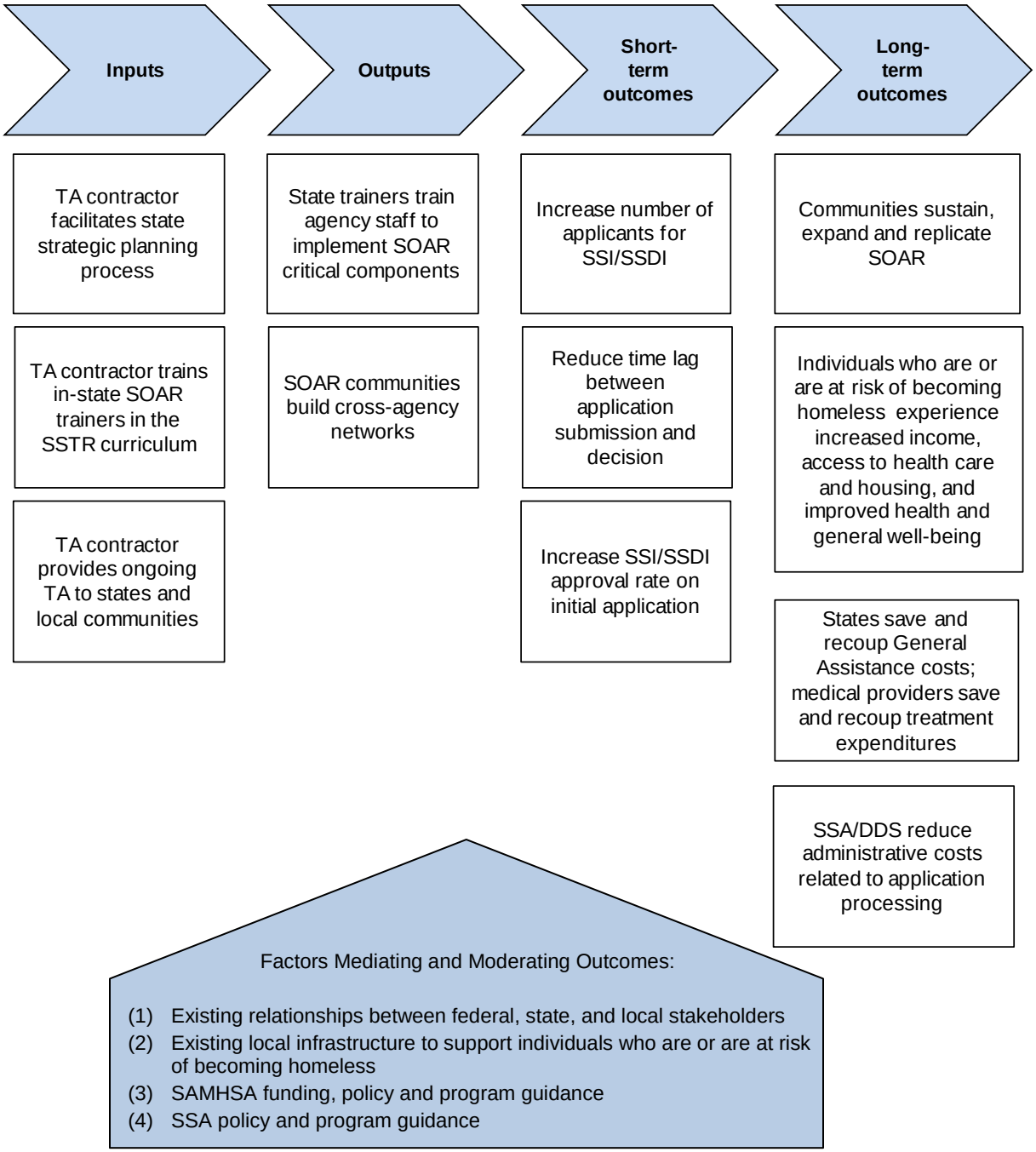
C. Objectives and methods of the SOAR evaluation

The overarching goal of the evaluation was to examine the extent to which the SOAR TA activities (that is, the inputs in the logic model) have led to the anticipated outputs and outcomes. This builds on a previous study of SOAR that included an assessment of and provided recommendations for enhancing the TA activities. To this end, the evaluation had three key objectives, drawn from the logic model:

1. **Document and measure the influence of SOAR TA on community implementation efforts.** As noted above, outputs reflect states' efforts to implement SOAR and are what enable SOAR to achieve its intended outcomes. We aimed to measure two key outputs: (1) the extent to which in-state trainers are able to use the knowledge and skills they have learned from the SOAR TA Center to train others to implement critical components of the Stepping Stones to Recovery curriculum, and (2) the extent to which organizations in SOAR communities build collaborative relationships.

2. **Examine the short-term outcomes of community implementation efforts.** We aimed to address two key questions with respect to short-term outcomes: (1) to what extent is SOAR associated with increases in initial application approval rates? and (2) to what extent is SOAR associated with decreases in initial application processing time? We were interested in learning not only whether SOAR is associated with positive application outcomes, but also how SOAR may help to achieve the desired results. For instance, do some components of the model seem to be driving any observed outcomes? Are some components implemented less than others and, if so, why and what are the implications of that? Are there certain contextual factors that make it harder or easier to implement SOAR and to achieve success?

Figure I.2. SOAR logic model



Note: Critical components of SOAR include the following activities for trainees: (1) making time to assist with applications, (2) maintaining communications and contact with applicants, (3) becoming authorized representatives for applicants, (4) obtaining applicants' past and present medical records to submit with the application, (5) collaborating with physicians and psychologists for assessments and medical information, (6) preparing medical summary reports on applicants' functioning and getting them cosigned by a medical or mental health professional, (7) avoiding the need for consultative examinations, (8) submitting applications and medical information electronically whenever possible, (9) collaborating with DDS and SSA, (10) obtaining quality review of applications prior to submission, (11) acting as or providing for representative payees, (12) implementing an employability strategy with applicants, and (13) tracking data to assess results.

3. **Examine potential long-term outcomes of SOAR.** Data were not available to examine long-term outcomes for applicants, such as increased income or improved health and access to housing. However, we were able to provide a glimpse of potential long-term cost-efficiencies for states, medical providers, and SSA and DDS. Specifically, we sought to address what benefits these entities might realize from the implementation of SOAR.

The SOAR intervention was not designed or implemented to facilitate rigorous experimental evaluation of impacts. SOAR-trained staff are generally able to meet the demand for SOAR services and, given the vulnerability of the target population, ethical issues involved in creating excess demand for services for purposes of random assignment precluded that option. Moreover, generating a sample size during the evaluation period large enough to determine a meaningful effect size at the individual level was unlikely given the rate at which applicants tend to seek SOAR services. Given the process by which the SOAT TA Center selected states and communities to receive SOAR TA and by which communities selected staff to receive training, a cluster design (for instance, conducting random assignment at the staff, provider, or community level) also was not feasible in the current context. Rather, Mathematica drew on multiple sources—both qualitative and quantitative—to produce a comprehensive evaluation of SOAR's outputs and outcomes, which included the following:

- **Process analysis,** based on a series of interviews with SOAR stakeholders and observations of SOAR activities for up to three years after the implementation of SOAR in select communities
- **Social network analysis,** based on a survey of key SOAR stakeholders approximately two to three years after implementation of SOAR in select communities
- **Outcomes analysis,** based on (1) management information system (MIS) data that SOAR trainees collected over a period of two to three years after implementation of SOAR in select communities, and (2) administrative data from SSA's Structured Data Repository (60-0320) and Systems of Records for all adult SSI and SSDI applications initially filed in FY 2010 nationally[8]
- **Exploratory analysis of SOAR's relationship to outcomes**, based on SSA administrative data for adult SSI and SSDI applications initially filed in FY 2010 and a separate file of applications initially filed in 2005

Each type of analysis included in the study draws from a different stage of the SOAR TA rollout because of the differing analytical needs. In both the process and social network analysis, for example, we needed to observe the implementation of SOAR from the very earliest stages of TA in a state (the strategic planning forum) through execution of the action plan. The only states that provided this opportunity were those that began receiving federally funded TA in FY 2010 or FY 2011 (since the evaluation began in October 2010). In each of these states, we focused evaluation resources on collection and analysis of data in one local community where the state

[8] The SSA Systems of Records from which data were extracted include SSA's Supplemental Security Income Record (60-0103), Master Beneficiary Record (60-0090), National Disability Determination Services File (also known as the 831/832) (60-0044), Completed Determination Record–Continuing Disability Determinations (also known as the Disability Control File) (60-0050), Hearings and Appeals Case Control System (60-0009), and Hearing Office Tracking System of Claimant Cases (60-0010).

planned to focus most of its efforts (which Mathematica selected in collaboration with the state and the SOAR TA Center). Throughout the report, we refer to these communities as the local evaluation sites.

To maximize the value of the MIS data for the outcome analysis, we needed a mechanism to ensure that states collected complete, high quality data (historically, states were not required to track outcome data as a condition of receiving SOAR TA). Thus, we included in this analysis only states that began receiving federally funded TA in FY 2010 or FY 2011 so that we could provide evaluation funds to them (through subcontracts with the SOAR TA Center) to track outcomes from the earliest stages of SOAR TA through the SOAR MIS or an alternative MIS. The SOAR MIS is a web-based program that the Center designed for SOAR trainees to enter and store data on the components of the SOAR model used during the SSI and SSDI application process, as well as information on the outcomes of application submissions. Most of the states with subcontracts used the SOAR MIS to track outcomes, but two used their homeless management information system (HMIS). Throughout the report, we refer to SOAR MIS and HMIS data generally as MIS data. All but one state that began receiving TA in FY 2010 or FY 2011 used an MIS system to track SOAR data statewide. So that we could analyze MIS data together with process and social network analysis data, however, we focus in the body of the report on the local evaluation sites where all three sources of data exist. We present MIS data from all communities within these states in Appendix B.

Table I.1 provides an overview of the data sources and states included in each analysis. Appendix A describes our methods in more detail.

Table I.1. Overview of data analyses

Analysis	Type of data	States included
Process	Site visits or telephone interviews	13 of the 14 states that began receiving TA in FYs 2010 or 2011[a]
Social network	Survey	13 of the 14 states that began receiving TA in FYs 2010 or 2011[a]
Outcomes		
Tracked by SOAR trainees	MIS data	13 of the 14 states that began receiving TA in FYs 2010 or 2011[a]
Tracked by SSA	SSA administrative data	All states
Exploration of SOAR's relationship to outcomes		
Regression	SSA administrative data	All states
Difference in differences	SSA administrative data	18 of the 35 states that began receiving TA in FYs 2005, 2006, or 2007

[a]One state that began receiving SOAR TA in FY 2010 (Arkansas) was not included in the analysis because the state's strategic planning forum was held too early (in November 2009) for the evaluation team to collect data there.

The remainder of this report presents the evaluation findings. Chapter II provides additional detail on the SOAR intervention as context for interpreting the study results. Chapter III discusses the efforts of states and localities to implement the intervention. Chapter IV describes the outcomes of their implementation efforts and presents analyses exploring the relationship

between SOAR and these outcomes. Finally, Chapter V summarizes the findings, discusses the future of SOAR, and presents considerations for further research.

D. Highlights from the chapter

- Accessing SSI or SSDI is challenging for individuals who are homeless or who are at risk of homelessness because of personal struggles and logistical obstacles in the application process.
- SOAR aims to improve access to SSI and SSDI benefits for eligible individuals who are homeless or who are at risk of being homeless by providing TA to states and local communities to (1) create systems-level change through promoting collaboration among agencies that serve this population, (2) train professionals to assist individuals through the application process, and (3) sustain and strengthen each of these efforts over time.
- The goal of the evaluation was to examine the extent to which the SOAR TA has influenced community implementation efforts and examine the outcomes of these efforts using data from (1) qualitative interviews and observations, (2) a social network survey, (3) the SOAR or an alternative MIS, and (4) administrative SSA files.

II. THE SOAR INTERVENTION

The crux of the SOAR intervention is the provision of assistance to vulnerable individuals by trained professionals to improve the quality and completeness of SSI and SSDI applications that are submitted. States and local communities must conduct two essential activities to ensure the availability of this assistance and support it. First, they must train people who work with the target population to provide the assistance. Second, they must facilitate relationships among various entities that may play a role in supporting the assistance process. This chapter elaborates on these intervention components.

A. Who does the intervention target?

SOAR targets a particularly vulnerable population: individuals who are homeless or at risk of homelessness and who have mental illness. SOAR uses the same definition of homelessness as SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program: "persons who are homeless or at imminent risk of becoming homeless," (Public Health Services Act, Part C, Section 522 [a][2]). Indeed, those who submit applications through the SOAR process have varied experiences with homelessness. MIS data suggest that more than half (55.3 percent) of initial SSI and SSDI applicants who go through the SOAR process are housed at the time of their application submission, though almost all of them are at risk of homelessness (Table II.1). Among those who are homeless, more than half (53.1 percent) meet the federal government's definition of chronically homeless based on the length of time that they have been homeless.[9] SOAR participants are typically between the ages of 25 and 65. Just over half are male and over one-fifth receive another form of cash public assistance (General Assistance or Temporary Assistance for Needy Families). Few (only 7 percent) are veterans.

Analyses of SSA data confirm that SOAR indeed primarily serves individuals who have mental illness. SSA categorizes each primary medical diagnosis (of which there are hundreds) into a single body system that best reflects the general nature of the impairment. Twenty unique body system codes exist in the SSA administrative data, though among initial SSI and SSDI applications filed in FY 2010, virtually no primary diagnoses fell into five of them. Among applications identified as submitted through the SOAR process in that period, 69 percent of them had a primary diagnosis categorized as a mental impairment compared to 43 percent among all homeless applicants and 26 percent among the general applicant population (Table II.2)

[9] HUD defines a chronically homeless person as "either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years." (See https://www.onecpd.info/resources/documents/DefiningChronicHomeless.pdf.)

Table II.1. Characteristics of SOAR applicants at the time of initial SSI or SSDI application submission

	Percentage of adult SOAR applicants
Housing status (N = 664) [a]	
Homeless	44.7
Housed	55.3
Among those homeless, length of time homeless (N = 271)[b]	
Less than 1 month	10.0
1–2 months	7.0
3–12 months	29.9
1–3 years	34.3
More than 3 years	18.8
Age	
18-24	10.4
25-44	42.1
45-64	46.8
65 +	0.6
Male	54.9
Receiving General Assistance or Temporary Assistance for Needy Families	22.8
Veteran	7.0
N	696

Source: SOAR MIS or HMIS in the local evaluation sites in the 13 states that began receiving SOAR TA in FY 2010 or FY 2011.

[a]Homeless is defined as living outdoors, in a shelter, or in transitional housing. Over 90 percent of those housed are reported to be at risk of homelessness.

[b]Wisconsin did not report this data.

B. What kind of application assistance is provided and by whom?

The application assistance component of the SOAR intervention is based on the Stepping Stones to Recovery curriculum, which emphasizes 10 practices as critical for improving the quality of SSI and SSDI applications and facilitating timely determinations.[10] On average, the SOAR TA Center reports that between 20 and 40 hours may be required to conduct the work necessary to assist one individual in submitting an SSI or SSDI application using these critical components, with the range reflecting variability in how much effort is necessary to engage and maintain contact with the applicant. The 10 critical components are as follows:

1. **Making time to assist with applications**. Receiving training is the first step in the SOAR application assistance process. But to apply the precepts of the model, trainees must have availability to assist with applications.

[10] The SOAR model emphasizes three other critical components that are not associated directly with facilitating timely approvals, but represent good practice in quality improvement and in supporting individuals during and after the application process. These include (1) acting as or providing for representative payees, (2) implementing an employability strategy with the applicant, and (3) tracking and assessing results.

Table II.2. Body system of primary diagnosis among initial SSI or SSDI applications

	Percentage of adult SSI or SSDI applicants in FY 2010			
	All applicants	Identified as homeless	Identified as SOAR	Not identified as homeless
Musculoskeletal	30.9	21.5	11.1	31.1
Special senses and speech	2.3	1.5	0.5	2.3
Respiratory	3.9	3.0	2.1	4.0
Cardiovascular	7.0	4.3	2.5	7.0
Digestive	2.4	2.1	2.0	2.4
Genitourinary	1.3	0.5	0.3	1.3
Hematological	0.4	0.2	0.0	0.4
Skin	0.3	0.3	0.3	0.3
Endocrine	3.8	2.4	1.6	3.8
Multiple Body Systems	0.1	0.0	0.0	0.1
Neurological	7.1	3.7	3.1	7.2
Mental	25.9	42.8	68.8	25.5
Neoplastic	4.7	1.2	0.8	4.8
Immune System	2.5	2.4	1.0	2.5
Special/other	7.5	14.2	6.1	7.3
Total initial applications	**2,438,944**	**55,797**	**804**	**2,383,147**

Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

2. **Maintaining communications and contact with applicants.** The SOAR target population is highly mobile and isolated, so it is incumbent upon SOAR-trained practitioners to conduct extensive outreach to track their whereabouts, establish rapport, and engage applicants on an ongoing basis.

3. **Becoming an applicant's authorized representative.** By signing an SSA-1696 Appointment of Representative form, applicants allow SOAR trainees to communicate with and receive information from SSA and DDS on their behalf. This is particularly beneficial for applicants with no steady address or phone number.

4. **Submitting applications with medical records**. The curriculum encourages SOAR providers to collect medical evidence to submit along with the application so that DDS examiners have everything they need to make a determination quickly and do not have to gather evidence themselves from treatment providers—which can take time, particularly if

there are multiple providers or providers that are unfamiliar to the examiner and must be located.

5. **Collaborating with physicians and psychologists for assessments and medical information.** Closely related to the previous component, conducting these activities can ensure that the SSI or SSDI application provides as much information as possible to help examiners make a medical determination, which may help avoid the need for a consultative exam.

6. **Writing a medical summary report and getting it cosigned by a medical or mental health professional.** Because SOAR-trained providers often have existing relationships with applicants, interact with applicants in their own surroundings and may know more about their routines and social histories than DDS examiners and treatment providers, the curriculum encourages SOAR providers to write and submit along with the application a report that summarizes how the applicant's disability affects his or her daily functioning. If medical or mental health professionals then review and sign the reports, DDS examiners may consider them as medical evidence. Unsigned reports may also be useful to examiners by painting a more holistic picture of the applicant and the implications of his or her physical or mental limitations.

7. **Avoiding consultative examss**. Consultative exams can contribute to application delays and inaccurate determinations, particularly for homeless applicants who may have trouble receiving communications about an exam or keeping appointments or who may appear during the exam appointment as better functioning than usual. The curriculum emphasizes making every effort to avoid a consultative exam, not only by gathering medical evidence and writing a medical summary report to submit with the application, but also by arranging privately for a medical assessment by a physician or psychologist prior to submission.

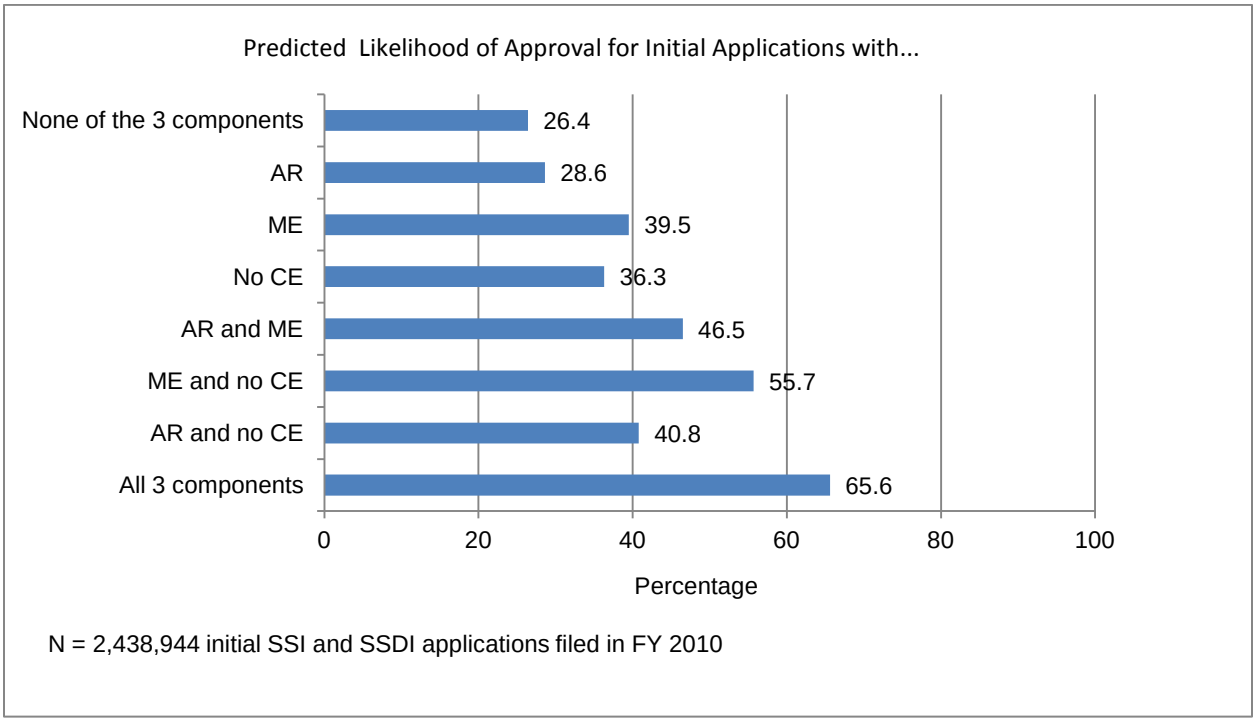
8. **Electronically submitting the application and medical information whenever possible.** Filing applications electronically avoids a wait in the SSA field office, can establish a protective filing date for the application, and allows individuals to start an application and come back to it later (which may be valuable to individuals who cannot tolerate a long interview). Submitting documentation online can be more efficient than by mail and can electronically link the information to the application.

9. **Communicating and collaborating with SSA and DDS.** Agencies providing SOAR application assistance are encouraged to request that SSA and DDS (1) flag applications from assisting agencies, (2) expedite review of applications from assisting agencies, (3) assign claims representatives and disability examiners who specialize in applications from homeless people, (4) communicate directly with assisting agencies about their information needs for particular applications, and (5) contact the assisting agency if a consultative exam is needed.

10. **Obtaining a quality review of the application before submission.** To ensure that information provided in the application is clear, complete, and accurate, the curriculum suggests that an expert in SOAR (perhaps an agency supervisor or director, the state or local lead, an in-state SOAR trainer, or the SOAR TA Center) review the application prior to submission.

Although the Stepping Stones to Recovery curriculum identified these ten components as critical based on practice wisdom rather than rigorous analyses, available data from SSA on the use of an authorized representative, the submission of medical evidence with the application, and the avoidance of a consultative exam confirm that they are, in fact, predictive of higher initial application approval rates alone and in combination (Figure II.1). [11] Additionally, the application's chances of being approved increase as more of these components are used. Regardless of participation in SOAR or homeless status, the likelihood, on average, that an initial SSI or SSDI will be approved is 66 percent if all three measurable critical components are used, compared to 26 percent if none of them is used. Using only one of the critical components raises the likelihood of approval to between 29 and 40 percent; using two increases the likelihood to the 40 or 50 percent range. Regression analyses, presented in Appendix B, indicate that these components are significantly correlated with approval rates—even when holding other aspects of the application (such as the applicant's age, prior application, primary diagnosis, and state) constant.

Figure II.1. Relationship of select critical components to initial application approval



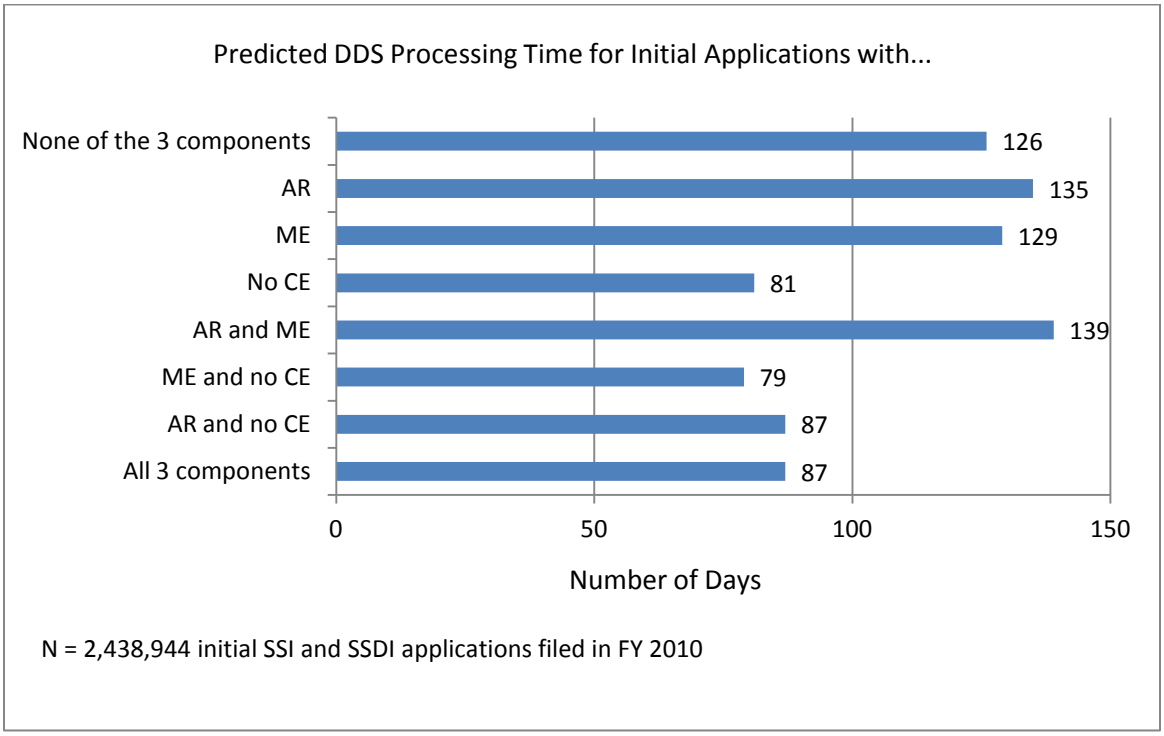
Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

Note: AR stands for authorized representative. ME stands for medical evidence. CE stands for consultative exam.

[11] Submission of medical evidence with the application and avoidance of a consultative exam are likely related, however; the more medical evidence that is submitted with the application, the less likely the DDS examiner will need to gather additional evidence through a consultative exam. Data on the other seven components are not available in the SSA files we obtained for analysis.

Also regardless of SOAR participation or homeless status, the critical component most predictive of shorter DDS application processing time is avoidance of a consultative exam (Figure II.2). Consultative exams can add length to processing time for several reasons. First, the process of ordering a consultative exam may take time. As explained in Wittenburg et al. (2012), examiners must document the rationale for ordering a consultative using a worksheet that varies in content and length by state. In some states, some examiners must obtain supervisory approval to order the exam. Second, consultative exam appointments are scheduled based in large part on availability of the medical provider (which can either be the applicant's doctor or a state-contracted provider). Third, for applicants who either cannot attend or miss their appointment, DDS must reschedule for a later date. Fourth, if information provided in the resultant report is inadequate or incomplete, DDS must follow up to obtain a complete report, resolve discrepencies, and make a determination. Predicted application processing time is between 79 and 87 days for avoidance of a consultative exam alone or in combination with each of the other two components. If the application is submitted with an authorized representative and/or medical evidence but still requires a consultative exam, predicted processing time increases to between 129 and 139 days.

Figure II.2. Relationship of select critical components to initial application DDS processing time



Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

Note: AR stands for authorized representative. ME stands for medical evidence. CE stands for consultative exam.

Practitioners are trained to apply these ten critical practices during a two-day, in-person training facilitated by individuals in their states who have received training from the SOAR TA Center on the Stepping Stones to Recovery curriculum and on strategies for instructing adult

learners. In-state trainings occur with varying frequency across states and localities. State and local SOAR leads work with in-state trainers on scheduling and meeting logistics. In most instances, state and local leads identify organizations whose staffs have the most potential to apply SOAR in practice and invite them to send staff to the trainings. Organizations sometimes also initiate training requests for their staffs. These organizations primarily include homeless, mental health and other community-based service providers, but they may also include hospitals, correctional facilities, and agencies that administer other benefits and social service programs. Typically, training is not mandatory, but states and localities set their own parameters, including expectations of participants after training. In most, there are no conditions for receipt of training, but a few (for instance one of the 13 evaluation states) require that participants complete a minimum number of applications through SOAR each quarter or year after training. Because training is intended to impart skills to apply in work with homeless individuals, training the staff who interact with this population directly is most important, but some organizations also send administrators and others to training.

C. What systems support the application assistance?

Applying some of the critical components for application assistance requires cooperation from various entities. For instance, collaborating with SSA and DDS or with medical providers requires that these stakeholders be engaged in SOAR—at a minimum, by learning about the model and its objective, and ideally, by becoming active participants in facilitating the application process. Thus, developing cooperative relationships is integral to the intervention. The strategic planning process requires identification and active engagement of a range of community stakeholders and aims to facilitate communication and collaboration between them. The objective is to create organizational networks by encouraging state and local entities that often serve the same population, but rarely interact, to work jointly toward the common goal of facilitating the SSI and SSDI application processes for homeless individuals. Typical stakeholders and their anticipated roles in the network include the following:

- **State and local leads**. Whether at the state or local level, SOAR leads (1) encourage initial and ongoing participation of stakeholders; (2) help stakeholders identify resources for SOAR; (3) facilitate ongoing stakeholder communication, informally and through regular meetings; (4) assist organizations in identifying and overcoming potential challenges in implementation; and (5) coordinate outcome data tracking and requests for ongoing TA.
- **SSA and DDS.** Ideally, SSA and DDS staffs will understand the challenges SOAR applicants face, accommodate those difficulties to the extent possible, and develop relationships with SOAR practitioners to whom they can turn for additional information about applicants. Notable ways these agencies can facilitate their roles is by designating a point of contact to handle SOAR-related issues and applications and by flagging and expediting applications submitted through SOAR.
- **Medical providers.** The medical community—both physical and mental health treatment providers—contributes to SOAR in three key ways: (1) by providing medical records, both to applicants to submit with their applications and to DDS medical examiners who request it to support their decisions; (2) by reviewing and signing medical summary reports prepared by SOAR practitioners to submit as medical evidence along with the application; and (3) by conducting medical exams arranged by practitioners prior to application submission as part

of their efforts to avoid the need for a consultative exam. Medical providers may also send their own staffs to training to provide SOAR application assistance (in some communities, SOAR leadership has actively encouraged hospitals to send benefits counselors to training and has provided training to Healthcare for the Homeless staff).

- **Other local service providers.** It is primarily the staffs at these agencies—which include mental health and homeless services providers and other community-based social service organizations—that provide SOAR application assistance. Part of this role entails offering peer support to one another to share best practices and to provide ideas and encouragement for addressing challenges. In addition, agencies without SOAR-trained practitioners can act as referral agencies, sending homeless individuals or those who are at risk of homelessness to agencies that do use SOAR.

D. Highlights from the chapter

- SOAR targets and serves both people who are homeless and people who are at risk of homelessness and primarily serves individuals with mental illness.
- The SOAR model of application assistance is intensive, emphasizing 10 practices that are critical for facilitating timely application approvals.
- Regardless of participation in SOAR or homeless status, the likelihood, on average, that an initial SSI or SSDI will be approved is 66 percent if the application is submitted with an authorized representative, with medical evidence, and with enough support to bypass a consultative exam; by comparison, likelihood of approval is 26 percent without these components.
- States and localities determine the schedule for and frequency of training in their communities, and have flexibility in determining which individuals become trainers and which individuals in which organizations to train as SOAR providers.
- A key component of the intervention is organizational networking to facilitate relationships among various entities that may play a role in supporting the application assistance process.

III. IMPLEMENTING THE INTERVENTION

SOAR aims to improve SSI and SSDI application outcomes for individuals either experiencing or at risk of experiencing homelessness by changing the behavior of professionals who work with them (through the Stepping Stones to Recovery training) and changing the way agencies that serve them interact with one another (through community-wide strategic planning and networking). States and local communities are responsible for implementing the SOAR intervention by relying on the TA they receive from the SOAR TA Center, but receive no funding to do so. Still, there are costs associated with the implementation process, primarily through dedication of staff time to facilitate the effort, attend training, and conduct and support application assistance. Thus, the quality of implementation varies based on the effort and resources communities are able and willing to expend on the process. In this chapter, we describe the combined efforts of SOAR communities to implement the intervention. In Chapter IV, we explore how variation in implementation affects outcomes.

A. Building the infrastructure for implementation

States have trained a considerable number of staff on the SOAR model, but many who are trained never complete an application using the SOAR process. Through December 2013, the 13 evaluation states that began receiving SOAR TA in FY 2010 or FY 2011 had trained about 2,745 individuals through approximately 135 different training sessions. SOAR leaders in these states estimate that 563 of those trained work in the local evaluation sites. As of December 2013, however, only about 13 percent (75 individuals) had completed an application using the SOAR process, as evidenced by entering information about the application into an MIS. Although it is possible that others have used the SOAR process without entering data into an MIS, it is unlikely for two reasons: (1) Mathematica provided extensive TA throughout the evaluation to ensure that SOAR trainees in the local evaluation sites were consistently tracking outcomes, and (2) evaluation states received a small amount of funding from the evaluation to designate a data liaison to oversee the outcome data collection and offset associated costs (see Appendix A for more information on these arrangements). Based on our stakeholder interviews and direct observation of sites, there are several reasons why many trained individuals do not complete applications using the SOAR process:

- **Lack of direct interaction with homeless populations.** Agency supervisors and directors, who do not work directly with homeless individuals and are thus not in a position to offer application assistance personally, often attend SOAR training to familiarize themselves with the model and support their staff or partners who use it. Other individuals who do provide direct service may also attend training for purposes of staff development with no intention of providing application assistance themselves. Still others who provide direct service may want to learn about SOAR, even though they don't work with the target population. Given that it is important for these types of people to be aware of the SOAR process, many states offer an abridged version of the training for them, but participants sometimes do not attend the training most appropriate for them. [12]

[12] To encourage the correct audience for full-scale trainings, some states have begun to require that participants attest that they work directly with individuals who are homeless (for example, Mississippi) or that they will commit to completing a minimum number of applications each year (for example, New Mexico).

- **Lack of time.** Using all of the components of the SOAR model to complete an application requires time and commitment. Case managers in direct service agencies are often already overburdened with other responsibilities and high caseloads. Without a clear mandate to implement SOAR (for instance, through specific funding to do so or through a contractual vehicle), SOAR trainees report that it is challenging to carve out time for SOAR.
- **Staff turnover.** The homeless services workforce generally is characterized by high staff turnover (Mullen and Leginski 2010; Olivet et al. 2009). Evaluation staff who conducted interviews with SOAR stakeholders characterized the evaluation sites in 10 of the 13 states that began receiving SOAR TA in FY 2010 or FY 2011 as having a moderate-to-high level of turnover among direct services staff. Some trainees leave their positions or agencies before having an opportunity to implement SOAR. If they take a new job providing direct services to homeless individuals elsewhere, their new agency may not support the dedication of time and resources to SOAR.
- **Need for additional support**. While each trainee receives a hard copy of the curriculum and there are many TA materials on SAMHSA's SOAR TA Center website, some trainees interviewed for this evaluation reported feeling overwhelmed and intimidated at the prospect of having to put the training information into practice. Half of the states that began receiving TA in FY 2010 or FY 2011 have provided refresher trainings to bolster the skills and confidence of trainees, and in all but three there is a point of contact located in the evaluation site (typically the state or local lead or an in-state trainer) to answer questions and provide support. Still, some trainees may be too apprehensive to implement SOAR immediately after training and the longer they delay, the more their knowledge may wane over time.
- **Challenging population.** Staff report that it often takes time to identify and then engage clients in the SOAR target population (that is individuals who are homeless or at risk of homelessness and who have mental illness). The target population is a relatively narrow one and, although street outreach is a core service that many SOAR providers conduct, most providers tap clients for SOAR from their existing caseloads. Some providers require that individuals have mental illness to receive SOAR services while others more broadly serve individuals who are homeless or at risk of homelessness.

Communication between stakeholders increased in all evaluation sites after the introduction of SOAR, as measured by density. Density is a calculation of the total amount of communication present in a network divided by the total amount of communication possible in that network. Density may be used as a measure of group cohesion, or how unified or tight-knit the group is. Zero-percent density indicates that none of the organizations in the network are communicating with each other, while 100-percent density indicates that all are. On average, across all local evaluation sites, network density increased by nearly one-third (32.9 percent) from before respondents' involvement in SOAR to about two years after (Table III.1), accounting for both new lines of communication after SOAR and increases in pre-existing communication. Changes to network density over time ranged from a high of 80 percentage points to a low of 11.9 percentage points. Although one site had achieved 100-percent network density at the time of the survey, sites do not need to achieve 100-percent density to successfully implement SOAR processes and realize positive application outcomes. For example, in a site with multiple SOAR practitioners at different agencies, communication between them may not be necessary.

Although density increased in all sites, four sites remained at or below 50-percent density about two years after starting their work on SOAR.

Table III.1. Network densities over time, by local evaluation site

Site	Density pre-SOAR (%)	Density at time of survey (%)	Percentage-point change in density over time	Number of stakeholders in the network
1	33.3	50.0	16.7	6
2	20.0	100.0	80.0	6
3	23.8	64.3	40.5	7
4	30.0	65.0	35.0	5
5	10.7	64.3	53.6	8
6	33.9	66.1	32.1	8
7	21.4	50.0	28.6	7
8	30.0	56.7	26.7	6
9	45.2	57.1	11.9	7
10	50.0	66.7	16.7	7
11	20.0	50.0	30.0	6
12	16.7	40.0	23.3	6
13	33.3	66.7	33.3	4
Average	28.3	61.3	32.9	6

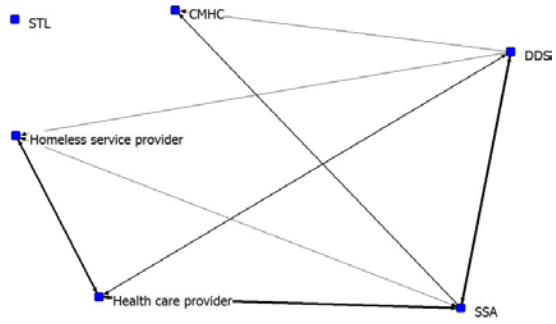
Source: Mathematica calculations based on the social network survey in the 13 states that began receiving SOAR TA in FYs 2010 or 2011.

Plotting specific lines of communication between SOAR stakeholders illustrates the specific nature of changes in communication. Figure III.1 provides an example (diagrams for all local evaluation sites are available in Appendix C). Among the six stakeholders in the network, communication increased substantially from before SOAR TA was provided in the community to two to three years afterward. This figure shows not only an increase in agencies communicating with one another (indicated by the presence of a line between agencies, and arrows indicating the directionality of the communication), but also an increase in the amount of communication between them (with thicker lines indicating more frequent communication).

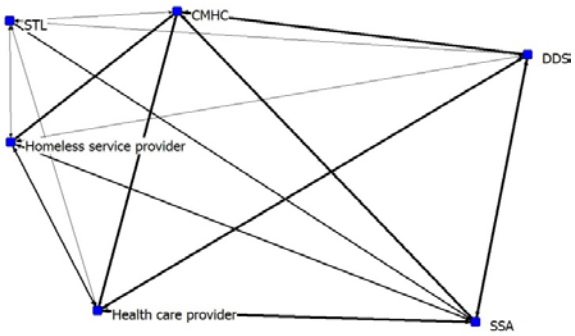
The biggest gains in communication in most sites occurred between state leads and other organizations. State leads were often assigned their role in SOAR as an extension of their work around mental health or homelessness, but most had not previously been involved in SSI or SSDI processes or the intersection of mental health, homelessness, and benefits access. Thus, they had relatively little communication with most relevant agencies before their involvement in SOAR and became the focal point of bringing agencies together afterward.

Figure III.1. Example of increased communication between SOAR stakeholders

Before SOAR



After SOAR



Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

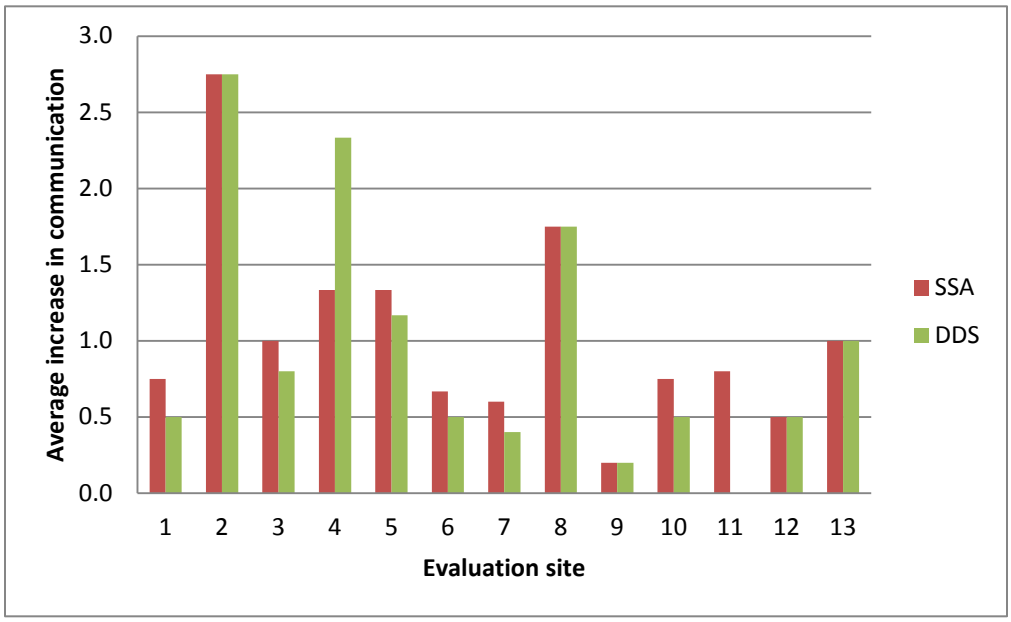
All sites reported increased communication with SSA field offices and DDS staff. We asked stakeholders to report the frequency of communication with one another both before and two to three years after their involvement with SOAR on the following scale: never, once or twice a year, every month or two, every week or two, or more than once a week. We assigned one point to each incremental increase. The greatest change possible is in a site that reported no communication with SSA or DDS before the site became involved with SOAR, but then communicated with SSA or DDS more than once a week at the time of the survey. This example would yield an increase of 4 points. The change in frequency of communication varied by site, but on average, all sites reported increased communication with SSA and DDS (Figure III.2). (Individual site breakdowns are available in Appendix C.)

Site visit data suggest that this increased communication has indeed led to active collaboration with SSA and DDS in the local evaluation sites (Table III.2). Field or regional offices in each local evaluation site and DDS offices in each evaluation state identified a liaison for SOAR providers and applicants—although, the extent to which they were proactive in communicating with or responsive to providers and applicants varied. DDS partners in most states, however, regularly attended trainings and SOAR team meetings. In all but two sites, SSA and DDS flagged applications that went through the SOAR process. Because it is not possible to add a variable that indicates the application as SOAR in SSA's data system, SSA and DDS typically flagged applications by including comments in the remarks field of the electronic records. SOAR providers typically alerted SSA and DDS to an application that went through the SOAR process by attaching a cover sheet to the application submission or by writing "SOAR" in the address fields of the application. Some (four SSA partners and one DDS partner) treated these flagged applications no differently from other applications, however.[13] The remainder

[13] Another two SSA partners and one DDS partner did not know whether they treated applications flagged as "SOAR" differently from others because they hadn't received such an application in the past year.

expedited or prioritized these applications, although three DDS partners did so for all applications from homeless individuals and not specifically because of their SOAR designation.

Figure III.2. Changes in communication frequency with SSA and DDS, by evaluation site



Source: Social network survey from SOAR stakeholders.

Table III.2. SSA and DDS practices in local evaluation sites

	Local evaluation site in state...												
	1	2	3	4	5	6	7	8	9	10	11	12	13
SSA or DDS flag applications as SOAR	X	X	X	X	X		X	X	X	X	X		X
SSA identified a liaison for SOAR providers	X	X	X	X	X	X	X	X	X	X	X	X	X
DDS identified a liaison for SOAR providers	X	X	X	X	X	X	X	X	X	X	X	X	X
SSA expedites or prioritizes SOAR applications		X	X	X			?[a]	X	X	X	?[a]		X
DDS expedites or prioritizes SOAR applications	X	X	X	X		X	X	X	X	X	X	?[b]	X

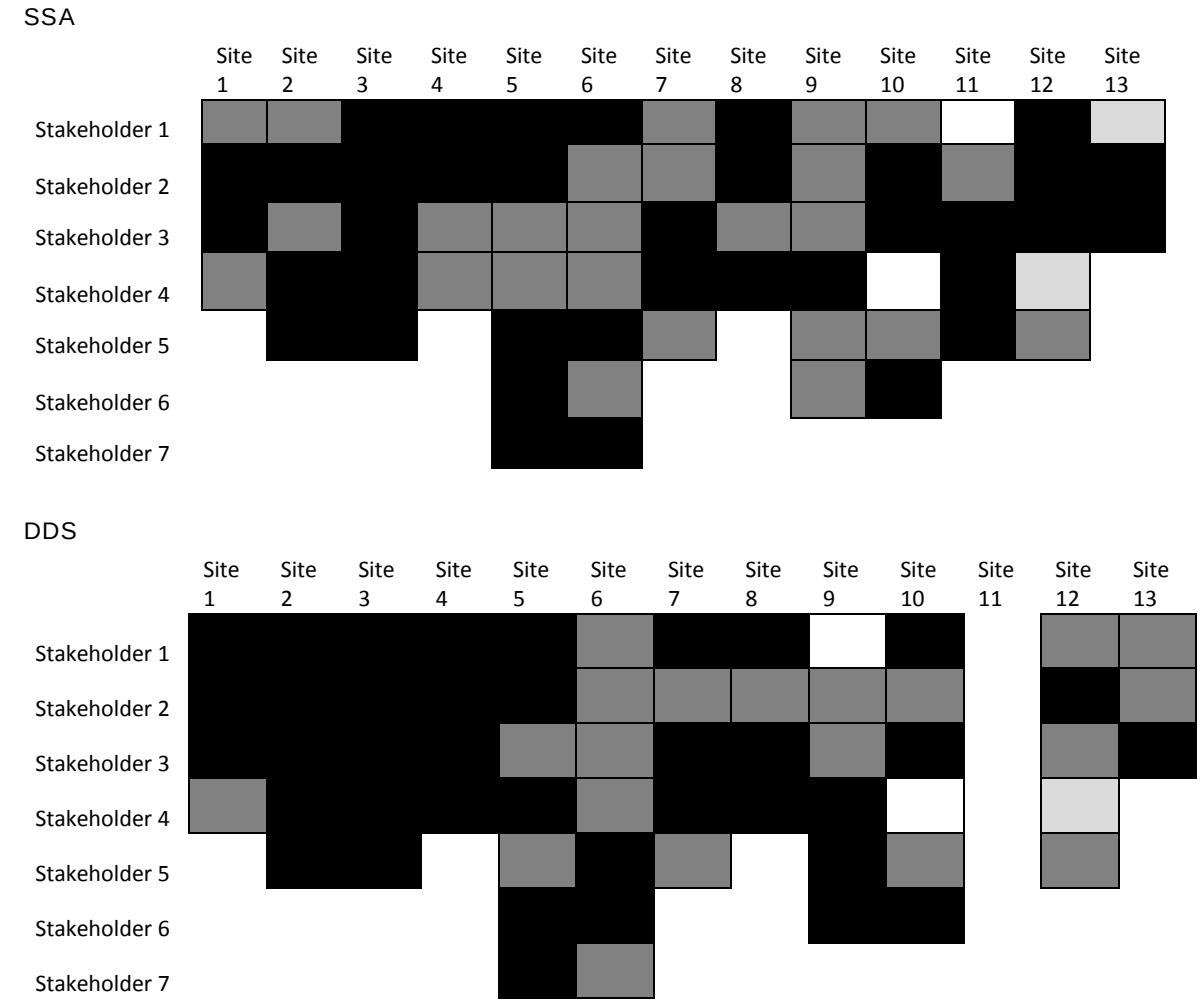
Source: Qualitative data collected during site visits to SOAR communities and telephone interviews with SOAR stakeholders.

[a]SSA staff reported being unaware of a SOAR submission in the year prior to our data collection so could not comment on whether they expedite or prioritize SOAR applications.

[b]DDS staff reported being unaware of a SOAR submission in the year prior to our data collection so could not comment on whether they expedite or prioritize SOAR applications.

A majority of network participants in every site found the collaboration with SSA and DDS helpful in assisting eligible homeless individuals access SSI or SSDI benefits. Figure III.3 shows agency reports of SSA and DDS helpfulness. Overall, stakeholders found both SSA and DDS helpful in carrying out SOAR, although individual reports varied. Black boxes in the figure represent stakeholders that reported that SSA or DDS helped them carry out their SOAR roles "to a considerable extent," dark grey boxes show reports that SSA or DDS were helpful "to some extent," and light grey boxes indicate reports that SSA or DDS were "not at all helpful." (White boxes indicate nonresponse.) The darker the overall pictorial, the more the organizations found SSA or DDS helpful. Few respondents indicated that SSA or DDS had not been helpful to them.

Figure III.3. Agency ratings of SSA and DDS helpfulness in carrying out SOAR



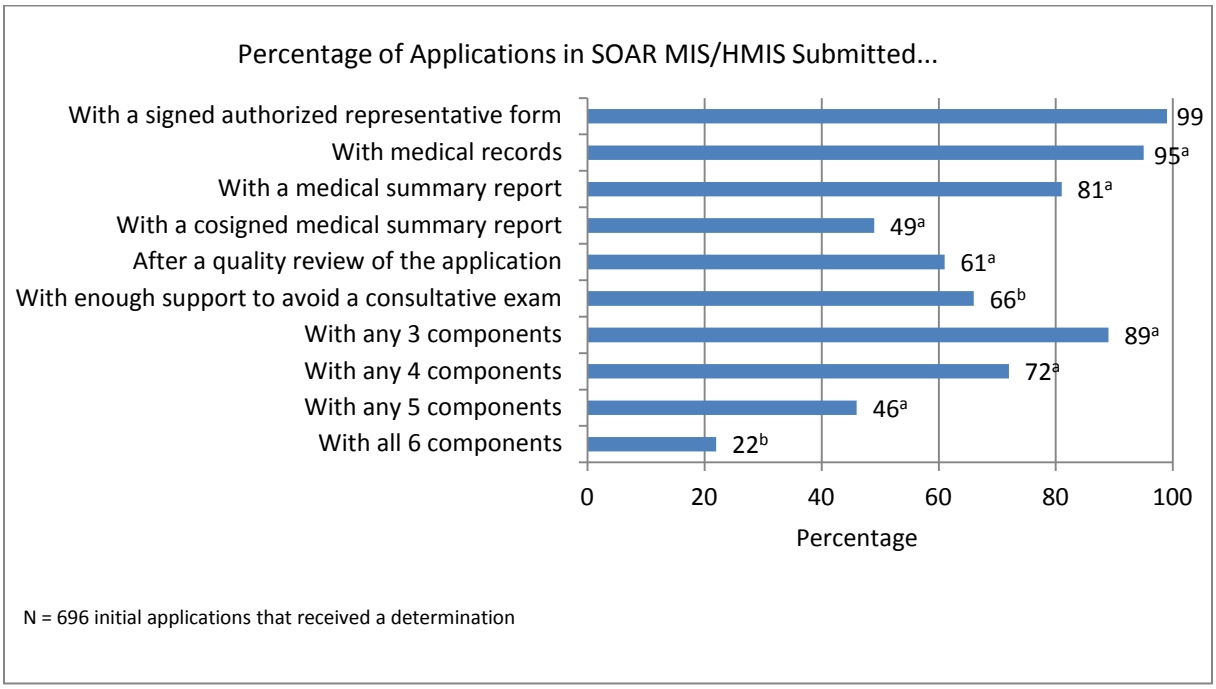
Source: Social network survey from SOAR stakeholders.

Note: In site 11, DDS was not an active stakeholder at the time of our survey. Gridlines for other sites indicate the number of stakeholders in the network other than SSA and DDS. For example, there were 4 stakeholders in site 1, 5 in site 2, and 7 in site 5.

B. Providing application assistance

Trainees who have completed applications using the SOAR process generally comply with the critical components. On most initial applications they helped to submit (and that received a decision), SOAR providers in the local evaluation sites implemented at least four of the six critical components that are tracked in their state's MIS (Figure III.4). They implemented five out of six components in just under half of the applications and all six components in just over a fifth of the applications. Almost all were submitted using authorized representatives and with copies of applicants' medical records. To facilitate this process, five of the sites developed formal agreements or memoranda of understanding with medical providers—such as state and regional hospital systems, community clinics, correctional agencies, and the state veterans administration—to provide medical records in support of SSI or SSDI applications for free and on an expedited basis. A quality review was completed for 61 percent of the initial applications that SOAR providers in the local evaluation sites helped to submit (either by the SOAR TA Center or by supervisors at the providers who were trained in the Stepping Stones to Recovery curriculum) and two-thirds of the applications were complete enough to avoid a consultative exam.

Figure III.4. Use of SOAR's critical components in local evaluation sites



Source: SOAR MIS or HMIS in the local evaluation sites in the 13 states that began receiving SOAR TA in FYs 2010 or 2011.

[a]Sample size is 634 because Wisconsin officials did not record these data in their HMIS.

[b]Sample size is 671 for avoiding a consultative exam because of missing data throughout the states.

[c]Sample size is 607 for using all components because of missing data throughout the states.

Four-fifths of the applications tracked in an MIS included a medical summary report, and half were submitted with a report signed by a medical or mental health professional. These components were the most challenging to implement. During site visits, some SOAR providers acknowledged that they do not write medical summary reports because of the time required or because they (or DDS) think they are duplicative with forms on an applicant's functionality that the state DDS already requires (for instance, Form SSA-3373). More frequently, providers wrote reports but could not obtain the signatures that would deem the summaries as medical evidence. SOAR providers who work in agencies that staff doctors and psychiatrists are typically able to obtain signatures. Other agencies have tried to address the challenge by developing partnerships with private providers to see their clients and review (and sign) medical summary reports a few times per month. Some agencies (though none that were in the local evaluation sites) have engaged Healthcare for the Homeless for this purpose. [14]

SSA data indicate that applications that went through the SOAR process use precepts from the Stepping Stones to Recovery curriculum more often than other applications. However, it is possible to measure use of only three of the SOAR critical components in the SSA administrative data. Analyses of these data indicate lower rates of implementation of these components than MIS data indicate, but suggests that applications that went through the SOAR process are substantially more likely than other applications (from other homeless individuals and individuals who were not homeless) to be submitted with an authorized representative and medical evidence (Table III.3). Applications submitted through SOAR are four times as likely to have an authorized representative as all applications from homeless individuals and were more than twice as likely to be submitted with medical evidence. They were also slightly less likely to require a consultative exam. [15] Almost a quarter of the applications that went through the SOAR process used all three of these critical components, while very few of the other applications did.

C. Other factors facilitating or impeding implementation

1. Financial resources

As noted above, states and localities receive no funding to implement SOAR, but they incur costs in the process. With support and guidance from the SOAR TA Center, some have been resourceful and sought opportunities to obtain funding through different avenues. They have used these funds to support the work of their state or local leads and to cover the salary of one or more individuals whose positions would solely entail providing SOAR application assistance. In

[14]Healthcare for the Homeless is a grant program supported by the Health Resources Services Administration within the U.S. Department of Health and Human Services that provides primary care (including primary health care and substance abuse services, emergency care and referrals, outreach and assistance in qualifying for entitlement programs and housing) to homeless people.

[15] According to published SSA data (SSA Advisory Board 2012), nationally in FY 2010, DDS purchased consultative exams in 48 percent of initial-level SSI and SSDI claims, on average. Our analysis indicates that consultative exams were ordered in 59 percent of initial SSI or SSDI claims nationally in FY 2010. The difference may reflect several factors such as (1) how consultative exams were counted (whether all consultative exams ordered were counted, as in our analysis, or just those purchased; in some cases SSA pays for an exam that DDS ordered even if it did not occur because the applicant canceled or did not show, and in some cases it does not), and (2) the time frame for the analysis (whether applications *initiated* in FY 2010 were included, as in our analysis, or whether all *active* applications at the initial level in FY 2010 were included). Our analysis of consultative exams is based on document codes in SSA's Structured Data Repository (60-0320) and Systems of Records.

these communities, this funding has helped facilitate the SOAR effort and propel it forward. Three key ways that communities have funded their efforts include the following: [16]

Table III.3. Use of SOAR's critical components in all initial SSI or SSDI applications

	Percentage of adult SSI or SSDI applicants in FY 2010			
	All applicants	Identified as homeless	Identified as SOAR	Not identified as homeless
Applicant has AR	15.3	20.5	82.0	15.4
Application submitted with ME	19.3	22.8	51.1	19.2
No CE ordered	41.2	35.1	44.0	41.4
Any 1 critical component	43.3	38.7	31.3	43.4
Any 2 critical components	13.6	14.1	38.2	13.6
All 3 critical components	1.9	3.8	23.1	1.8
Total initial applications	**2,438,944**	**55,797**	**804**	**2,383,147**

Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

Note: AR stands for authorized representative. ME stands for medical evidence. CE stands for consultative exam.

1. **Cost recovery from Medicaid.** In one site, the two main SOAR providers, which are community mental health centers, bill Medicaid for health care services provided to approved SSI and SSDI applicants who were not enrolled in Medicaid between the protective filing date on the SSI or SSDI application and the Medicaid enrollment date. [17] The funds obtained through these efforts are used to support the salaries of the frontline SOAR positions and to supplement the budgets of the centers. The costs recovered can be substantial—one of the centers reported a $95,000 Medicaid reimbursement for one applicant approved for SSI.

2. **State funds.** In one site, the state provided various agencies with seed money from a state homeless assistance trust fund (created over 25 years ago) to develop SOAR efforts, for a period of three years. The primary SOAR provider in the local evaluation site receives $50,000 per year and uses this money, in combination with PATH funds from the state's regional division of behavioral health, to support the salaries of two full-time SOAR practitioners. After three years, the state plans to eliminate the trust fund set-aside for SOAR and require organizations to compete for money from the trust fund or to pursue other funding sources. In another site, the department of health receives state general funds to

[16] A fourth way that some states (although, none of the evaluation states) have funded SOAR is through recovery of funds paid through their General Assistance program from SSA for General Assistance recipients who later qualified for SSI. Chapter IV describes this process in more detail.

[17] The state uses the same rules to decide eligibility for Medicaid as SSA uses for SSI, but requires the filing of a separate application. Providers can bill Medicaid for 90 days retroactive from the date of protective filing. See Chapter IV for more discussion of cost recovery from Medicaid.

employ a contractor to provide state-level coordination and trainings for SOAR as well as application assistance in the local evaluation site.

3. **Grants from federal funding streams.** At one site, an agency that provides SOAR application assistance wrote SOAR into a U.S. Department of Veterans Affairs Supportive Services for Veteran Families grant and used the resultant funds to support a part-time SOAR application assistant. The agency supplements these funds with limited funds from a HUD Continuum of Care grant through the local housing authority and the Community Services Block Grant. [18] At another site, an emergency shelter provider received a SAMHSA grant that allowed the use of personnel costs to hire a part-time SOAR application assistant.

2. Institutional and political support

SOAR is very susceptible to shifting fiscal, legislative, and political priorities. In communities that have not garnered funding to support SOAR, the effort suffered in the face of budgetary constraints. Many SOAR stakeholders reported limited availability of resources for homeless and mental health services generally. Additional funding cuts for community mental health services tended to restrict staff resources for SOAR. At one site, changes in allowable activities billable under Medicaid strained agencies' abilities to support efforts like SOAR. SOAR also often fell victim to shifting political priorities. For example, key SOAR staff in three sites among the middle group of performers had to shift focus from SOAR in order to prepare for the implementation of the Affordable Care Act. After a recent change in state administration at the poorest-performing site, state officials reorganized their behavioral health division, which led to decreased support for SOAR as other initiatives took priority.

Integrating SOAR into larger efforts to address homelessness helped buffer fiscal, legislative, and political impediments by legitimizing and institutionalizing the effort. Most of the high-performing and medium-performing sites (as described in Chapter IV), but none of the low-performing sites, incorporated SOAR into the Continuum of Care. In some of the better-performing sites, the Continuum of Care played an active role in SOAR as stakeholders used it to garner support for the effort, communicate with existing network partners, and recruit new partners. In all of the sites that incorporated SOAR into the Continuum of Care, SOAR was also written into the states' 10-year plan to end homelessness. The PATH program could also be a key source of support for SOAR, but most sites were not taking full advantage of this resource. Many SOAR agencies also received PATH funds, but in most, PATH funds were not specifically directed to SOAR activities. Two states recently required that staff in agencies receiving PATH funding integrate SOAR into their practice, designating a target for the number of SSI and SSDI applications to be completed through the SOAR process. In one of these states, the PATH contract performance standards required that 80 percent of PATH-enrolled clients who were not currently receiving SSI or SSDI benefits apply for them using SOAR. Whether this approach is successful in facilitating SOAR application assistance remains to be seen.

[18] According to HUD, a Continuum of Care is "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness." Continuums of Care submit a single application for and receive McKinney-Vento Homeless Assistance Grants to provide prevention services and assistance programs to those at-risk of or experiencing homelessness.

D. Highlights from the chapter

- Implementation of SOAR has entailed a wide-scale training effort, but application of the training has been relatively limited. This finding demonstrates the challenge of a model that (1) does not provide funding for implementation; (2) provides broad, rather than targeted, training to a workforce characterized by high workloads and high turnover; and (3) is targeted toward a narrow, difficult-to-reach population.
- Those who do apply the SOAR training in practice generally comply with the critical components emphasized in the Stepping Stones to Recovery curriculum. These practices have contributed to notable increases in the amount of information included in the SSI and SSDI applications compared to applications from both homeless individuals generally and non-homeless individuals.
- The organizational networking that SOAR communities facilitated was successful in increasing communication among entities that play important roles in supporting the application assistance process. State and local leads were vital to this process. The biggest payoff was in new collaborations between SOAR providers and SSA field offices and DDS staff.

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IV. OUTCOMES OF THE SOAR INTERVENTION

The most proximate outcomes of SOAR are the application approval rate and the average processing time. Mathematica worked diligently with SOAR providers in the 13 local evaluation sites to use an MIS to track these outcomes for applicants they assisted from the start of SOAR in their communities (FY 2010 or FY 2011) through December 2013. In the first section of this chapter, we present these MIS data and synthesize MIS and qualitative data to discuss the relationship between various implementation factors and outcomes.

SSA administrative data provide the unique opportunity to examine how outcomes for SOAR participants compare to the national homeless and non-homeless population. In the second section of this chapter, we use descriptive statistics to examine differences in outcomes between individuals who went through the SOAR process and those who did not. Differences between these groups alone, however, are not sufficient to conclude that SOAR played a role in producing the outcomes. For instance, better outcomes among SOAR applicants may not be related to SOAR per se, but could be because those who went through SOAR had more severe impairments than others and, thus, it was easier for examiners to make quick decisions and approve the applications. To explore the relationship between SOAR and the outcomes of interest, we also present the results of regression analyses and a difference in differences analysis based on the SSA data. The chapter concludes with a discussion of the potential implications of SOAR's outcomes for key participants in the SOAR network.

A. Application outcomes recorded in MIS

SOAR-trained practitioners reported an average of just over three months to receive a decision on an initial application. Average processing time for initial applications that had received a decision as of December 2013 was 99 days in the local evaluation sites of states that began receiving TA in FY 2010 or FY 2011. This is consistent with the average processing time (100 days) among all states since SOAR began, according to the most recent summary of SOAR outcomes compiled by the SOAR TA Center.[19] Some applications took substantially longer to process than others, driving up the average. The median processing time in the local evaluation sites was 82 days (meaning that half of the applications were processed more quickly and half took longer than 82 days to process); the longest time between application submission and decision was 29 months.

SOAR-trained practitioners reported a 73 percent application approval rate. MIS data suggest that as of December 2013 about 83.6 percent (696 of 833) of the initial applications that SOAR trainees helped homeless individuals submit in the local evaluation sites had received a decision. Among them, two-thirds (66.8 percent) were approved at initial application.[20] This approval rate is consistent with that reported among all states since SOAR began (65 percent), according to the most recent summary of SOAR outcomes compiled by the SOAR TA Center.[21]

[19] See http://soarworks.prainc.com/sites/soarworks.prainc.com/files/SOAR_Outcomes_2013.pdf.

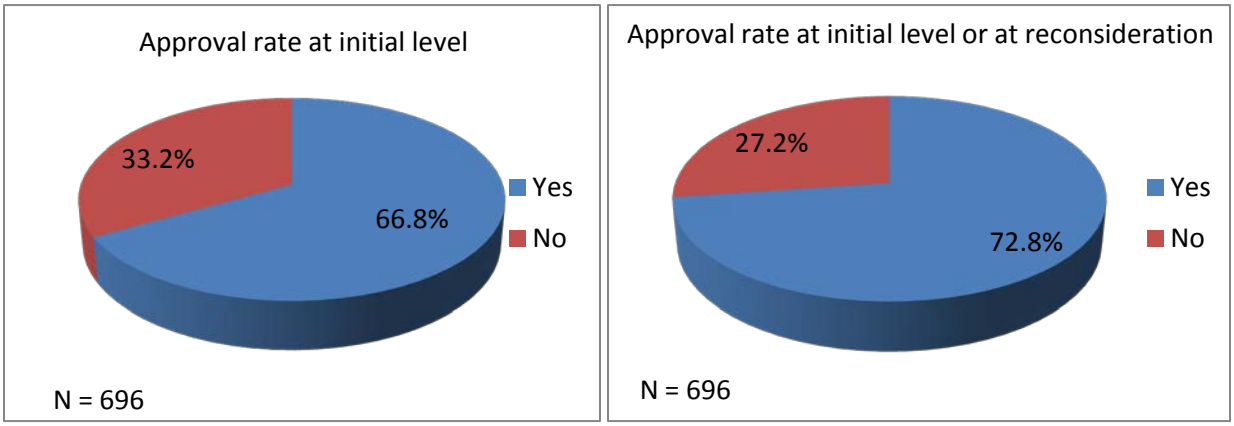
[20] The approval rate among all applications, including those without an initial decision, is 55.8 percent.

[21] See http://soarworks.prainc.com/sites/soarworks.prainc.com/files/SOAR_Outcomes_2013.pdf. SOAR outcomes complied by the SOAR TA Center are based on data states report directly to the Center every June. Some states use the SOAR MIS or HMIS to track the data they report; other states use other systems or processes.

Almost three-quarters (72.8 percent) of applications in the local evaluation sites were approved either at initial application or upon reconsideration (Figure IV.1). [22]

Sites' success with application submissions had less to do with the size of the effort (that is, the number of people trained) and more to do with trainees' availability to assist with applications. We assessed the relative performance of the 13 local evaluation sites based on the number of approved SSI and SSDI applications submitted through SOAR in each. The site with the most approvals boasts the largest number of SOAR trainees (135), but only 6 trainees (all within the same agency) have actually recorded submission of applications in the SOAR MIS. Two of the 6 are dedicated full-time to SOAR application assistance and, thus, are able to manage caseloads of between 10 and 30 clients at a time. In another top-performing site, where 100 applications were submitted through December 2013 at an approval rate of 86 percent, only 3 individuals within two agencies were trained in SOAR (Table IV.1). This site achieved its success by prioritizing access to SSI and SSDI for its clients and dedicating each of the 2 trainees at one agency to SOAR application assistance full-time. Other sites have trained dozens of staff, with varying levels of success with application submissions and approvals. In these sites, staff turnover was an impediment to completing applications through SOAR. Only three local evaluation sites were characterized as having low turnover among SOAR practitioners; these were three of the four best performers with respect to the number of application approvals.

Figure IV.1. Application approval rates in local evaluation sites among SOAR cases tracked in an MIS with a decision



Source: SOAR MIS or HMIS in the local evaluation sites in the 13 states that began receiving SOAR TA in FYs 2010 or 2011.

[22] The approval rate for reconsiderations was 54.2 percent, which is consistent with the rate of approval on reconsideration or appeal reported among all states since SOAR began (53 percent), according to the most recent summary of SOAR outcomes complied by the SOAR TA Center.

Table IV.1. Factors that may influence application approvals, by local evaluation site

Local evaluation site	1	2	3	4	5	6	7	8	9	10	11	12	13
Number of approved applications	111	93	86	41	29	27	21	19	17	9	5	3	0
Staff resources													
Number of people trained	135	24	3	33	85	40	53	45	15	40	28	~ 20	33
Staff dedicated solely to SOAR application assistance	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N
Funding designated for SOAR application assistance	Y	Y	Y	Y	Y	Y	N[a]	N	Y	N	N	N	N
Turnover among SOAR practitioners	L	L	M	L	M	M	H	M	M	H	M	H	H
Leadership													
State leadership actively engaged in SOAR	M	H	M	H	L	M	L	H	L	M	M	L	L
Local leadership actively engaged in SOAR	H	--[b]	L	--[b]	--[b]	L	L	M[b]	M	L	M	L	L
Communication													
Regular state-level stakeholder meetings	Y	Y	Y[c]	N	N	Y[c]	Y	Y	Y[c]	N	N	N	N
Regular local-level stakeholder meetings	Y	Y	Y	N	N	Y	N	Y	Y	Y	N	N	Y[c]

Source: Mathematica analysis of qualitative data collected during site visits and telephone interviews.

Note: H stands for high; M stands for moderate; L stands for low; ~ stands for approximately

[a]During the early evaluation period, however, the lead in the local evaluation site received state funds to support the work of SOAR trainers.

[b]In sites 2, 4, and 5, the state lead is located in the evaluation site and also serves as the local lead for that area. Site 8 had a separate local lead early in the evaluation period, but the state lead served as the local lead during the latter half of the evaluation period.

[c]This occurred early in the evaluation period, but not late in the evaluation period.

Creating SOAR-dedicated positions can ensure that SSI or SSDI application assistance does not compete for time with other staff tasks and demands and, therefore, increase the likelihood of success. The top three performers with respect to number of approved applications (as well as the top two moderate performers) had staff dedicated solely to conducting SOAR application assistance; none of the other eight local evaluation sites did. In each of these five sites, one or more frontline staff (that is, staff who worked directly with homeless individuals) worked exclusively on SOAR either part- or full-time. Two additional sites had leadership positions dedicated to SOAR. In the eight sites that did not have positions dedicated to SOAR application assistance, staff found it difficult to carve out time for SOAR amid other responsibilities and high caseloads, even when benefit access theoretically was an important component of their

work. In the sites that had staff dedicated to SOAR application assistance, SOAR providers had secured external financial resources for this purpose. [23]

Actively engaged leadership (at the state or local level) does not guarantee success, but it is difficult for SOAR to succeed without it. Three of the four strongest evaluation sites with respect to application submissions and approvals had a leader at the state or local level who was highly engaged in SOAR (Table IV.1). In the two poorest-performing sites, both the state and local leads were minimally engaged in the effort. Strong SOAR leaders developed partnerships around SOAR, facilitated regular communication among SOAR stakeholders, organized and promoted training opportunities, mediated issues with respect to application processing, and provided technical assistance and other support to SOAR stakeholders. Perhaps most importantly, leads who were highly invested in the effort followed up with SOAR-trained staff to encourage them to apply SOAR in practice.

Formal communication mechanisms appear to be more related to outcomes than the amount of communication among stakeholders does. Although the highest-performing sites had considerable communication—both formal and informal—among all SOAR stakeholders two to three years after the implementation of SOAR, most of the moderately successful sites did as well (although, the two poorest performers were characterized either by a relatively loosely connected network or a tight-knit network of very few agencies). Figures illustrating communication patterns between stakeholders are presented in Appendix C. Opportunities for regular, formal communication through facilitated meetings seem more related to outcomes. Steering committee meetings offer a forum for discussing (1) challenges pertaining to SOAR and potential solutions, (2) the establishment of processes for processing applications, and (3) collaboration on strategic planning. All top-performing states maintained regular communication via state and local steering committee meetings; two of them used the existing Continuum of Care structure to facilitate these meetings. Participants in these committees typically included the state and local leads, SSA and DDS representatives, supervisors or staff from current and potential SOAR providers, health care agencies providing medical records and assessments, and other partners such as correctional or vocational rehabilitation agencies. None of the three poorest performers had steering committees at either the state or local level (although, during the early part of the evaluation period one held regular meetings for key stakeholders in the local evaluation site).

B. Application outcomes recorded in SSA administrative data

Applications submitted through the SOAR process are approved at much higher rates than other applications. SSA data portray lower approval rates among SOAR applicants than SOAR-trained practitioners report, but suggest that applications submitted through the SOAR process are approved at much higher rates than those from both homeless applicants generally and

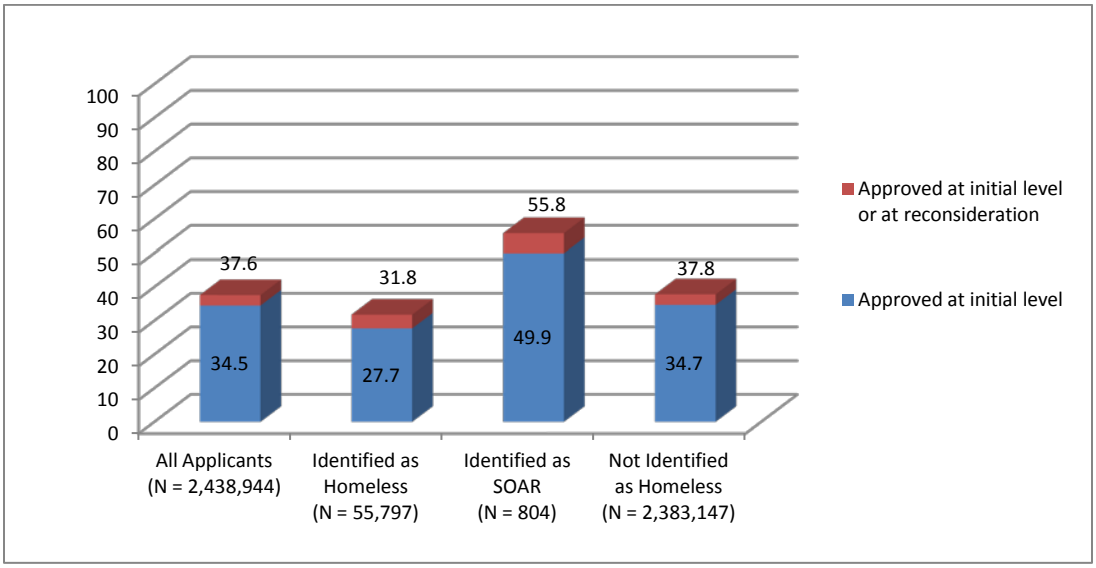
[23] In the absence of external financial resources, another way to dedicate staff to SOAR application assistance is by shifting responsibilities so that one or two staff members take on all SOAR work for agency clients while the balance of staff divvy up the previously assigned tasks and caseloads of those staff members. None of the local evaluation sites, however, used this model. Rather, of the five sites in the middle of the ranking that did not have dedicated staff, agency supervisors or directors encouraged their staff to make time for SOAR despite their other responsibilities. Staff who were able to make the most time for SOAR were often benefits specialists, so SOAR was another tool in their benefits access toolbox.

applicants who are not homeless. According to SSA administrative data, in FY 2010, SOAR participants were approved for SSI or SSDI at the initial level at a rate of almost double that for all homeless applicants—50 percent compared with 28 percent—and a rate that was substantially higher than for applicants who were not homeless (35 percent). Relatively more SOAR applicants who were initially denied went on to reconsideration—46 percent compared with about 40 percent among all homeless applicants and applicants who were not homeless—and relatively more of those reconsiderations were approved—26 percent among SOAR applicants compared with 14 percent among all homeless applicants and 12 percent among applicants who were not homeless. As a result, about 56 percent of SOAR applicants were approved at either level, compared with 32 percent of all homeless applicants and 38 percent of applicants who were not homeless (Figure IV.2).

SOAR applicants have relatively lower processing times in comparison to other applicants nationally. According to SSA administrative data, in all states in FY 2010 homeless applicants were approved for SSI or SSDI at the initial level in an average of 110 days. SOAR applicants, however, were approved for SSI or SSDI at the initial level in an average of 97 days.

To extend the descriptive analysis above, we examined whether SOAR participation is correlated with higher application approval rates and shorter average processing time, while controlling for other characteristics (for example, applicant's age) that might influence these outcomes. We also constructed a difference in differences model to examine how outcomes among all homeless individuals in SOAR communities in select states change over time relative to homeless individuals in the balance of communities that have not implemented SOAR in those states. We intended to use this model to estimate the effects of SOAR, but once the data became available for analysis, we identified limitations that make it difficult to isolate the role that SOAR plays in producing outcomes. A major challenge in estimating effects is that many factors

Figure IV.2. Initial application decisions among adult SSI and SSDI applicants, by homelessness and SOAR status



Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

may influence application outcomes, including the SOAR intervention. A difference in differences analysis attempts to isolate the influence of an intervention by mitigating the influence of external factors. It cannot, however, eliminate the influence of trends in the outcome measures, creating potential bias in the results. We observed large differences in baseline characteristics between SOAR and non-SOAR communities that may be indicative of differences in such trends across the two types of communities. In addition, the data revealed that vis-à-vis the size of the homeless and SSI applicant populations there are very few SOAR participants, making it difficult to tease out SOAR's influence on outcomes using a difference in differences approach. Thus, we conducted the difference in differences analysis to be consistent with the evaluation design, but interpret the results as general trends in application outcomes rather than intervention effects. Below we present the results of these two analyses.

1. Regression analyses comparing SOAR participants to nonparticipants

We used a logit model to assess whether SOAR is correlated with higher initial SSI and SSDI application approval rates. The dependent variable was one for an approved application and zero otherwise. We pooled homeless applicants in SOAR and non-SOAR communities to estimate the model for FY 2010. We defined a dummy variable that equaled one if the application was submitted through the SOAR process and zero otherwise. We also controlled for other individual and state factors that may influence the application decision (applicant age, primary diagnosis, state of residence, and whether the applicant had ever submitted an application previously). [24] Details on the methodology used to derive these results may be found in Appendix A. Coefficients for other variables included in the model are presented in Appendix B.

SOAR applicants had higher approval rates relative to non-SOAR applicants, consistent with the descriptive findings above. As with any non-experimental analysis, it is not possible to assess whether the correlation reflects unobserved characteristics of SOAR participants (for instance, motivation given their voluntary engagement with SOAR practitioners) or the SOAR intervention itself. Nonetheless, the findings provide further evidence to complement the descriptive findings above that SOAR applicants had higher approval rates even after controlling for multiple other variables. Among homeless applicants, the odds of approval at the initial level for individuals who went through the SOAR process are about 130 percent higher than the odds for individuals who did not (based on the odds ratio estimate of 2.30), holding these other variables constant (See Table IV.2 below).

We used a linear regression model to assess how initial application processing times varied between SOAR and non-SOAR homeless applicants using the same set of control variables as above. The dependent variable was application processing time. The role of SOAR is statistically significant even after controlling for other factors that may influence processing time (specifically, applicant age, primary diagnosis, state of residence, as well as whether the applicant had ever submitted an application previously). Among homeless applicants,

[24] Although many other factors may influence the application decision, these were the only ones available in the administrative data files for analysis.

Table IV.2. Relationship between SOAR and initial application approval rate among adult homeless SSI and SSDI applicants in FY 2010

	Initial application approval among homeless adult SSI and SSDI applicants in FY 2010
Log odds estimate	0.83*
Standard error	0.13
Maximum rescaled R^2	0.171
Odds ratio estimate	2.30
N	55,797

Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

*Significant at the .01 level, binary logit model. Control variables include age, prior application, primary diagnosis, and state.

participation in SOAR was associated with a reduction in application processing time of an average of 10.2 days, holding these variables constant (Table IV.3).

2. Difference in differences analysis comparing SOAR communities and other communities

Our findings from the difference in differences analysis indicate a negative trend in application outcomes generally over time, but of lesser magnitude in SOAR communities than non-SOAR communities. The difference may reflect a combination of characteristics of the communities, the SOAR intervention, and external influences such as the economy. Generally, results indicate that initial application approval rates among homeless applicants declined from about 39 percent prior to the implementation of SOAR in communities across the board to 33.3 percent in SOAR communities and 26.8 percent in non-SOAR communities several years after implementation. Average application processing time, however, increased in SOAR communities from before to after SOAR implementation (from 110 to 114 days), while it held constant (at 111 days) in non-SOAR communities. Appendix A provides more detail on the difference in differences approach, our methods for conducting the analysis, and the results.

C. Potential implications of application outcomes related to costs

Certain SOAR stakeholders may stand to benefit financially from the higher application approval rates that may be associated with SOAR. For instance, states that offer General Assistance programs can recover costs expended on providing GA benefits to individuals who qualify for SSI, and medical providers can recover treatment expenditures for those individuals. This section describes the infrastructure supporting these opportunities for recovering costs and presents exploratory analyses of the potential value of cost-recovery efforts. Although higher approval rates increase costs for SSA and DDS associated with providing and administering benefits, SOAR has the potential to save SSA and DDS costs related to application processing, assuming those who apply for benefits with SOAR assistance would have eventually applied in the absence of SOAR. This section concludes with a discussion of these issues.

Table IV.3. Relationship between SOAR and initial application processing time among adult homeless SSI and SSDI applicants in FY 2010

	Initial application processing time among homeless adult SSI and SSDI applicants in FY 2010
Coefficient	-10.2*
Standard error	4.3
Maximum rescaled R^2	0.098
N	55,797

Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

*Significant at the .05 level, linear regression. Control variables include age, prior application, primary diagnosis, and state.

1. Opportunities for states to recover General Assistance expenditures

Thirty states operate a GA program (sometimes called General Relief) that provides monthly cash assistance for very poor individuals who are unable to work. Funds are provided wholly by states or localities to support basic needs such as food, clothing, shelter, transportation, and personal hygiene or emergency medical care. GA may be an important resource for eligible nonrecipients of SSI and SSDI; more than half of the states with these programs (18 of 30) provide assistance only to individuals with physical or mental disabilities (Schott and Cho 2011).

States may be reimbursed for GA payments when SSI applicants are approved for benefits through a program called Interim Assistance Reimbursement (IAR). Reimbursement is available for months in which an individual received GA and an SSI payment (typically during the period between the SSI protective filing date and approval date).[25] As noted in SSA's Program Operations Manual, "To participate in the IAR program a State must have an IAR agreement with SSA and a written authorization from the individual allowing SSA to reimburse the State from the individual's SSI retroactive payment."

Of the 13 states included in the evaluation's implementation and outcomes analysis, 7 had a GA program. We used MIS data to calculate the potential reimbursement to states for GA paid to individuals who were approved for SSI benefits with help from SOAR. The SOAR MIS includes a variable indicating whether applicants were receiving GA or Temporary Assistance for Needy Families (TANF) at the time of their application submission. To obtain an upper-bound estimate of potential cost reimbursement, we assumed that all applicants with this indicator were GA recipients and, for each one approved for SSI, multiplied the maximum GA benefit amount in their state by the number of months between their protective filing date and SSI approval date.[26]

[25] See the Social Security Administration, Social Security Act, Section 1631(g), available at http://policy.ssa.gov/poms.nsf/lnx/0502003001.

[26] Maximum GA benefits are as reported in Schott and Cho (2011), available at http://www.cbpp.org/files/10-26-11pov.pdf.

To obtain a more conservative estimate of potential cost reimbursement, we assumed that only the males with this indicator received GA and that all females were TANF recipients.[27]

The evaluation states could have collected between thousands and tens of thousands of dollars from IAR over the two to three years that they were assisting SSI applicants through SOAR (Table IV.4).[28] These estimates reflect a small number of applicants (a maximum of 67 statewide), yet in some states, this money could support an annual salary for one or more part- or full-time SOAR positions.

Table IV.4. Estimated interim assistance reimbursement to states

State	Number of applicants approved for SSI and receiving GA at application	Maximum state GA benefit	Average months between SSI protective filing date and approval date	Amount of reimbursable GA
Upper-bound estimate				
IA	2	$430	11.38	$9,790
IL	12	$100	3.57	$4,287
KS	67	$100	5.30	$35,523
ME	1	$725[a]	4.00	$2,900
NE[b]	62	$425	3.83	$100,923
NM	21	$245	5.85	$30,086
SD[b]	0	$435	NA	$0
More conservative estimate				
IA	0	$430	NA	$0
IL	5	$100	2.19	$1,097
KS	25	$100	5.06	$12,660
ME	1	$725[a]	4.00	$2,900
NE[b]	34	$425	3.71	$53,607
NM	15	$245	6.64	$24,386
SD[b]	0	$435	NA	$0

Source: Mathematica calculations based on SOAR MIS data in the 13 states that began receiving SOAR TA in FYs 2010 or 2011 and maximum GA benefit levels in 2011 reported in Schott and Cho (2011).

[a]This is a temporary maximum established in a state statute (http://www.mainelegislature.org/legis/statutes/22/title22sec4305.html) as 110 percent of the applicable existing housing fair-market rents as established by HUD, applying the zero-bedroom level for one person. In York County, Maine, in 2011, this was $659; statewide this was $725 (http://www.huduser.org/datasets/fmr/fmrs/fy2011_code/2011summary.odn?inputname=METRO38860N23031*Biddeford city&data=2011&fmrtype=Final&incpath=C:\HUDUser\wwwMain\datasets\fmr\fmrs\FY2011_code).

[b]These sites do not have overall maximum benefit levels. For this analysis, maximum benefit levels for rent and utilities were added together.

[27] Most TANF adult recipients are women; men only represented 14.8 percent of adult recipients, according to the Characteristics and Financial Circumstances of TANF Recipients, Fiscal Year 2010 report, available at http://www.acf.hhs.gov/programs/ofa/resource/character/fy2010/fy2010-chap10-ys-final. Given the time-limited nature of TANF, however, it is unlikely that all females with the indicator in MIS data were TANF recipients.

[28] Here we present estimates for the evaluation states as a whole, rather than for the local evaluation sites specifically.

2. Opportunities for medical providers to recover treatment expenditures

In most states, individuals receiving SSI are automatically enrolled in Medicaid, and in all states, individuals who have received SSDI for two years are automatically enrolled in Medicare. Medical providers, however, may incur costs for treatment provided to homeless individuals who are uninsured before SSI or SSDI approval. [29] Providers may recoup costs incurred between 90 days retroactive to the SSI or SSDI protective filing date and the approval date from the Centers for Medicare and Medicaid Services (the federal agency that administers Medicaid and Medicare). This evaluation did not have access to data to estimate the potential value of this opportunity, but there were unverified anecdotal reports of the amount communities had recovered or could recover. During site visits, health care providers at three sites reported either that they had recouped reimbursement from the federal agency and the state Medicaid agency, or that they had calculated their potential reimbursement. In the first site, two separate community mental health centers reported that they have generated enough reimbursement to support the salaries of one full-time SOAR case manager each and to supplement the budgets of the centers. According to the director of one of the centers, one SSI-approved applicant alone generated $95,000 in Medicaid reimbursement. In the second site, a SOAR-trained staff person at a hospital estimated $3 million in savings for just one individual who had received uncompensated care through dozens of visits to the emergency room in a single winter. In the third site, the SOAR state lead estimated potential Medicaid reimbursement to providers of $200,000 as of December 2013, and is sharing that information with the state Medicaid agency to explore the processes for recouping those costs.

3. Potential cost-efficiencies for SSA and DDS in processing applications

SSA and DDS incur costs for each application they process, including labor and other direct costs. (Although DDSs are state agencies, in this section we treat SSA and DDS as a single entity because they are both funded entirely by SSA.) The more time and effort required to make a determination of disability, the more the application costs these agencies. In this section, we explore potential savings from SOAR to SSA and DDS from reductions in both labor costs and two specific types of other direct costs involved in application processing—consultative exams and medical evidence. In actuality, SOAR may only save SSA and DDS costs in these areas if those who apply for SSI or SSDI through the SOAR process would likely have applied at some point in the absence of SOAR.

a. Labor

Assessing the amount of labor SOAR might save SSA and DDS requires a time-use study, which the evaluation was not designed to conduct. Higher approval rates on initial applications through SOAR, however, clearly reduce the amount of time claims representatives and disability examiners must spend on reconsiderations, as well as the amount of agency resources that must be expended on appeals. Indeed, among all applications submitted, fewer that go through the SOAR process proceed to reconsideration than those from homeless individuals generally. [30] Furthermore, although we do not know the rate of appeals among these groups, relatively fewer

[29] Individuals with ALS or end-stage renal disease are eligible for Medicare immediately upon SSDI eligibility.

[30] As noted above, relatively more SOAR applicants *who were initially denied* went on to reconsideration than other applicants who were initially denied.

applications that went through SOAR were denied upon reconsideration and, thus had the potential to appeal (see Table IV.5 below). In addition, the findings presented earlier in this chapter indicate that initial decisions are rendered more quickly on SOAR applications than other applications from homeless individuals—although, it is hard to know whether shorter processing time translates into less staff labor. SSA and DDS staffs in two evaluation sites reported during site visits and telephone interviews that they indeed spend less time on applications submitted with SOAR assistance than on other applications, which frees up time to process other cases. Staffs at two other sites reported that that online applications and other submissions take SSA field office staff less time to process and that applications submitted through SOAR are (1) submitted in person or by telephone less frequently than others, and (2) associated with less paper to process (submitting application information electronically whenever possible is a SOAR critical component).

Table IV.5. Reconsiderations among applications from homeless individuals

	All homeless applicants	Homeless applicants who went through SOAR
Applications that proceeded to reconsideration (%)	29.0	23.1
Applications denied at reconsideration (%)	85.7	74.2
Total (N)	**55,797**	**804**

Source: Administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

b. Consultative exams

DDS orders and SSA pays for consultative exams for applicants who lack enough evidence in their medical record to substantiate the severity of an impairment, or when conflicting or ambiguous evidence is present. [31] Fees for consultative exams are set by states and vary across and within states by type of examination (SSA 2012). According to a study that examined a small sample of applications that were processed in 2009 and that contained consultative exams procured to assist in the determination of disability, the average cost of the basic exam was approximately $171 at the initial level (and $243 at the hearing level) (Wittenburg et al, 2012). [32] Across both initial and hearing levels, average costs of consultative exams were higher for mental health ($236) and musculoskeletal ($210) than for internal medicine exams ($158). SSA and DDS also incur costs for individual tests that are often ordered in addition to exams (for instance, psychological tests, x-rays, or lab studies). SSA also may have to pay fees when an applicant fails to show up for a scheduled consultative exam; for these applicants, SSA may pay both a no-show fee and the consultative exam fee once the exam actually occurs.

[31] See http://policy.ssa.gov/poms.nsf/lnx/0422510005.

[32] The sample was stratified by exam type and adjudication level and included consultative exams from the two largest physical health exam categories (internal medicine and musculoskeletal) as well as a general mental health exam category.

As described in Chapter II, applications submitted through SOAR result in lower rates of consultative exams compared with non-SOAR homeless applicants. According to administrative data on all states from SSA's Structured Data Repository and Systems of Records, 44 percent of initial SSI and SSDI applications identified as submitted through the SOAR process in FY 2010 did not have a consultative exam ordered. According to MIS data, this statistics is 65 percent in the 13 evaluation states. The consultative exam avoidance rate for homeless applicants generally is 35 percent, according to SSA administrative data. (We do not have information on homeless applicants generally in the MIS data.) Although the proportions vary by data source, the findings are consistent in that SOAR applicants avoid consultative exams more often than homeless applicants generally.

Applying the average cost of a basic consultative exam at the initial level ($171), as documented in Wittenburg et al. (2012), to the reduction in consultative exams associated with SOAR suggests that SSA and DDS spend substantially less on exams for SOAR participants compared with other homeless applicants. We first estimated potential cost savings in the 13 evaluation states by multiplying the average consultative exam cost by the estimated reduction in the number of applicants with consultative exams as a result of SOAR. The estimated reduction is the difference between the number of initial SSI and SSDI applications that avoided a consultative exam, according to MIS data on SOAR participants, and the number that might have been expected to avoid a consultative exam in the absence of SOAR, based on the consultative exam avoidance rate among all homeless applicants observed in SSA administrative data (35 percent). For the applications SOAR providers helped homeless individuals submit over two to three years, SSA and DDS potentially saved over $89,000 across the 13 evaluation states (Table IV.6) on consultative exams. This is likely a lower-bound estimate for three reasons: (1) multiple exams are often ordered for the same applicant; (2) SSA and DDS may incur fees for missed appointments and additional tests; and (3) most SOAR participants have a mental health diagnosis and on average mental health exams are more expensive than others.

Nationally, SOAR has the potential to save SSA and DDS millions of dollars on consultative exams. We calculated two estimates of potential cost savings nationally—one applying the relatively high rate of consultative exam avoidance among SOAR participants in the evaluation states based on MIS data (65 percent) to all homeless applicants, and one applying a more conservative rate based on SSA administrative data (44 percent). Using the methodology described above, we estimate potential cost savings ranging from just over $800,000 to just over $2.8 million. For the reasons noted above, these are likely lower-bound estimates.

c. Medical evidence

DDS is also responsible for collecting medical evidence to support a claim, which most nonfederal health care providers charge fees for providing.[33] As with consultative exams, fee schedules for medical evidence vary by state, so calculating precise cost savings from SOAR is difficult. For example, in 2013, the Washington Division of Disability Determination Services paid each medical evidence provider $22 for the first 20 pages and $0.50 for each additional page,[34] while the Oregon Department of Human Services Disability Determination Services paid

[33] See http://policy.ssa.gov/poms.nsf/lnx/0422505040.

[34] See http://www.dshs.wa.gov/pdf/DDS/2014FeeSchedule.pdf.

a maximum of $22.50 per request.[35] However, in some states such as Ohio, DDS does not charge for records collected in association with a disability application—if requested by the patient, an authorized representative, or another authorized person, and submitted with proof of the disability application.[36]

Table IV.6. Potential cost savings from avoiding consultative exams in disability determinations

	Number of initial SSI and SSDI applicants	Applicants with no consultative exam ordered (A)		Applicants expected to have no consultative exam ordered without SOAR (B)		Applicants for whom SSA and DDS Saved consultative exam costs through SOAR (C)		Average cost savings (C*$171)
		Percentage	Number	Percentage	Number	Percentage	Number	
SOAR participants in the 13 evaluation states	1,758	64.85[a]	1,140	35.10[b]	617	29.75	523	$89,433
Homeless applicants in all states—conservative estimate	55,797	44.00[b]	24,551	35.10[b]	19,585	8.9	4,966	$849,186
Homeless applicants in all states—moderate estimate	55,797	64.85[a]	36,184	35.10[b]	19,585	29.75	16,599	$2,838,429

Source: Mathematica calculations based on SOAR MIS data in the 13 states that began receiving SOAR TA in FYs 2010 or 2011 and administrative data on all initial adult SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

[a]Based on MIS data.

[b]Based on SSA administrative data.

More applications submitted through the SOAR process include medical evidence than other applications. According to SSA administrative data, more than half (51 percent) of applications that went through SOAR were submitted with medical evidence compared to less than a quarter (23 percent) of all applications from homeless individuals. MIS data from the 13 local evaluation sites suggest that almost all (95 percent) applications submitted through SOAR included medical evidence. However, data is not available to assess if the medical evidence submitted with these applications was sufficient for examiners to determine disability or whether they needed to gather and pay for additional medical evidence. Additionally, some DDS staff in the evaluation sites reported that they request and pay for medical evidence themselves even when it is submitted with the application—often because they already have agreements with providers (such as local Veterans Administration hospitals) to get the evidence electronically. So although

[35] See http://www.dhs.state.or.us/policy/spd/rules/411_200.pdf.

[36] See http://codes.ohio.gov/orc/3701.741.

SOAR has the potential to reduce SSA and DDS costs associated with medical evidence, given the varying costs of obtaining medical evidence, the unknown amount and quality of medical evidence submitted through SOAR, and the different DDS practices involving medical evidence, it is not possible at this time to estimate the potential cost savings.

D. Highlights from the chapter

- Sites that relied on a few staff to conduct application assistance yielded better outcomes than sites that trained many staff and expected them to incorporate SOAR into their other job responsibilities—suggesting that targeted trainings for staff dedicated to SOAR would likely be a more efficient use of resources than broad-based training.
- Actively engaged SOAR leads and formal stakeholder meetings play a role in supporting SOAR trainees to generate positive outcomes.
- Applications submitted through the SOAR process are approved at much higher rates and more quickly than other applications.
- The higher approval rates associated with SOAR can help states recover costs expended on providing General Assistance benefits to individuals who qualify for SSI and help medical providers recover treatment expenditures for those individuals.
- Assuming SOAR participants would have eventually applied for SSI or SSDI in the absence of SOAR, the effort also has the potential to save SSA and DDS costs related to application processing.

V. CONCLUSION

SOAR is one of SAMHSA's key projects, in which it has made a substantial financial investment. In recent contract procurements, SAMHSA has noted that "in recent years, there has been an increasing interest in evaluating public programs and assessing their performance with the aim of better allocating public resources." Despite the fact that SOAR has been implemented in every state—some starting as far back as 2005—to date, there has been no independent assessment of SOAR's outcomes. This evaluation provides the first external evidence of the relationship between communities' implementation of SOAR and the outcomes of their efforts, which SAMHSA can use to begin to assess its investment. In this chapter, we summarize key findings from the evaluation (drawing on qualitative, social network, and MIS data from 13 select sites in states that implemented SOAR in FY 2010 or FY 2011 and SSA administrative data on SSI and SSDI applications submitted nationally in FY 2010), discuss the future of SOAR, and conclude with outstanding questions that provide direction for further research.

A. Summary of findings

This evaluation drew on multiple data sources to develop an understanding of state and local efforts to implement SOAR, the immediate outcomes of those efforts, and factors that facilitate or impede success. Findings suggest that providing application assistance using the SOAR critical components shows substantial promise for helping individuals who are either experiencing homelessness or who are at risk of homelessness to access SSI or SSDI, and that the strategic planning process promotes systems-level collaboration toward that end. The current model of promulgating training to provide this application assistance, however, appears to be an inefficient use of resources. Taken together, the findings demonstrate the challenge of a model that (1) provides no funding for implementation; (2) presents broad, rather than targeted, training to a workforce characterized by high workloads and high turnover; and, (3) focuses on a narrow, difficult-to-reach population. Key findings include the following:

- **SOAR training is prolific, but most who are trained never complete an SSI or SSDI application using the SOAR process.** Some trainees are not in a position to use SOAR (for instance, because they are agency supervisors or directors), but others lack the time and support to do so. Of 563 individuals who were trained in SOAR and who work in the local evaluation sites, 13 percent completed an application using the SOAR process.
- **Those who do apply SOAR training in practice generally comply with the critical components, which are key to generating positive application outcomes.** Each critical component alone and each combination of components measurable in the SSA administrative data (submission of the application with an authorized representative, inclusion of medical evidence with the application, and avoidance of a consultative exam) is significantly correlated with both the initial application approval rate and average processing time. Applications submitted from SOAR participants include these components substantially more often than other applications, providing more information to DDS to facilitate timely determinations.
- **Applications submitted through the SOAR process are approved at a higher rate than other applications.** SOAR-trained providers report an average approval rate of two-thirds on initial application and almost three-quarters overall. SSA data portray lower approval

rates than SOAR-trained practitioners report, but suggest that applications submitted through the SOAR process are approved at much higher rates than other applications—50 percent at the initial level among SOAR participants compared to 28 percent among all homeless applicants (it is likely that many applications that went through the SOAR process are not identified in the SSA data, potentially accounting for the discrepancy in outcomes based on MIS data and those based on SSA data). Moreover, analyses of SOAR's relationship to outcomes suggest that SOAR is significantly correlated with higher SSI and SSDI approval rates.

- **Achieving positive application outcomes has less to do with the size of the SOAR effort (that is, the number of people trained) and more to do with trainees' availability to assist with applications.** The five local evaluation sites with the highest number of application approvals each had staff dedicated solely to SOAR application assistance. None of the other eight sites had such staff. Additionally, turnover among SOAR trainees was low in three of the four top-performing sites, but moderate to high in all of the others.

- **The organizational networking that the SOAR model promotes is successful in increasing communication among entities that play important roles in supporting the application assistance process.** On average, across all local evaluation sites, network density increased by nearly one-third (32.9 percent) from before implementation of SOAR to about two years after. Successful application outcomes appear more closely tied to formal opportunities for collaboration (for instance, through regular state- and local-level stakeholder meetings), however, than to the amount of communication (formal or informal) between entities; communication between stakeholders increased in local evaluation sites across the board, but sites that conducted formal meetings regularly tended to have more successful application outcomes than those that did not.

- **Actively engaged leadership facilitates positive application outcomes.** Three of the four strongest local evaluation sites with respect to application approvals had a leader at the state or local level who was highly engaged in SOAR, while in the two poorest-performing sites both the state and local leads were minimally engaged in the effort.

- **Because communities do not receive direct funds from SAMHSA to implement SOAR, the effort is susceptible to shifting fiscal, legislative, and political priorities, as well as state and local budgetary constraints.** Some communities have addressed this challenge by securing financial resources for the effort (through Interim Assistance Reimbursement, cost recovery for uncompensated medical care, or grants from federal funding streams) and by integrating SOAR into larger efforts to address homelessness (such as PATH, the state's 10-year plan to end homelessness, or HUD's Continuum of Care program).

- **SOAR may save SSA administrative costs associated with application processing, help states recover General Assistance payments, and help medical providers recover uncompensated medical expenditures.** Assuming SOAR participants would have eventually applied for SSI or SSDI in the absence of SOAR, the effort has the potential to save SSA costs related to consultative exams, acquisition of medical evidence, and labor associated with reconsiderations and hearings. A lower bound estimate of savings from the reduction in consultative exams attributed to SOAR, for example, ranges from $800,000 to $2.8 million nationally. In several evaluation states, the estimated amount of General Assistance payments states could have recovered from SSA or medical expenditures

providers could have recovered from the Medicaid agency for applicants who were approved for SSI with assistance from SOAR could support an annual salary for one or more part- or full-time SOAR positions.

B. The future of SOAR

Every state has engaged to some extent in SOAR. Thus, the key charge going forward is providing states with TA to sustain and improve as well as expand their efforts—both to new providers in existing SOAR communities and to new communities. In large part, this will entail the enhancement and development of new partnerships and collaborations with federal, state, and local agencies to promote SOAR. SAMHSA has been encouraging expansion to new communities through HUD's Continuum of Care program and by engaging a broader range of stakeholders—such as staffs in hospitals, jails, and prisons—in training. At the same time, SAMHSA is attempting to address two shortcomings of SOAR identified in this evaluation: (1) the inefficiency of in-person training, and (2) inconsistency in SOAR leadership across communities. These efforts are described below.

1. Mode of training

In-person training and TA can be costly, particularly if, as the evaluation findings suggest, the majority of trainees never complete applications through the SOAR process. The SOAR TA Center has developed effective strategies for providing TA remotely, including delivering webinars, maintaining resource materials on its website, facilitating learning communities, disseminating issue briefs and electronic news alerts, and consulting frequently with individual states and communities by telephone. Recently, SAMHSA funded the SOAR TA Center to convert the in-person Stepping Stones to Recovery curriculum to an online version intended to become the primary training method in future years. The online training is interactive, self-guided, free, and available to anyone. It is designed to take approximately 16 hours to complete in full, but users progress at their own pace. It includes seven modules and provides opportunities to practice applying acquired knowledge and skills by developing hypothetical applications that SOAR TA Center staff will critique. Users may access specific components of the training as a primer or refresher on certain aspects of the SSI and SSDI applications or the SOAR process, or they may register for the full course—which results in a certification upon successful completion. Ideally, the SOAR leads will follow up with a quarterly in-person or web-based training for all who have completed the online course to reinforce the SOAR fundamentals, explain any state- or community-specific SOAR processes (including outcome data tracking), respond to questions, and offer ongoing support.

2. Leadership development

Study findings suggest that strong SOAR leads can help facilitate strong application outcomes through the SOAR process. Although the SOAR TA Center has provided training on the application assistance process (and on how to train others) and TA on developing strategic partnerships, until now professional development training for SOAR leads has not been available. The SOAR Leadership Academy is the newest element of the SOAR model. Its goal is to create local leaders who can coordinate community or regional SOAR programs. The three-day academy will provide (1) coaching on how to provide a one-day "SOAR Fundamentals" training for those who have completed the in-person or online SOAR training, (2) tips for giving

support to SOAR-trained providers, (3) guidance on creating and maintaining a steering committee, (4) instruction on collecting outcomes and using data to leverage support for SOAR, and (5) advice on funding and sustaining SOAR implementation.

C. Recommendations for future research

This evaluation provides the first independent assessment of SOAR's outcomes and the mechanisms through which it produces those outcomes. It is important, however, to recognize several limitations to the study. The qualitative, social network, and MIS data collection and analysis was focused in the last group of states (barring two) to implement SOAR, and primarily in just one local site within each state. Implementation efforts in these states may not be representative of SOAR implementation generally because these states benefitted from practice wisdom the TA contractor had acquired since the initiation of the effort and because their relatively late start may differentiate them in unobservable ways from other states. (In addition, no western or mid-Atlantic states are included.) Furthermore, outcome analyses based on SSA administrative data likely undercount homeless applicants and those who submitted applications through the SOAR process. These data also contain limited variables to use as controls in regression analyses.

Despite this study's contributions and given its limitations, several questions remain that could be addressed in future studies. For instance, how would the results change if all homeless applicants and SOAR participants were properly identified in the data? Are the observed short-term application outcomes associated with positive long-term outcomes for SSI and SSDI applicants experiencing or at risk of homelessness? How will outcomes from the online training compare with the in-person training? What would a rigorous evaluation of SOAR's effects show? In this section, we suggest further efforts that can address these and other questions of interest.

1. Match MIS and SSA administrative data to properly identify SOAR participants

Because there is no variable in the SSA administrative data to identify applicants who have gone through the SOAR process, it is incumbent upon SSA and DDS staffs to include remarks in the electronic case file to identify these applicants. This occurs inconsistently and substantially less frequently than in 100 percent of applications from SOAR participants. The SOAR MIS data contain unique identifiers for each SSI and SSDI applicant assisted through SOAR, and the SOAR TA Center instructs practitioners to maintain a crosswalk between those identifiers and applicants' social security numbers (SSNs) (though not all do). If provided with a file that contains the SSN and all of the associated MIS data for each SOAR participant, SSA could use the SSN to conduct a match with its own administrative data and return a file for research purposes that contains all MIS and relevant SSA data, but no personally identifiable information. The match would yield outcomes for substantially more SOAR participants than we were able to capture in this evaluation, and enable a comparison of outcomes and usage of critical components as recorded in the MIS and the SSA data.

2. Assess the use and outcomes of the online training curriculum

An evaluation of the web-based training could help answer critical questions about how users interact with it, what they gain from it, and its value compared to the traditional in-person

training.[37] Results may inform improvements to the training and identify additional supports that may be necessary to reinforce its content and maximize its utility. Key aspects to assess include the following:

- **Patterns of usage.** The online course was developed by a subcontractor to the SOAR TA Center using Google Analytics to store statistics on web traffic and patterns of usage. Standard and customized reports available through Google Analytics can provide data on demand to measure and understand site engagement. Examples of the types of data that may be included in reports are (1) the number of learners who access the training site without formally registering for the course, the pages they visit, and their average length of stay; (2) the number of learners who formally register for the course and their dates of registration; and (3) among those who formally register for the course, the total number of visits to the training site, the average number of visits per learner, the average length of each visit to the training site, the average length of visit to each course component, the number of certificates of completion issued and the dates issued, and the average length of time on the site and number of visits between registration and certification. Comparing actual data to anticipated usage (recall that the training is designed to take approximately 16 hours to complete in full) might provide valuable information about whether length of training may be a barrier to its completion and the components of training with which users may be struggling.[38]
- **Characteristics of learners.** Through follow-up surveys, it may be possible to examine characteristics of online training users and their opinions of the training. Analyses of user data can provide useful information on who is engaging with the training and for what purpose, as well as offer feedback on areas for improvement. Characteristics of interest may include demographic as well as employment characteristics, such as type of employer, job title, work roles, and tenure. Prior experience with SOAR and with the SSI and SSDI application process generally may also be of interest. Combined with data on patterns of usage, survey data can inform how training completion rates vary by these characteristics to determine the types of participants for whom online training might be best-suited.
- **Outcomes and effects of online training.** Perhaps the most compelling unanswered questions relate to how effective the online training is compared with the in-person training. Relative to the in-person training, how many of those who complete the online training apply SOAR in practice and with what level of fidelity? How does the volume of post-training applications they help to submit and the approval rate and average processing time among them compare with the volume and outcomes of applications in-person training participants help to submit? Modifying the SOAR MIS to require that users enter data on the type of training they have received—online, in-person, or both—could enable an exploration of these comparisons (although, without a mandate to track data through the SOAR, issues with data quality and completeness could limit the analysis). Regression analyses that control for baseline characteristics of SOAR trainees can assess relative outcomes among the groups while accounting for their differences. Given that online training users may differ

[37] An early assessment of participation in the online training is forthcoming from PRA.

[38] It is likely that users will develop the required fictitious application for practice offline, so this time will not be reflected in the Google Analytics data.

from in-person training participants in ways that might also affect their application of SOAR in practice, however, the best way to assess the relative effects of the two types of training is through experimental evaluation in which some individuals are randomly assigned to take the online training and otherwise similar individuals are randomly assigned to take the in-person training and denied access to the online training. Such an experiment, however, may not be practical or feasible.

3. Collect data on long-term outcomes

As depicted in the logic model presented in Chapter I, SOAR ultimately aims to effect positive change in the lives of individuals who are experiencing homelessness or who are at risk of homelessness, with respect to their income, housing, health, and general well-being. Collecting data on these outcomes requires tracking SOAR participants for some time after their SSI or SSDI application decision is rendered. Although it may be possible to observe changes in some outcomes relatively quickly after the application decision (for instance, income, which can be expected to increase at first benefit issuance), others may take time to realize. Changes in health status may not occur until an individual becomes enrolled in Medicaid or Medicare, identifies a treatment provider, and seeks treatment. Thus, follow-up data collection may be warranted at various intervals through several years after the application decision. Some measures of outcomes may be available in administrative data systems. Medicaid data, for instance, may be a source of information on treatment and health status, HMIS data may be a source of information on housing and related service use, and SSA data may be a source of information on employment and involvement in SSI and SSDI work incentive programs. For many outcomes of interest, however, survey or ethnographic data collection may be more appropriate.

4. Conduct a more in-depth analysis of potential cost savings from SOAR to SSA and DDS

Although SSA and DDS have supported SOAR in many communities by changing processes and staffing structures to be attentive to applications submitted with SOAR assistance, they have not contributed to the effort financially. Yet, in several ways SOAR may save these agencies administrative costs associated with application processing (assuming that applicants who apply for SSI or SSDI with SOAR assistance would have eventually applied on their own in the absence of SOAR). The administrative data from SSA that were used in this evaluation enabled only a cursory examination of potential cost savings from SOAR related to consultative exams and was insufficient to yield any data on potential cost savings related to medical evidence. A case review of a sample of SSA's electronic folders would yield, per applicant, an unduplicated count of the number and specific types of consultative exams ordered, cancelled (or not attended), and rendered, as well as the number of unique sources from which DDS obtained medical evidence. Information from state consultative exam and medical evidence fee schedules, which SSA maintains, can be applied to estimate the costs for consultative exam and medical evidence for each individual SSI and SSDI applicant. A review and comparison of a representative sample of initial case claim folders for each of three groups of applicants—individuals not identified as homeless, individuals identified as homeless but not identified as served through the SOAR process, and individuals identified as homeless and served through the SOAR process—can shed additional light on the extent to which SOAR may contribute to financial savings for SSA and DDS. More in-depth research may also be conducted on potential

cost savings from greater utilization of online application submissions and from reductions in reconsiderations and hearings. The findings may suggest the value of new investments in SOAR in light of its return.

5. Conduct a broader cost-benefit analysis of SOAR

This evaluation identifies promising short-term outcomes of SOAR. If SOAR is successful in producing long-term outcomes, it has the potential to produce savings in several domains as well—for instance, in health care, emergency and transitional housing services, and corrections. However, increasing access to SSI and SSDI may result in long-term costs to SSA in the provision of benefits. Investments in SOAR extend far beyond the funding that has supported provision of training and TA. State and local communities have contributed substantial staff time and, in some cases, financial resources of their own. A large-scale cost-benefit analysis would provide SAMHSA with an understanding of the value of federal, state, and local investments in the effort, the extent to which SOAR reduces or produces institutional costs, and the costs and benefits of the effort to society as a whole.

6. Consider experimental evaluation

The SOAR intervention was not designed or implemented to facilitate rigorous evaluation of impacts. The exploratory statistical analyses conducted in this evaluation provide some evidence that SOAR is correlated with positive application outcomes, but the limited availability of control variables mutes the conclusions. The difference in differences analysis shows that changes in outcomes before and after SOAR implementation were more positive in SOAR communities than in non-SOAR communities. But, this analysis does not provide evidence of SOAR's effects due to potential biases arising from sites' self-selection for TA and limitations associated with the size of the SOAR population compared to the general homeless population. Even if we were able to address the limitations of these analyses, however, experimental evaluation—in which outcomes among some entities that are randomly assigned to receive an intervention are compared with outcomes among otherwise similar entities that are randomly assigned to not receive the intervention—is the gold standard for determining the actual impacts of an intervention.

In the context of SOAR, implementation of a large-scale experimental evaluation would be challenging. In particular, random assignment of individuals may not be palatable to service providers—given that the target population is a particularly vulnerable one and the services being tested address a critical need. Moreover, there may not be sufficient flow of applicants to generate a sample size large enough to determine a meaningful effect size. A more viable design may be a cluster (or group) trial in which larger units are assigned to treatment or comparison groups. Implementation of this design, however, poses challenges as well. One option would be to assign direct services staff in community agencies to attend a Stepping Stones to Recovery training (treatment staff) or not (control staff). Applicants working with treatment staff would receive SOAR services and applicants working with control staff would not. However, contamination (when control group members receive the treatment) is a concern in this design, as treatment staff may share SOAR procedures with fellow control staff in the same office. Random assignment of service provider agencies within communities or random assignment of communities themselves may also be problematic. In the former, spillover (when control group members may be affected by the intervention) would likely occur because direct service staff are

highly mobile (moving frequently from one agency to another) and because aspects of the intervention (for instance, strategic planning and networking) occur at a community level. In the latter, finding well-matched communities to randomly assign that have not already been introduced to SOAR would likely prove challenging because, although SOAR has far from saturated the field, it is operational in every state.

Nonetheless, policymakers may want to consider possibilities for opportunistic experiments—randomly controlled trials (RCTs) that study the effects of an existing or planned intervention, rather than an intervention implemented for purposes of research. Opportunistic experiments typically rely on existing administrative data, rather than new data collection, and an existing pool of participants, rather than participants recruited for purposes of the study. In this way, they are often less costly than traditional large-scale RCTs and less disruptive to staff and participants (Resch et al. 2014). The federal government is increasingly encouraging opportunistic experimentation. In July 2013, the Office of Management and Budget released guidance for 2013 agency budget submissions that encouraged agencies to propose "high-quality, low-cost evaluations" that "should help agencies improve the quality and timeliness of evaluations—for example, by building evaluation into ongoing program changes and by reducing costs by measuring key outcomes in existing administrative datasets" (Burwell et al. 2013). Planned expansion of Stepping Stones to Recovery training into new communities through HUD's Continuum of Care program or to new populations (such as staff at hospitals, jails, or prisons) may provide a ripe context in which to embed an RCT. Administrative SSA files also are a reasonably accessible source of data for the key outcomes of interest—SSI and SSDI application approvals and processing time. The challenge will be to identify opportunities to create treatment and control groups randomly, with integrity, and of sufficient size to generate meaningful effect estimates.

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APPENDIX A

DETAILED METHODOLOGY

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A. Process analysis

We included 13 of the 14 states that began receiving federally funded SOAR TA in FY 2010 or 2011 in the process analysis.[1] We visited each state twice—once to observe the initial state strategic planning forum and then one or two years after the forum to examine the progress of the effort. Our visits were to one of the local communities in which the state planned to focus most of its efforts (which Mathematica selected in collaboration with the state and the SOAR TA Center). These local evaluation sites and the dates of the visits are provided in Table A.1. During the second visit, we conducted a series of interviews with SOAR stakeholders—including the state and local leads, staff who prepare SOAR applications and their supervisors, SSA field office staff, DDS staff, in-state SOAR trainers, and others—to gather various perspectives on SOAR's implementation. Finally, we conducted telephone interviews in the fall of 2013 with key respondents from the second site visit to track ongoing SOAR implementation efforts in the states.

Table A.1. States, local evaluation sites, and site visit dates for implementation analysis

State	Local evaluation site	Date of strategic planning forum (first site visit)	Date of in-person data collection (second site visit)
IA	Polk County	August 2010	April 2012
ID	Boise	March 2011	March 2012
IL	DuPage County	July 2010	February 2012
KS	Douglas, Franklin, Miami counties	September 2010	July 2011
ME	York, Cumberland counties	October 2010	September 2012
MO	Columbia	September 2010	August 2011
MS	Hancock, Harrison, Jackson counties	January 2011	September 2011
NE	Lincoln	September 2010	September 2011
NM	Albuquerque	April 2009[a]	July 2011
SC	Columbia	September 2010	September 2011
SD	Sioux Falls	April 2011	April 2012
WI	Racine County	July 2010	September 2011
WY	Cheyenne	April 2009[a]	By phone in June 2012[b]

[a]In 2009, both New Mexico and Wyoming held strategic planning forums outside of the federal initiative, using state funds to support TA from the SOAR TA Center. The states then reintroduced the effort in 2010.

[b]We conducted the "visit" in Wyoming by telephone rather than in-person because there were too few respondents to warrant the expenditure of resources on an in-person visit.

[1] We did not include Arkansas in the evaluation because the state held its strategic planning forum too early (in November 2009) for the evaluation team to collect data there.

B. Social network analysis

The primary source of data for this analysis was a five- to ten-minute self-administered survey of key SOAR stakeholders. The survey, presented as Figure A.1 below, was ground in network theory, which focuses on the relationships and ties among individuals or organizational entities (Wasserman and Faust 1994). The sections below describe our processes for collecting and analyzing the survey data.

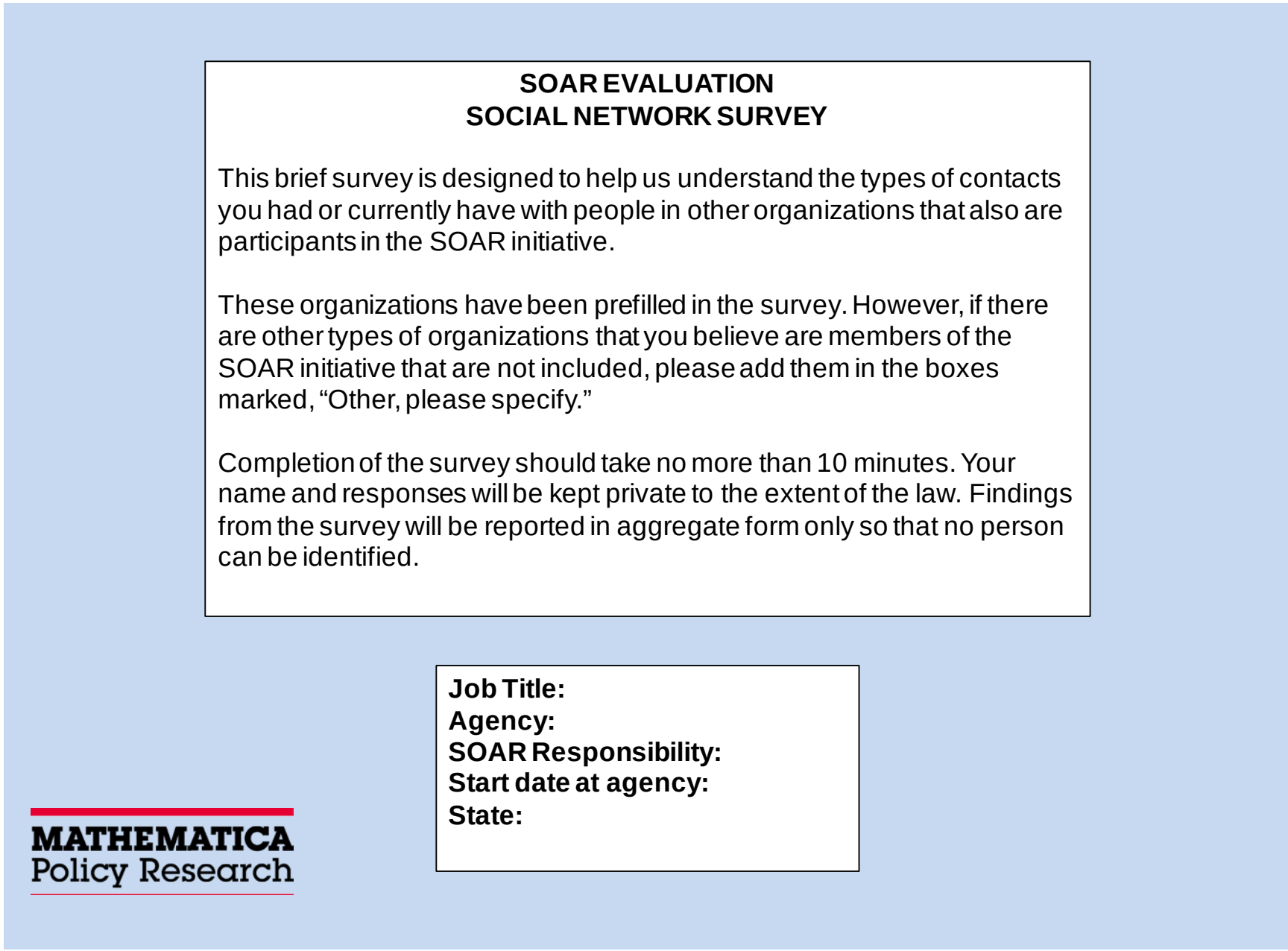
1. Data collection

As described above, in the fall of 2013 research staff conducted follow-up telephone interviews with key respondents from the process analysis site visits to assess the evolution of their SOAR efforts. At the end of each telephone interview, staff described a social network survey that would be emailed to respondents after the interview, and requested that they complete the survey and either email or fax it back.[2] The survey asked respondents about their frequency of communication with other stakeholders both before and after their participation in SOAR, and their perceptions of how helpful each of these stakeholders had been with respect to the SSI and SSDI application assistance process. Each survey was prefilled with the names of the stakeholders in the network (that is, the generic stakeholder types in Figure A.1 were replaced with the names of specific organizations or individuals in the community), but the survey also allowed respondents to include other stakeholders who were not listed (respondents were able to include more than two others by adding lines to the survey form). For the analysis, we then classified stakeholders by type (for example, homeless service provider) and numbered them if more than one agency of the same type was involved (e.g. health care provider 1, health care provider 2).

Response rates varied by site, from a low of 75 percent to a high of 100 percent (six sites had a response rate of 100 percent). We requested a total of 102 social network surveys and received 92 surveys by the end of the data collection period, for a response rate of 90 percent across all sites. Of those not responding to the survey, the majority were unreachable because they had left their positions.

[2] We also sent surveys to 13 respondents who participated in the process analysis site visits but were not selected for a follow-up telephone interview.

Figure A.1. SOAR evaluation social network survey



SOAR EVALUATION
SOCIAL NETWORK SURVEY

This brief survey is designed to help us understand the types of contacts you had or currently have with people in other organizations that also are participants in the SOAR initiative.

These organizations have been prefilled in the survey. However, if there are other types of organizations that you believe are members of the SOAR initiative that are not included, please add them in the boxes marked, "Other, please specify."

Completion of the survey should take no more than 10 minutes. Your name and responses will be kept private to the extent of the law. Findings from the survey will be reported in aggregate form only so that no person can be identified.

Job Title:
Agency:
SOAR Responsibility:
Start date at agency:
State:

MATHEMATICA
Policy Research

Figure A.1 *(continued)*

For each row, please place an "X" in the column that best answers the question.

	QUESTION 1					QUESTION 2					QUESTION 3		
	PRIOR to the start of your participation in SOAR, how frequently did you have contact with anyone in the following organizations about the SSI/SSDI application process specifically?					**NOW** how frequently do you have contact with anyone in the following organizations about the SSI/SSDI application process?					**To what extent has each of the following organizations helped your organization carry out its role in assisting individuals who are homeless access SSI/SSDI benefits?**		
	A	B	C	D	E	A	B	C	D	E	A	B	C
	Never	Once or twice a year	Every month or two	Every week or two	More than once a week	Never	Once or twice a year	Every month or two	Every week or two	More than once a week	Not at all	To some extent	To a considerable extent
SSA office (state or local)													
DDS office (state or local)													
Public housing and public assistance agencies													
State public and private health systems													
Local public and private health systems													
Homeless service providers													
Community MH providers													
Correctional agencies or facilities (state or local)													
State SOAR lead													
Local SOAR lead													
Other [please specify]: _____													
Other [please specify]: _____													

2. Data analysis

We present resultant data from the survey at an agency level. When there were multiple respondents from the same agency, we averaged their survey responses. In some sites, we determined after an interview that a respondent played no role or only a trivial role in SOAR, despite the state lead's recommendation to conduct the interview. In this case, we excluded the respondent's responses. Our analysis uses quantitative methods to assess the extent to which SOAR enlists and engages stakeholders around the SSI and SSDI application process. We use a combination of metrics and graphics, described below, to present the findings in different, broadly accessible ways:

- **Network density.** Density is a calculation of the total amount of any communication present in a network divided by the total amount of communication possible in that network. We calculate density values based on binary data—that is, whether or not a respondent reported communicating with every other stakeholder—rather than how frequently they communicated. We chose to calculate the network density based on communication frequency of at least every month or two to show meaningful communication density. Values range from 0 to 100 percent; the closer the density value is to 100 percent, the more respondents reported communication of every month or two with all other stakeholders in that network.
- **Communication diagrams.** We use a program called Net Draw, which is designed to interpret social network data and create diagrams, to visually display communication between individuals and organizations both before and after SOAR participation. [3] For each evaluation site, we present in a set of social network diagrams the key stakeholders and their relationships to all other possible stakeholders, using consistent depictions across sites. Blue symbols indicate key stakeholders who completed a survey and red symbols indicate stakeholders that did not. Lines connecting stakeholders represent the reported average amount of communication between them. Lines range from thin to very thick, with the thinnest lines representing lower communication frequency (once or twice per year) and the thickest lines representing the most frequent communication (more than once a week). Arrows indicate the direction of communication reported. In a line with arrows at each end, both agencies reported contact with one another. The absence of lines between agencies occurs when neither stakeholder reported communication with the other. [4]
- **Helpfulness matrices.** We also developed matrices to present responses regarding how helpful each stakeholder rated the others with respect to the SSI and SSDI application process. Black boxes indicate reports that a stakeholder was helpful to a considerable extent, dark grey boxes indicate reports that that a stakeholder was helpful to some extent, light grey boxes indicate reports that a stakeholder was not helpful, and white boxes indicate nonresponses. Red boxes appear because stakeholders were not asked to rate themselves.

[3] Borgatti, S.P. *Netdraw Network Visualization*. Harvard, MA: Analytic Technologies, 2002.

[4] For example, if agency 1 reported a little communication with agency 2, and agency 2 reported a lot of communication with agency 1, then the figure would show a line between them of medium thickness (representing a moderate level of communication), with arrows on each end of the line. If agency 1 reported no communication with agency 2, and agency 2 reported moderate communication with agency 1, then the figure would show a thin line between them (representing a low level of communication) and there would be one arrow pointed toward agency 1.

C. Outcomes analysis

Each of the 13 states that began receiving federally funded SOAR TA in 2010 or 2011 and that was included in the evaluation was required to track outcomes through the Online Application Tracking Program (OAT), which we refer to in the body of the report as the SOAR MIS, or an alternative management information system (MIS) as a condition of receiving TA. The OAT is a web-based program that the SOAR TA Center designed for SOAR trainees to enter and store data on the components of the SOAR model used during the SSI and SSDI application process as well as the outcomes of application submissions. These states were also required to assign a data liaison to the evaluation to assist with data tracking. A small sum of money was provided to the states through subcontracts with the Center to compensate state or local agencies for the burden associated with this activity. The Center entered into subcontracts with 12 of the 13 states. Wyoming declined the funds but still assigned a data liaison and tracked outcomes in the aggregate, rather than through an MIS. All but two of the other states used OAT. Wisconsin and Iowa used their homeless management information systems (HMISs) to collect data on SOAR outcomes.

Mathematica provided in-person training for data liaisons, state leads, and agency staff in the local evaluation sites on their roles in data tracking and on the use of OAT or HMIS. Mathematica also provided ongoing TA on data collection. Although all of the states (with the exception of Wyoming) used these systems to track SOAR data statewide, we have the most confidence in the data from the local evaluation sites because the TA that Mathematica provided there was designed to ensure complete and high quality data collection. For the analysis of SOAR outcomes using MIS data, we produced descriptive statistics of data from these systems for both the local evaluation sites and all sites within the states. In the body of the report, we focus on findings from the local evaluation sites, but we present findings from both analyses in Appendix B. All data are current through December 2013.

Administrative data from SSA's Structured Data Repository (60-0320) and Systems of Records also contributed to the outcomes analysis.[5] The source of data was a file containing all SSI and SSDI applications nationwide that were initially filed in FY 2010. We conducted descriptive analyses of the data comparing applicants who were not homeless to homeless applicants, and among homeless applicants, those whose applications were or were not identified as being submitted through the SOAR process. Our process for identifying homeless applicants and SOAR participants in the data is described in detail below.

D. Exploratory analyses of SOAR's relationship to outcomes

The exploratory analyses of SOAR's relationship to outcomes were based primarily on the SSA administrative data file containing all SSI and SSDI applications nationwide initially filed in FY 2010, described above. For each application, the file contained data on application

[5] The SSA Systems of Records from which data were extracted include SSA's Supplemental Security Income Record (SSR) (60-0103), Master Beneficiary Record (MBR) (60-0090), National Disability Determination Services (NDDS) File (also known as the 831/832) (60-0044), the Completed Determination Record – Continuing Disability Determinations (also known as the Disability Control File (DCF)) (60-0050), Hearings and Appeals Case Control System (60-0009), and Hearing Office Tracking System of Claimant Cases (60-0010).

processes and outcomes through August 2013. This section describes our process for identifying homeless applicants and SOAR participants in the data and for conducting the exploratory analyses.

1. Identifying homeless applicants and SOAR participants in the FY 2010 file

We used a multistep process to identify applications submitted by homeless individuals in the data file containing all SSI and SSDI applications nationwide initially filed in FY 2010. Until now, there were no published statistics with which we could compare results from our analysis on the percentage of SSI and SSDI applicants who are homeless and the approval rate among them. For many years, SSA has had a field in its data system enabling SSA and DDS staff to flag applications submitted by homeless individuals, but SSA only published a policy defining homelessness and identifying procedures for processing these cases in July 2012. [6] Before then, this flag was not used consistently and not terribly conducive to research on homeless applicants. To identify applicants that were homeless at the time of their application in the post-intervention period (in FY 2010), we used the homeless flag in conjunction with the address fields as well as unstructured fields that enable SSA and DDS staff to record remarks about an applicant. We searched these fields for an indication of the applicant's living situation. [7] Despite our efforts, the 55,797 homeless applicants we identified nationwide in FY 2010 is likely an undercount. A breakdown of those we did find and how we found them is as follows:

- 18,785 (33.7 percent) were identified through the flag only
- 13,226 (23.7 percent) were identified through the flag and an address or remark field
- 23,786 (42.6 percent) were identified through an address or remark field only

We identified individuals who submitted applications through the SOAR process by searching the remarks fields for the word "SOAR" (a variable identifying applications submitted through the SOAR process has never existed in the SSA data system). It is incumbent upon SSA and DDS staff to include remarks in the electronic case file to identify these applicants based on communications they receive from SOAR representatives. This occurs inconsistently and substantially less frequently than in 100 percent of applications from SOAR participants. Thus, our count of 804 applications submitted through the SOAR process nationwide in FY 2010 is a likely gross underestimate of the actual number of those applications.

Although virtually no data exist on application outcomes among homeless individuals with which to compare our results, our data on all applications compare well to other published statistics. For instance, we calculated an approval rate—the number of medical allowances divided by all medical decisions—of 34.5 percent at the initial adjudicative level among applications filed in FY 2010 among the general population and 11.8 percent at the reconsideration level. The approval rates published in the 2011 Annual Statistical Report on the

[6] See DI 11005.004 in the Program Operations Manual System, available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0411005004.

[7] We considered applicants as homeless if they had no permanent living arrangement (that is, they were "couch surfing," or living in a shelter, in temporary or HUD housing, in a vehicle, in a vacant house, in a hotel or motel, in public transportation venues, or outdoors).

Social Security Disability Insurance Program were 36.3 percent at the initial adjudicative level for applications filed in 2010 and 8.1 percent at the reconsideration level (SSA 2012). [8]

2. Regression analyses and predicted probabilities

To model the variation in each outcome variable (application approval rate and average application processing time), we opted for a fixed-effect regression approach with dummy variables for the states and robust standard errors to account for the clustering. We also considered a random-effect model. However, because the intraclass correlation (ICC) was relatively low (2 percent for the approval rate and 9.8 percent for average processing time in the models for all adult SSI or SSDI applicants)—indicating that only a small percentage of variation in the outcome variable is due to the state—the random-effects approach was not considered appropriate for this analysis.

The advantage of the fixed-effect modeling approach is the ability to control for all stable characteristics of the individuals in the study, thereby eliminating potentially large sources of bias. One notable downside of the fixed-effect approach, however, is that it forgoes the between-subject variation and focuses only on the within-subject variation in the regression model. Although discarding the between-subject variation can yield standard errors that are considerably higher than those produced by methods that utilize both within- and between-person variation (such as random-effects regression), accounting for clustering of the outcomes within states and calculating robust standard errors mitigates this issue and allows unbiased regression estimates and standard errors.

We estimated a regression model with robust standard errors using the Huber-White sandwich estimator. Such robust standard errors can effectively mitigate concerns about failure to meet the model assumptions—such as normality, heteroscedasticity, and others. With this approach, the point estimates of the coefficients are exactly the same as in an ordinary least squares (OLS) method, but the standard errors take into account that the observations within states are not independent (thus, mitigating the issues concerning heterogeneity and lack of normality).

We examined the relative importance of the SOAR critical components using predicted probabilities of application approval and processing time. Although the outcome of a logistic regression is either a 0 or a 1, the predicted values for each observation are not—they are the probability of an outcome being a success (or a failure). Because the response variable (Y) is binary, it is necessary to specify the regression model in such fashion that the probability of the

[8] Our calculated rates may differ slightly from the published rates for three reasons: (1) we examine applications filed in fiscal year 2010, while the Annual Statistical Report examines applications filed in calendar year 2010; (2) the data we use are current through August 2013, while the data used in the Annual Statistical Report are current through June 2011 (some applications that were pending as of June 2011 and, thus, not included in the rates published in the Annual Statistical Report may have been determined by August 2013, potentially changing the actual approval rates from the report's published rates); and (3) the data we use include all SSI and SSDI applications, while the data in the Annual Statistical Report include decisions for Social Security–only applications and applications for both Social Security and SSI (they do not include SSI-only applications).

outcome (π) is bounded between 0 and 1 for each observation x. The logistic regression model specifies a linear relationship between the log odds or odds ratios of this probability and *X*:

(1) $\text{Logit}[\pi(x)] = \log(\pi(x)/(1 - \pi(x)) = \alpha + \beta x.$

The odds of the favorable response can in turn be expressed as

(2) $\text{Odds}(Y = 1) = \pi(x)/(1 - \pi(x) = \exp(\alpha + \beta x) = e^{\alpha}(e^{\beta})^{x}.$

Re-arranging terms in the Equation (2), the logistic regression model can also be expressed as a direct relationship for the probability of the "success" of the outcome ($Y = 1$):

(2) $\pi(x) = \exp(\alpha + \beta x)/(1 + \exp(\alpha + \beta x)).$

The predicted probabilities are also constrained between 0 and 1 and are arguably the most convenient form for plotting and understanding results from logistic regression to express fitted values on the scale of probabilities, rather than log odds or odds ratios.

PROC LOGISTIC in SAS calculates predicted logits and predicted probabilities for each observation. We created a separate file using the OUTPUT statement in SAS, which contained probabilities of the outcome as well as the lower and upper bounds for a 95 percent confidence interval for the true probability for each case in the model using the inverse transformation of logit to probability, Equation (2).

3. Difference in differences analysis

While there are various applications of the difference in differences methodology, the simplest is where outcomes are observed for two groups in two time periods. One of the groups is exposed to a treatment in the second period (the post-intervention period) but not in the first period (the pre-intervention period). The second group is not exposed to the treatment during either period. Observing the same units within each group within each time period, the average change in the outcome measure over time in the second (comparison) group is subtracted from the average change in the first (treatment) group to produce the estimated effect of the intervention. The intent of this process is to remove biases in second period comparisons between the treatment and comparison group that could be the result of permanent or relatively invariant differences between those groups, as well as biases from comparisons over time in the treatment group that could be the result of general trends. In a difference in differences analysis, as in other nonexperimental evaluations, the comparison group is judged to be comparable to the treatment group, except for not having received the treatment. The validity of the findings relies on the assumption that the changes in the key outcomes of interest over time would have been similar for the two groups in the absence of the intervention.

a. Specifications for the analysis

In the context of the SOAR evaluation, we considered the treatment for the difference in differences analysis to be the strategic planning, training, and ongoing TA provided by the SOAR TA Center; the unit of analysis to be benefit applications submitted at the initial level by

homeless individuals; and treatment and comparison groups to be different communities within the same state. Here we describe our process for selecting those communities and the time periods for analysis.

Selection of time periods for analysis. We defined benefit applications initially submitted in FY 2005 as pre-intervention applications (no SOAR TA in any state began until August 2005) and applications initially submitted in FY 2010 as post-intervention applications. We used data from the file containing all SSI and SSDI applications nationwide that were initially filed in FY 2010 to measure outcomes in the post-intervention period. To measure outcomes in the pre-intervention period, we obtained a second file from SSA containing data on all SSI and SSDI applications initially filed in FY 2005. Because no flag identifying homeless applicants existed yet in FY 2005 as it did in FY 2010, to identify applicants that were homeless at the time of their application in the pre-intervention period, we used a code indicating type of residence in conjunction with residential address fields. Applicants indicated as "transient" (individuals with no fixed place of residence and neither a member of a household nor a resident of an institution) were counted as homeless.

We tracked outcomes among each set of applications through August 2013. Though the FY 2005 applications had more opportunity for resolution than FY 2010 applications in the analysis, no FY 2010 applications were pending at the initial level as of August 2013 (that is, all had a decision at the initial level). Because SSA administrative data on SSDI applicants were not available for FY 2005, the difference in differences analysis was limited to SSI applicants.

Selection of treatment and comparison groups. We used a two-step process to select treatment and comparison groups. First, we identified states to include in the analysis. To allow sufficient time for application submissions through SOAR and related outcomes to occur (and thus maximize our potential to observe differences between the pre- and post-intervention periods within the treatment group), we limited the analysis to the states that began receiving SOAR TA in FY 2005, 2006, or 2007 (35 states).[9] We then excluded states in which only trivial SOAR activity had ever occurred based on our conversations with the SOAR state leads and the data states reported on outcomes to PRA.[10] Of the remaining 21 states, we further excluded 3 for which a difference in differences analysis was not possible because SOAR was implemented statewide (and therefore would offer no within state comparison groups). The resultant 18 states were the subject of the difference in differences analysis.

Second, we identified SOAR communities (which we considered to be either cities or counties) within each of the 18 states based on consultations with the SOAR TA Center, documentation of the Center's TA efforts in states, and interviews with state SOAR leads. We considered SOAR communities (i.e., the treatment group) to be those in which nontrivial SOAR

[9] Given the extensive strategic planning and training process involved in SOAR, it often takes a year or more to realize associated application outcomes. We assumed that states that first began receiving TA in FY 2008 or later may not have had sufficient time to accumulate post-intervention outcomes in our data set.

[10] We excluded from the analysis states that reported less than 90 decisions on applications submitted through the SOAR process as of the time of site selection. Thus, the states included in the analysis were not representative of the broader SOAR effort but of states that had demonstrated some level of success with the effort.

activity occurred during the post-intervention period, and all other communities in each state as the comparison group (to maximize our potential to observe differences between the treatment and comparison groups during the post-intervention period).[11] We designated up to three SOAR communities per state, which enabled us to capture all nontrivial SOAR activity in a state (by comparing homeless applicants in all of these communities combined with homeless applicants in non-SOAR communities) while preserving our ability to analyze the relative estimates for different communities within a state (by comparing homeless applicants in one SOAR community at a time with homeless applicants in non-SOAR communities). Where we were uncertain of the geographic bounds within which SOAR operated, we first defined the SOAR community as a city and then as a county so that we could compare results using alternative definitions. The 18 states included in the analysis and the SOAR communities (treatment group) within them are identified in Table A.2.

b. Limitations of the analysis in the context of SOAR

After we received the SSA data, we implemented several analyses to test the underlying assumptions that would support a difference in differences analysis. Specifically, we looked to see if there was evidence of selection bias among the SOAR communities and we identified the number of applications that were submitted through the SOAR process. Here we describe these findings and their implications for the credibility of the difference in differences analysis.

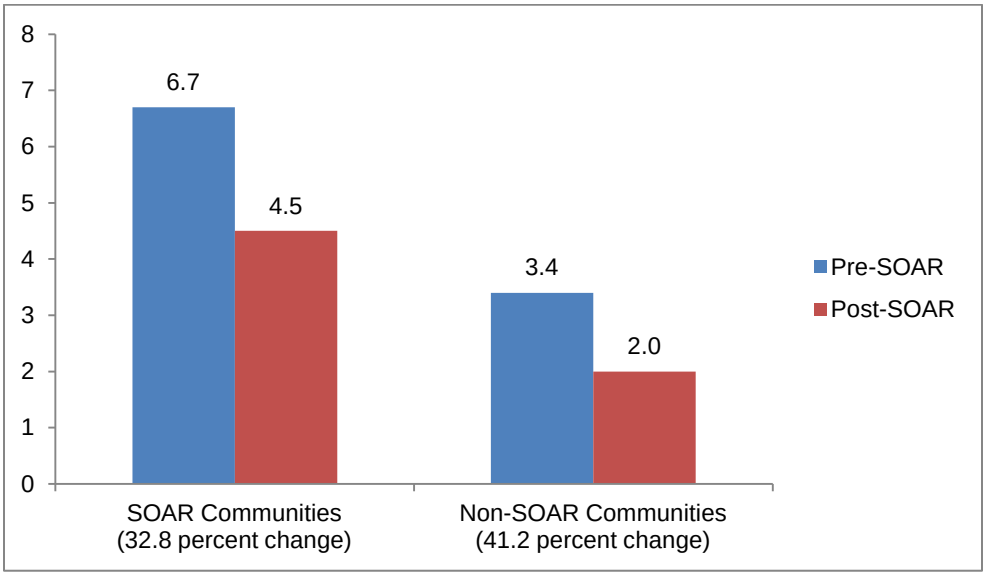
Evidence of selection bias. Selection bias occurs when the mean outcomes among the treatment and comparison groups differ even in the absence of the intervention. SOAR communities are self-selected, likely based on perceived need for the intervention (perhaps indicated by the size and characteristics of their homeless populations) and pre-existing infrastructure to facilitate implementation of the intervention. As such, it is likely that SOAR communities (the treatment group) are different in observable and non-observable ways from non-SOAR communities (the comparison group) in the same states. Given the available data, there was little opportunity for us to control for these differences. Indeed, analyses of SSI application submissions from homeless individuals across these groups suggest one key baseline difference; in the pre-intervention period, the percentage of SSI applications submitted by homeless individuals was almost twice as high in the treatment group as in the comparison group (Figure A.2). Such a large baseline difference is difficult to overcome in any analysis of program effects.

[11] Ideally, we would have selected to comprise the comparison group a subset of other, non-SOAR, communities that were well-matched to SOAR communities with respect to demographic, economic, and service environment characteristics, but data were not available to support such a selection procedure.

Table A.2. SOAR communities designated for difference in differences analysis

State	Primary definition of first SOAR community	Alternate definition of first SOAR community	Second SOAR community	Third SOAR community
CO	City of Denver	County of Denver		
DE	New Castle County			
FL	Miami-Dade County		City of Orlando	Broward County, City of Key West, City of Melbourne, Palm Beach County, City of Rockledge, City of Fort Walton Beach
GA	City of Atlanta	Counties of DeKalb and Fulton		
KY	City of Louisville	Counties of Jefferson and Kenton	City of Covington	
MD	City of Baltimore		Prince George's County	
MN	Ramsey County		Hennepin County and Polk County	
NV	City of Las Vegas		City of Reno	
NY	Town of Ossining	Westchester County		
NC	Counties of Buncombe, Durham, Forsyth, New Hanover		Counties of Guilford, Mecklenburg, Orange, Pitt, Wake	
OH	Counties of Summit, Hancock, Stark, Athens, Hamilton, Franklin, Lucas, Mahoning		Counties of Wood, Hocking, Vinton, and Meigs	
OK	Pottawatomie County	Town of McCloud and City of Lexington	Cleveland County	
OR	City of Portland	Multnomah County	Josephine County	
PA	City of Philadelphia	Philadelphia County		
TN	City of Nashville		City of Memphis	
TX	City of Houston	Harris County	Lubbock County	
UT	Salt Lake City	Salt Lake County		
VA	City of Richmond			

Figure A.2. Percentage of initial SSI applications submitted by individuals identified as homeless



Source: Administrative data on 18 states from SSA's Structured Data Repository (60-0320) and Systems of Records

Another way to test the key assumption underlying the difference in differences analysis about the comparability of the treatment and comparison groups and potential biases that could result from general trends among the treatment group over time is to conduct a sensitivity test using different time periods for analysis. The test relies on an alternative difference in differences analysis in which the first and the second period in the model are both prior to the introduction of the intervention.[12] If the estimate from the primary difference in differences analysis truly reflects the influence of the intervention and not other external factors, the estimate from the alternative difference in differences analysis should be zero or close to zero. However, it was not possible for Mathematica to obtain and analyze earlier data for the evaluation.

Evidence on the relative size of the SOAR intervention. Vis-à-vis the size of the homeless and SSI applicant populations, SOAR is very a small intervention, making it difficult to isolate its influence on the application outcomes of interest using a difference in differences approach. After we obtained the data, we found that SSA identified only 769 SSI applications that were submitted through the SOAR process in FY 2010, representing 1.45 percent of all homeless SSI applicants identified (53,058) and 0.05 percent of the SSI applicant population (1,579,132) in that year. We recognize that the count in the SSA administrative data of the number of applications submitted through the SOAR process is likely a gross undercount of the actual number, given that there is no specific variable in the data system that allows SSA field office or DDS staff to flag these applications (rather staff must identify these applications in the system by

[12] James J. Heckman and V. Joseph Hotz. "Choosing among Alternative Nonexperimental Methods for Estimating the Impact of Social Programs: The Case of Manpower Training." Journal of the American Statistical Association, Volume 84, Issue 408, December 1989.

noting SOAR in the address or comments fields, a practice which occurs inconsistently and substantially less than 100 percent of the time). However, even if in actuality twice as many applications were submitted through the SOAR process as the SSA data suggest, they would still represent a tiny fraction of all applications submitted by homeless individuals, making the likelihood of detecting effects from the intervention on community-level outcomes very small.

c. Illustration of the results

With the limitations described above in mind, in Table A.3 we present the results of the difference in differences analysis. Looking at the analysis focused on the primary SOAR community using the broadest catchment area for that community, initial application approval rates among homeless applicants declined from about 39 percent in FY 2005 in communities across the board to 33.3 percent in SOAR communities and 26.8 percent in non-SOAR communities in the same states in FY 2010. Because the percentage decline was greater in non-SOAR communities, the difference in differences estimate is positive (17.6 percentage points). The analysis shows the opposite for application processing time; average processing time increased in SOAR communities between FY 2005 and FY 2010 (from 110 to 114 days) while it held constant (at 111 days) in non-SOAR communities.

The results themselves suggest further caution in drawing inferences from the analysis for two reasons. First, results are fairly sensitive to the analytical definition of a SOAR community. For example, in the analyses that compare all SOAR communities to non-SOAR communities, the directionality of the estimates changes going from the narrow to the broad definition of those communities. In the analyses that compare primary SOAR communities to non-SOAR communities, the magnitude of the estimates changes by a non-negligible amount going from the narrow to the broad definition. Second, that approval rates among homeless applicants are higher in both SOAR and non-SOAR communities in FY 2005 than in FY 2010 is curious and there are no extant data on approval rates among homeless applicants to compare them with.[13] There are at least three potential reasons. First, differences in our methodology for identifying homeless applicants in each time period may account to some extent for the difference in the approval rates. To explore this possibility, we conducted the difference in differences analysis using a broader definition of homeless applicants in 2010 that was more consistent with the definition we used for 2005 (that is, one that included applicants flagged as "transient" as well as those flagged as homeless or with an address or remark that suggested the applicant had no permanent living arrangement). Results from this analysis, however, were extremely similar to results from the original analysis. Second, it is possible that the homeless population in FY 2005 looked quite different from the population in FY 2010, and that the population's characteristics led to a higher allowance rate.[14] Third, it is possible that the relatively large increase in the number of applications to SSA over this time period played a role.[15] We cannot identify any changes to SSA

[13] The approval rate among all SSI applicants (including homeless and non-homeless applicants) in the analysis states was around 36 percent in FY 2005.

[14] The raw number of homeless applicants in FY 2010 was almost 3.5 times as large as in FY 2005. It is possible that the FY 2010 population was more diverse with respect to the severity of their impairments or other factors that affect the allowance rate but we do not have data to examine this.

[15] The number of SSI claims SSA received increased from 24,994,000 in FY 2005 to 31,245,000 in FY 2010 (see http://www.ssa.gov/policy/docs/statcomps/).

policy or process during this period that may have contributed to the decline. Without more understanding of the general trends in application outcomes among SOAR's target population it is difficult to draw conclusions from the difference in differences estimates.

Table A.3. Difference in differences estimates on application outcomes among SSI applicants identified as homeless

	Number or percentage						
	SOAR communities			Non-SOAR communities			
	Pre-SOAR	Post-SOAR	(a) Percent change	Pre-SOAR	Post-SOAR	(b) Percent change	(c = a - b) Difference in differences estimate in percentage points or days
All SOAR communities (narrow definition)	6.2	4.1	-33.9	3.8	2.3	-39.5	5.6
Applicants identified as homeless (%)	41.1	29.5	-28.2	39.2	28.8	-26.5	-1.7
Initial application approval rate (%)	112.2	111.0	-1.1	110.9	112.2	1.2	-2.3
Initial application processing time (in days)							
All SOAR communities (broad definition)	6.4	4.1	-35.9	3.4	2.0	-41.2	5.3
Applicants identified as homeless (%)	39.7	31.7	-20.2	39.5	26.8	-32.2	12.0
Initial application approval rate (%)	110.9	112.4	1.5	111.4	111.4	0.0	1.5
Initial Application Processing Time (in days)							
Primary SOAR community (narrow definition)	6.5	4.9	-24.6	3.8		-39.5	14.9
Applicants identified as homeless (%)	40.4	31.1	-23.0	39.2	2.3	-26.5	3.5
Initial application approval rate (%)	111.4	113.0	1.6	110.9	28.8	1.3	0.3
Initial application processing time (in days)					112.2		
Primary SOAR communities (broad definition)	6.7	4.5	-32.8	3.4	2.0	-41.2	8.4
Applicants identified as homeless (%)	39.0	33.3	-14.6	39.5	26.8	-32.2	17.6
Initial application approval rate (%)	110.2	114.0	3.8	111.4	111.4	0.0	3.8
Initial application processing time (in days)							

Source: Administrative data on 18 states from SSA's Structured Data Repository (60-0320) and Systems of Records

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APPENDIX B

COMPENDIUM OF RESULTS FROM THE MIS AND SSA ADMINISTRATIVE DATA ANALYSES

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I. MIS

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Table B.1. Outcomes among initial SSI or SSDI applications submitted with SOAR assistance

State	Initial applicants with an initial decision					Initial applicants without an initial decision	
	Number	Initial application approval rate	Mean time to decision	Median time to decision	Approval rate at initial application or reconsideration	Number	Percent
Local evaluation sites							
1	188	59.04%	91.71	76	69.31%	7	3.59%
2	113	82.30%	97.35	80	83.33%	42	27.10%
3	100	86.00%	70.49	64	92.00%	3	2.91%
4	62	72.58%	117.00	117	72.58%	0	0.00%
5	65	44.62%	73.46	60	55.38%	19	22.62%
6	46	58.70%	186.26	123	65.22%	17	26.98%
7	28	75.00%	79.43	70	75.00%	6	17.65%
8	27	70.37%	80.33	71	74.07%	7	20.59%
9	35	48.57%	146.60	134	57.14%	14	28.57%
10	12	75.00%	53.83	51.5	75.00%	0	0.00%
11	12	41.67%	101.62	59	41.67%	20	62.50%
12	3	100.00%	80.33	86	100.00%	1	25.00%
13	5	0.00%	173.80	132	20.00%	1	16.67%
All	696	66.81%	99.21	82	72.78%	137	16.45%
All sites in evaluation states							
1	603	58.54%	78.97	69	68.60%	38	5.93%
2	241	68.46%	101.40	87	69.01%	87	26.52%
3	489	78.73%	119.28	93	81.91%	43	8.08%
4	62	72.58%	117.00	117	72.58%	0	0.00%
5	90	53.33%	83.92	68.5	64.44%	29	24.37%
6	46	58.70%	186.26	123	65.22%	17	26.98%
7	138	65.22%	95.42	86	65.22%	21	13.21%
8	54	62.96%	82.93	76.5	72.22%	18	25.00%
9	35	48.57%	146.60	134	57.14%	14	28.57%
10	34	76.47%	221.91	74	76.47%	5	12.82%
11	12	41.67%	101.62	59	41.67%	20	62.50%
12	3	100.00%	80.33	86	100.00%	16	84.21%
13	5	0.00%	173.80	132	20.00%	2	28.57%
All	1812	66.11%	103.23	83	71.62%	310	14.61%

Source: SOAR MIS or HMIS in 13 evaluation states

Table B.2. Characteristics of SOAR participants at time of initial SOAR application

	All initial applicants with a decision		Initial applicants approved for SSI or SSDI at initial level		Initial applicants approved for SSI or SSDI at initial level or reconsideration	
	Percentage	Number	Percentage	Number	Percentage	Number
Local evaluation sites						
Housing status						
Homeless[a]	44.73%	297	46.95%	208	46.50%	226
< 1 Month	9.96%	27	7.14%	14	8.10%	17
1-2 Months	7.01%	19	7.65%	15	7.62%	16
3-12 Months	29.89%	81	25.00%	49	25.71%	54
1-3 Years	34.32%	93	40.31%	79	39.05%	82
3+ Years	18.82%	51	19.90%	39	19.52%	41
Subtotal	100.00%	271	100.00%	196	100.00%	210
Housed	55.27%	367	53.05%	235	53.50%	260
At risk of homelessness	90.39%	333	88.63%	211	89.83%	236
Total	100.00%	664	100.00%	443	100.00%	486
Gender						
Male	54.89%	348	56.67%	238	56.37%	261
Female	45.11%	286	43.33%	182	43.63%	202
Total	100.00%	634	100.00%	420	100.00%	463
Age						
18-24	10.44%	66	11.22%	47	10.82%	50
25-44	42.09%	266	38.66%	162	39.39%	182
45-64	46.84%	296	49.16%	206	48.92%	226
65+	0.63%	4	0.95%	4	0.87%	4
Total	100.00%	632	100.00%	419	100.00%	462
Veteran status						
Yes	6.97%	44	6.94%	29	6.94%	32
No	91.76%	579	91.15%	381	91.32%	421
Don't know	1.27%	8	1.91%	8	1.74%	8
Total	100.00%	631	100.00%	418	100.00%	461
Receiving GA or TANF[a]	22.76%	536	19.44%	360	20.56%	394
Sample size	696		465		508	
All sites in evaluation states						
Housing status						
Homeless[a]	51.86%	891	53.29%	600	53.75%	660
< 1 Month	12.09%	104	12.95%	76	12.46%	80
1-2 Months	6.74%	58	7.33%	43	6.85%	44
3-12 Months	32.44%	279	30.49%	179	29.91%	192
1-3 Years	29.19%	251	30.32	178	30.84%	198
3+ Years	19.53%	168	18.91%	111	19.94%	128
Subtotal	100.00%	860	100.00%	587	100.00%	642
Housed	48.14%	827	46.71%	526	46.25%	568
At risk of homelessness	77.96%	658	74.33%	409	75.78%	450
Total	100.00%	1718	100.00%	1126	100.00%	1228
Gender						
Male	59.71%	1045	61.41%	708	60.80%	763
Female	40.29%	705	38.59%	445	39.20%	492
Total	100.00%	1750	100.00%	1153	100.00%	1255

Table B.2 *(continued)*

	All initial applicants with a decision		Initial applicants approved for SSI or SSDI at initial level		Initial applicants approved for SSI or SSDI at initial level or reconsideration	
	Percentage	Number	Percentage	Number	Percentage	Number
Age						
18-24	11.84%	204	12.75%	144	12.43%	153
25-44	42.72%	736	39.42%	445	39.72%	489
45-64	45.15%	778	47.39%	535	47.44%	584
65+	0.29%	5	0.44%	5	0.41%	5
Total	100.00%	1723	100.00%	1129	100.00%	1231
Veteran status						
Yes	8.49%	146	8.02%	91	7.92%	98
No	90.52%	1557	91.01%	1033	91.03%	1126
Don't know	0.99%	17	0.97%	11	1.05%	13
Total	100.00%	1720	100.00%	1135	100.00%	1273
Receiving GA or TANF[a]	20.23%	1488	18.91	994	19.85%	1083
Sample size	1812		1198		1300	

Source: SOAR MIS or HMIS in 13 evaluation states

[a] Wisconsin did not report data on risk of homelessness, length of time homeless, or receipt of GA or TANF.

Table B3. Critical components among applications submitted through SOAR and with a decision

Initial applications submitted with:	State													
	1	2	3	4	5	6	7	8	9	10	11	12	13	All
Local evaluation sites														
Authorized representative	99.47	100.00	100.00	100.00	98.46	93.48	96.43	100.00	100.00	100.00	100.00	100.00	100.00	99.14
Medical records	98.40	100.00	99.00	n/a	84.62	97.83	85.71	100.00	100.00	100.00	41.67	100.00	20.00	95.27
Medical summary report	96.28	91.15	93.94	n/a	83.08	47.83	53.57	59.26	37.14	91.67	8.33	100.00	40.00	81.20
Co-signed medical summary report	34.04	75.22	94.00	n/a	26.15	30.43	32.14	59.26	2.86	91.67	0.00	0.00	40.00	49.37
Quality review prior to submission	33.51	75.22	84.85	n/a	66.15	21.74	71.43	100.00	97.14	66.67	83.33	100.00	20.00	61.30
Enough support to avoid a consultative exam	55.43	60.19	88.00	56.45	53.13	67.39	73.91	92.31	62.86	100.00	83.33	100.00	60.00	65.72
Any one critical component	99.47	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	99.86
Any two critical components	99.47	100.00	100.00	56.45	100.00	100.00	100.00	100.00	100.00	100.00	91.67	100.00	100.00	95.83
Any three critical components	98.40	100.00	99.00	0.00	96.92	93.48	89.29	100.00	100.00	100.00	83.33	100.00	40.00	88.65
Any four critical components	70.74	98.23	96.00	0.00	66.15	47.83	60.71	100.00	82.86	91.67	33.33	100.00	40.00	71.55
Any five critical components	36.70	73.45	93.00	0.00	32.31	17.39	35.71	59.26	17.14	91.67	8.33	100.00	0.00	46.12
Any six critical components	8.51	27.43	70.00	0.00	15.38	0.00	14.29	48.15	0.00	66.67	0.00	0.00	0.00	21.84
Total Applications	188	113	100	62	65	46	28	27	35	12	12	3	5	696
All sites in evaluation states														
Authorized representative	99.34	100.00	99.39	100.00	97.78	93.48	97.10	100.00	100.00	100.00	100.00	100.00	100.00	99.12
Medical records	98.34	100.00	95.29	n/a	77.78	97.83	96.38	98.15	100.00	100.00	41.67	100.00	20.00	95.94
Medical summary report	94.36	86.31	75.98	n/a	66.67	47.83	71.01	57.41	37.14	94.12	8.33	100.00	40.00	80.61
Co-signed medical summary report	20.40	78.01	72.75	n/a	22.22	30.43	65.94	55.56	2.86	70.59	0.00	0.00	40.00	48.48

Table B.3 *(continued)*

Initial applications submitted with:	State													
	1	2	3	4	5	6	7	8	9	10	11	12	13	All
Quality review prior to submission	47.60	78.84	50.41	n/a	66.67	21.74	75.36	81.48	97.14%	79.41	83.33	100.00	20.00	58.10
Enough support to avoid a consultative exam	57.05	60.85	81.22	56.45	50.00	67.39	54.26	72.55	62.86	69.70	83.33	100.00	60.00	64.85
Any one critical component	99.83	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	99.94
Any two critical components	99.67	100.00	98.98	56.45	97.78	100.00	99.28	98.15	100.00	100.00	91.67	100.00	100.00	97.85
Any three critical components	97.84	99.17	93.25	0.00	86.67	93.48	92.03	92.59	100.00	97.06	83.33	100.00	40.00	91.94
Any four critical components	76.12	95.02	77.30	0.00	56.67	47.83	79.71	81.48	82.86	88.24	33.33	100.00	40.00	75.11
Any five critical components	35.99	71.78	68.92	0.00	25.56	17.39	60.14	53.70	17.14	76.47	8.33	100.00	0.00	50.00
Any six critical components	6.30	36.51	33.13	0.00	11.11	0.00	25.36	35.19	0.00	50.00	0.00	0.00	0.00	20.36
Total Applications	603	241	489	62	90	46	138	54	35	34	12	3	5	1812

Source: SOAR MIS or HMIS in 13 evaluation states

n/a = Not available

Table B.4. Approval rate among applicants who began receiving SOAR assistance at reconsideration

State	Number of reconsiderations with a decision	Reconsideration approval rate	Number of reconsiderations without a decision
Local evaluation sites			
1	16	43.75%	0
2	13	76.92%	5
3	11	54.55%	1
4	0	--	0
5	17	58.82%	3
6	1	100.00%	1
7	1	100.00%	0
8	9	44.44%	3
9	14	42.86%	1
10	0	--	0
11	0	--	1
12	1	0.00%	0
13	0	--	0
All	83	54.22%	15
All sites in evaluation states			
1	33	51.52%	5
2	38	63.16%	20
3	56	53.57%	6
4	0	--	0
5	19	57.89%	3
6	1	100.00%	1
7	1	100.00%	2
8	12	58.33%	4
9	14	42.86%	1
10	0	---	1
11	0	--	1
12	4	0.00%	6
13	0	--	0
All	178	54.49%	50

Source: SOAR MIS or HMIS in 13 evaluation states

Table B.5. Entities tracking data in MIS on applications assisted through SOAR process

State	Number of organizations	Number of trainees
Local evaluation sites		
1	1	6
2	12	23
3	2	3
4	1	1
5	5	14
6	5	5
7	4	7
8	3	4
9	1	5
10	1	1
11	2	2
12	1	1
13	2	3
All	40	75
All sites in evaluation states		
1	5	38
2	19	33
3	15	24
4	1	1
5	11	24
6	5	5
7	17	30
8	9	12
9	1	5
10	9	9
11	2	2
12	2	5
13	4	5
All	100	193

Source: SOAR MIS or HMIS in 13 evaluation states

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II. SSA ADMINISTRATIVE DATA

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Table B.6. Body system of primary diagnosis among initial SSI or SSDI applications

	Percentage of adult SSI or SSDI applicants in FY 2010			
	All applicants	Identified as homeless	Identified as SOAR	Not identified as homeless
Musculoskeletal	30.9	21.5	11.1	31.1
Special senses and speech	2.3	1.5	0.5	2.3
Respiratory	3.9	3.0	2.1	4.0
Cardiovascular	7.0	4.3	2.5	7.0
Digestive	2.4	2.1	2.0	2.4
Genitourinary	1.3	0.5	0.3	1.3
Hematological	0.4	0.2	0.0	0.4
Skin	0.3	0.3	0.3	0.3
Endocrine	3.8	2.4	1.6	3.8
Multiple Body Systems	0.1	0.0	0.0	0.1
Neurological	7.1	3.7	3.1	7.2
Mental	25.9	42.8	68.8	25.5
Neoplastic	4.7	1.2	0.8	4.8
Immune System	2.5	2.4	1.0	2.5
Special/other	7.5	14.2	6.1	7.3
Total initial applications	**2,438,944**	**55,797**	**804**	**2,383,147**

Source: Administrative data on all initial SSI and SSDI applications filed in all states in FY 2010 from SSA's Structured Data Repository (60-0320) and Systems of Records.

Table B.7. DDS application processing time and decisions, by homeless and SOAR status

	Percentage of adult SSI/SSDI applicants in FY 2010			
	All applicants	Identified as homeless	Identified as SOAR	Not identified as homeless
SSI applicants				
Initial Application				
Average DDS application processing time (days)	113	110	96	113
Approved (%)	28.3	27.5	50.6	28.3
Denied (%)	71.7	72.5	49.4	71.7
Denials that proceeded to reconsideration (%)	37.4	39.3	45.8	37.3
Total (N)	1,579,132	53,058	769	1,526,074
Initial Applications Proceeding to Reconsideration				
Approved (%)	10.3	14.4	27.0	10.2
Denied (%)	89.7	85.6	73.0	89.8
Total (N)	423,458	15,109	174	408,349
Initial Applicants Approved at Either Level (%)	31.1	31.6	56.7	31.0
SSDI applicants				
Initial Application				
Average DDS application processing time (days)	108	111	101	108
Approved (%)	35.0	22.3	37.7	35.2
Denied (%)	65.0	77.7	62.3	64.8
Denials that proceeded to reconsideration (%)	42.9	40.3	43.2	43.0
Total (N)	1,761,422	27,559	469	1,733,863
Reconsiderations				
Approved (%)	11.5	11.3	19.0	10.5
Denied (%)	88.5	88.7	81.0	89.5
Total (N)	491,432	8,635	126	482,797
Initial Applicants Approved at Either Level (%)	38.2	25.8	42.8	38.1
SSI or SSDI applicants				
Initial Application				
Average DDS application processing time (days)	109	110	97	109
Approved (%)	34.5	27.7	49.9	34.7
Denied (%)	64.5	72.3	50.1	65.3
Denials that proceeded to reconsideration (%)	41.3	40.1	46.2	40.7
Total (N)	2,438,944	55,797	804	2,383,147
Initial Applications Proceeding to Reconsideration				
Approved (%)	11.8	14.3	25.8	11.7
Denied (%)	88.2	85.7	74.2	88.3
Total (N)	648,956	16,157	186	632,799
Initial Applicants Approved at Either Level (%)	37.6	31.8	55.8	37.8

Source: Administrative data on all states from SSA's Structured Data Repository (60-0320) and Systems of Records

Table B.8. Relationship between SOAR and DDS application decision and processing time among adult homeless SSI/SSDI applicants in FY 2010

	Initial application approval				Initial application DDS processing time		
Variable*	Log odds estimate	SE	p-Value	Odds ratio estimate	Coefficient	SE	p-Value
Adult SSI Applicants (N=53,058)		R^2 = 0.169; ICC = 0.023			R^2 = 0.094; ICC = 0.110		
Homeless_1	0.88	0.13	0.00	2.41	-10.2	3.9	0.01
Age	0.05	0.00	0.00	1.05	-0.1	0.0	0.03
Prior application 1	-0.03	0.03	0.21	0.97	2.5	0.5	0.00
Prior application 2	1.61	1.41	0.25	5.01	59.0	18.5	0.00
Intercept	-4.08	0.16	0.00	--	128.3	3.0	0.00
Adult SSDI Applicants (N=27,559)		R^2 = 0.140; ICC = 0.018			R^2 = 0.093; ICC = 0.102		
Homeless_1	0.70	0.21	0.00	2.02	-6.1	4.3	0.17
Age	0.05	0.00	0.00	1.05	-0.03	0.03	0.32
Prior application 1	-0.07	0.03	0.01	0.93	3.4	0.5	0.00
Prior application 2	-0.27	1.42	0.85	0.76	130.3	1.2	0.00
Intercept	-3.45	0.17	0.00	--	125.7	2.8	0.00
Adult SSI or SSDI Applicants (N=55,797)		R^2 = 0.171; ICC = 0.020			R^2 = 0.095; ICC = 0.098		
Homeless_1	0.83	0.13	0.00	2.30	-10.2	4.3	0.02
Age	0.05	0.00	0.00	1.05	-0.1	0.0	0.10
Prior application 1	-0.03	0.03	0.19	0.97	2.6	0.5	0.00
Prior application 2	0.70	0.89	0.42	2.02	41.0	36.6	0.27
Intercept	-4.16	0.15	0.00	--	126.2	3.1	0.00

Source: Administrative data on all states from SSA's Structured Data Repository (60-0320) and Systems of Records

* Primary diagnosis codes not shown, but for initial application approval rate, all log odds estimates are significant at the .05 level for all adult SSI or SSDI applicants; for initial application processing time, estimates for 5 of 20 codes are significant at the .05 level for all adult SSI or SSDI applicants. States are also included as control variables, and the ICC presented is the variation in the outcome variable due to state.

Table B.9. Initial applications submitted with SOAR critical components, by homeless and SOAR status

	Percentage of adult SSI or SSDI applicants in FY 2010			
	All applicants	Identified as homeless	Identified as SOAR participants	Not identified as homeless
Applicant has authorized representative	15.3	20.5	82.0	15.4
Application submitted with medical evidence	19.3	22.8	51.1	19.2
No consultative exam ordered	41.2	35.1	44.0	41.4
Any one	43.3	38.7	31.3	43.4
Any two	13.6	14.1	38.2	13.6
All three	1.9	3.8	23.1	1.8
Total (N)	2,438,944	55,797	804	2,383,147

Source: Administrative data on all states from SSA's Structured Data Repository (60-0320) and Systems of Records

Table B.10. Correlation between DDS application decision/processing time and SOAR critical components

Presence of critical component			Adult SSI or SSDI applicants in FY 2010	
Authorized representative	Medical evidence	No consultative exam request	Estimate	SE
Initial application approval (maximum rescaled R^2 = 0.051)				
X			0.11*	0.04
	X		0.60*	0.01
		X	0.45*	0.05
X	X		0.18*	0.06
	X	X	0.19*	0.03
X		X	0.07*	0.03
X	X	X	0.06	0.04
Initial application DDS processing time (maximum rescaled R^2 =0.153)				
X			8.4*	1.54
	X		2.4	2.44
		X	-45.0*	2.45
X	X		1.5	1.52
	X	X	-5.2*	1.52
X		X	-3.3*	1.03
X	X	X	2.0	1.53

Source: Administrative data on all states from SSA's Structured Data Repository (60-0320) and Systems of Records
N = 2,438,944
* p<.01, binary logit model for initial application approval and linear regression for initial application processing time.

Table B.11. Predicted probabilities of DDS application decision/processing time, by SOAR critical components

Presence of critical component			
Authorized representative	Medical evidence	No consultative exam request	Adult SSI or SSDI applicants in FY 2010
Initial application approval (predicted probability in percentage points)			
			26.4
X			28.6
	X		39.5
		X	36.3
X	X		46.5
	X	X	55.7
X		X	40.8
X	X	X	65.6
Initial application DDS processing time (predicted probability in days)			
			126.4
X			134.8
	X		128.8
		X	81.4
X	X		138.7
	X	X	78.6
X		X	86.5
X	X	X	87.1

Source: Administrative data on all states from SSA's Structured Data Repository (60-0320) and Systems of Records
N = 2,438,944

APPENDIX C

SNA FIGURES FOR EACH LOCAL EVALUATION SITE

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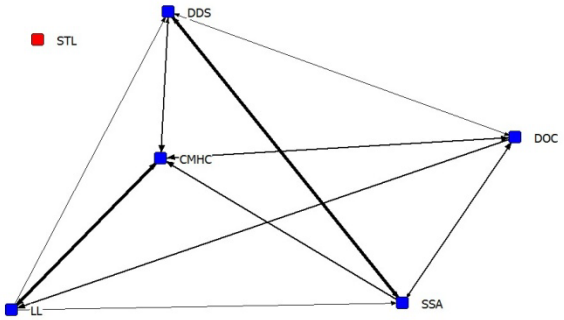
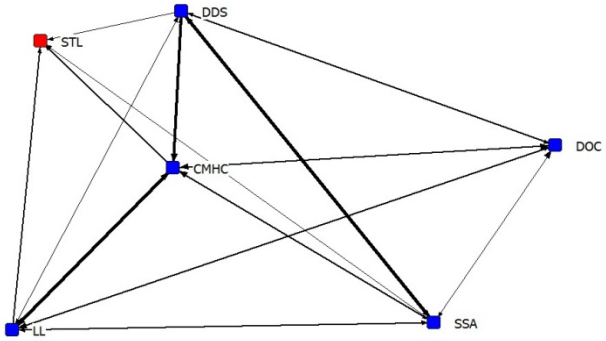
Figure C.1. Social network survey of communication before and after SOAR in Site 1

Before SOAR



After SOAR



Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center, DOC-Department of Corrections. The STL did not respond to the survey in this site.

Source: Social Network Survey from SOAR stakeholders.

Figure C.2. Agency perceptions of the helpfulness of others to the SOAR effort in Site 1

	SSA	DDS	STL	LL	CMHC	DOC
SSA						
DS						
LL						
CMHC						
DOC						

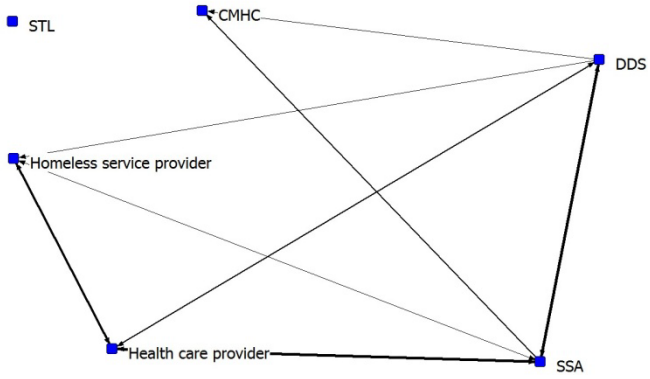
Not at all helpful
Helpful to some extent
Helpful to a considerable extent
Nonresponse
Not applicable

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center, DOC-Department of Corrections

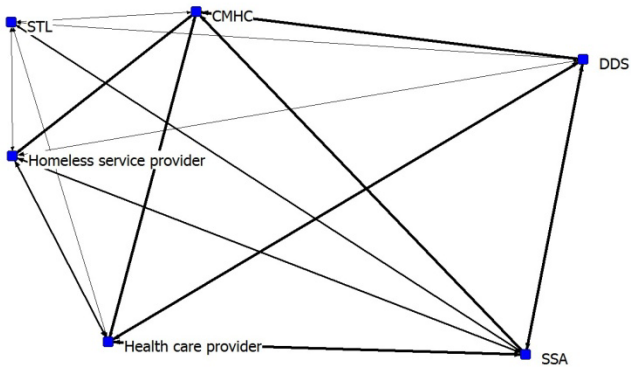
Source: Social Network Survey from SOAR stakeholders.

Figure C.3. Social network survey of communication before and after SOAR in Site 2

Before SOAR



After SOAR



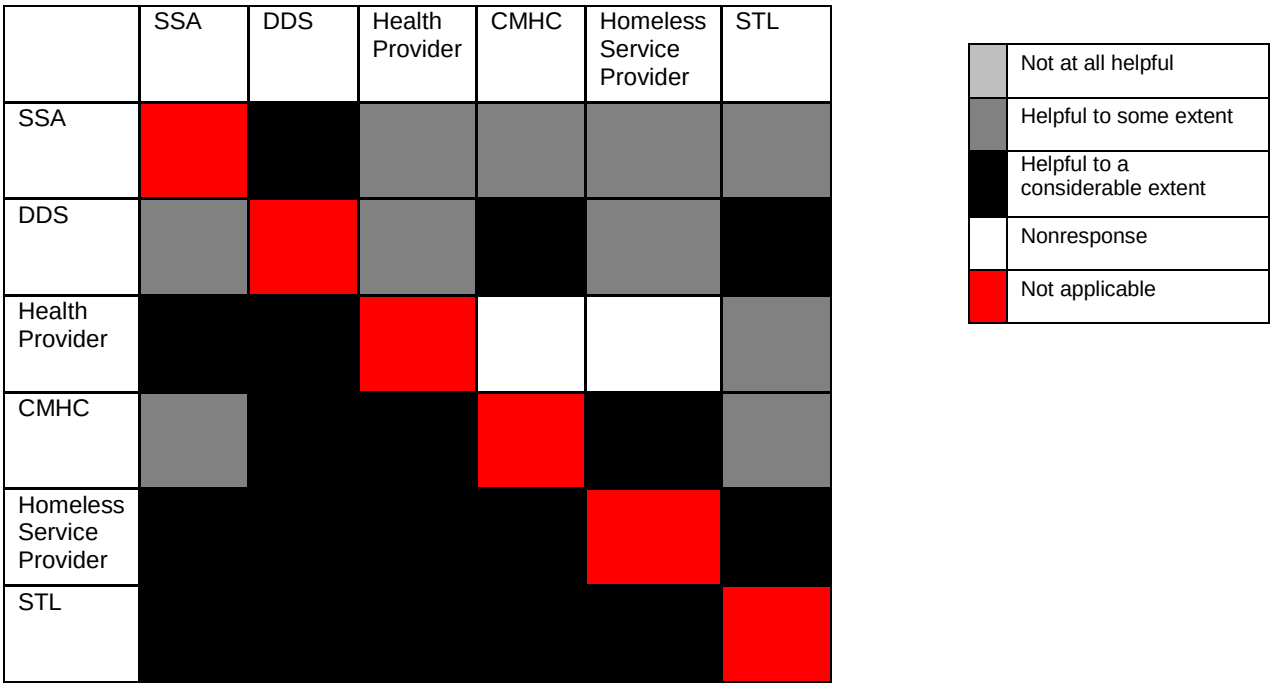
Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

Figure C.4. Agency perceptions of the helpfulness of others to the SOAR effort in Site 2

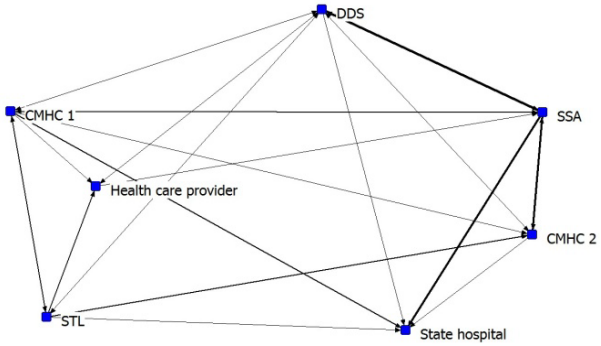


Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

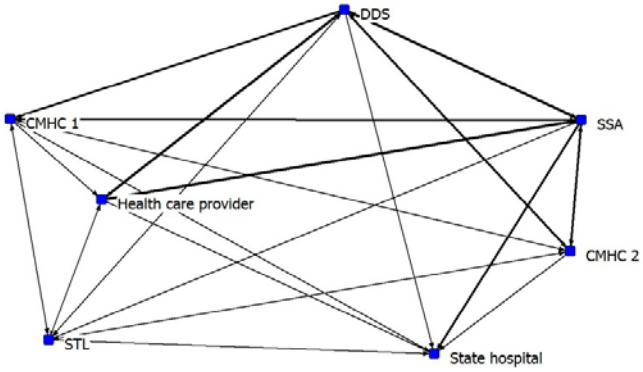
Source: Social Network Survey from SOAR stakeholders.

Figure C.5. Social network survey of communication before and after SOAR in Site 3

Before SOAR



After SOAR



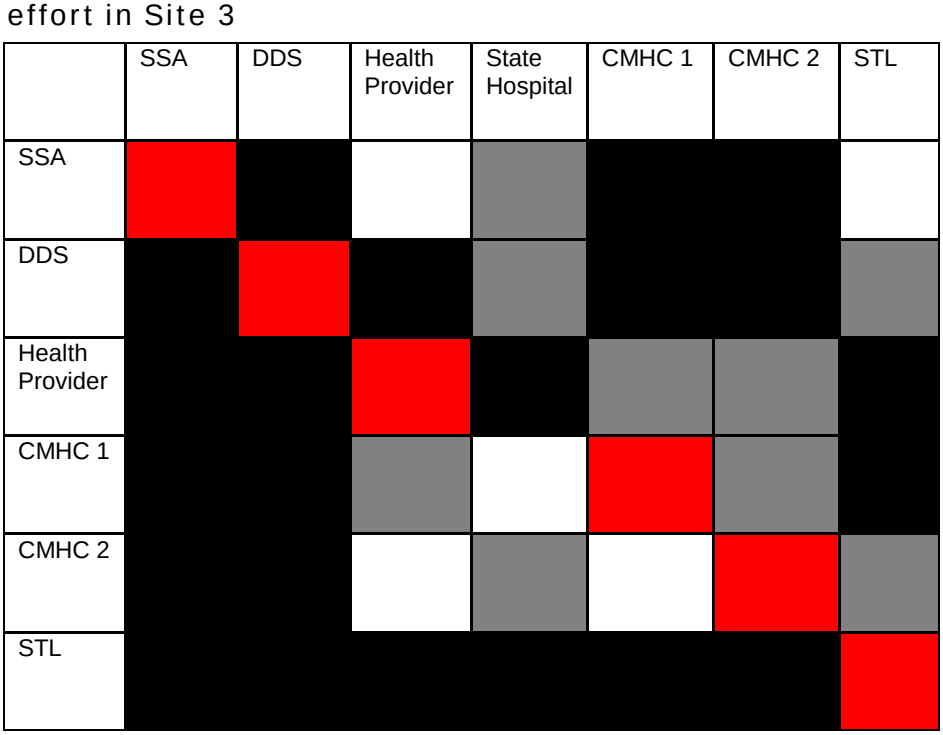
Key: Surveyed; Not surveyed

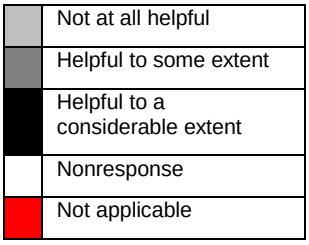
Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

Figure C.6. Agency perceptions of the helpfulness of others to the SOAR effort in Site 3



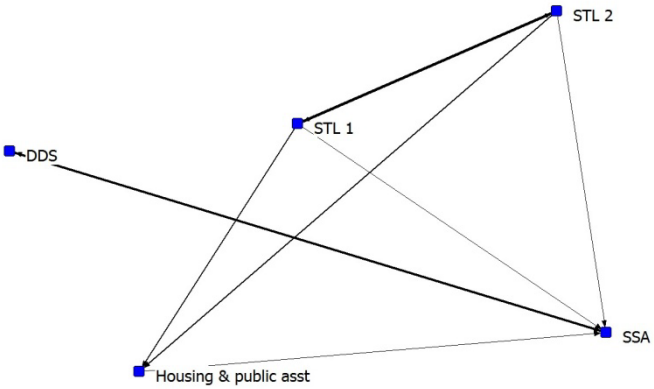


Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

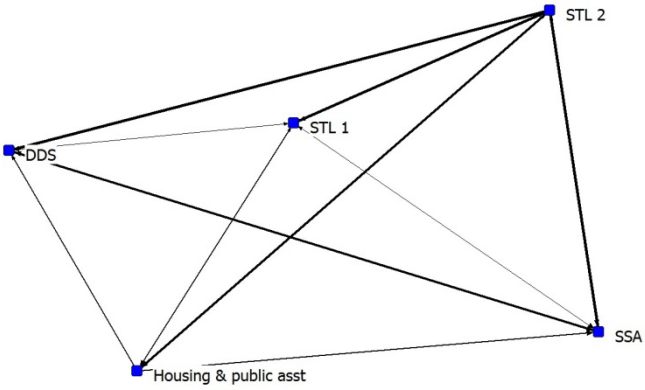
Source: Social Network Survey from SOAR stakeholders.

Figure C.7. Social network survey of communication before and after SOAR in Site 4

Before SOAR



After SOAR



Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead

Source: Social Network Survey from SOAR stakeholders.

Figure C.8. Agency perceptions of the helpfulness of others to the SOAR effort in Site 4

	SSA	DDS	STL 1	STL 2	Housing & Public Asst
SSA					
DDS					
STL 1					
STL 2					
Housing & Public Asst					

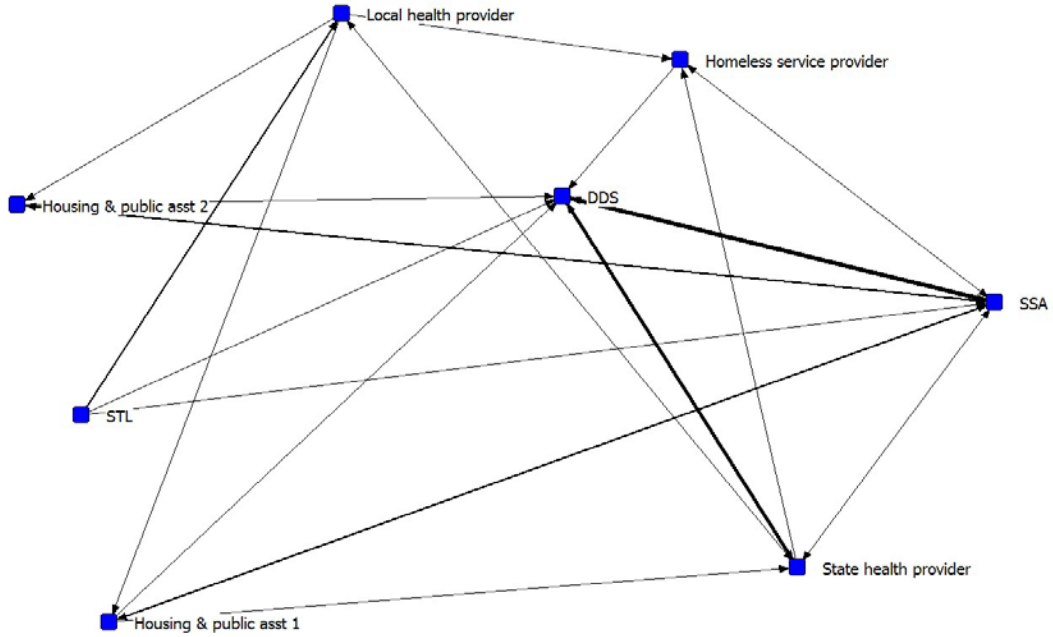
	Not at all helpful
	Helpful to some extent
	Helpful to a considerable extent
	Nonresponse
	Not applicable

Note: STL-State SOAR Lead

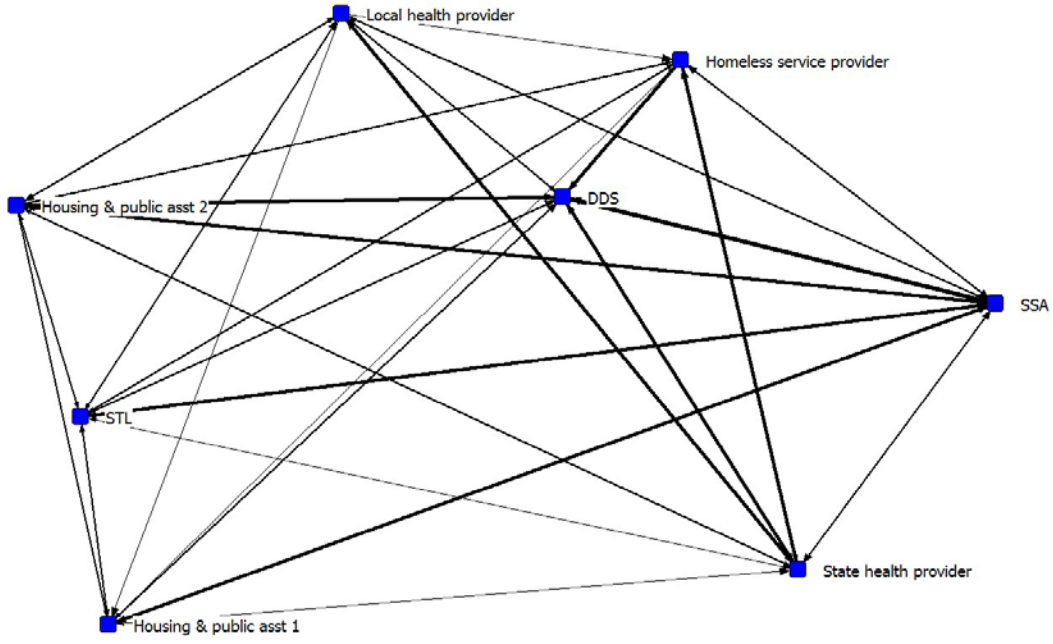
Source: Social Network Survey from SOAR stakeholders.

Figure C.9. Social network survey of communication before and after SOAR in Site 5

Before SOAR



After SOAR



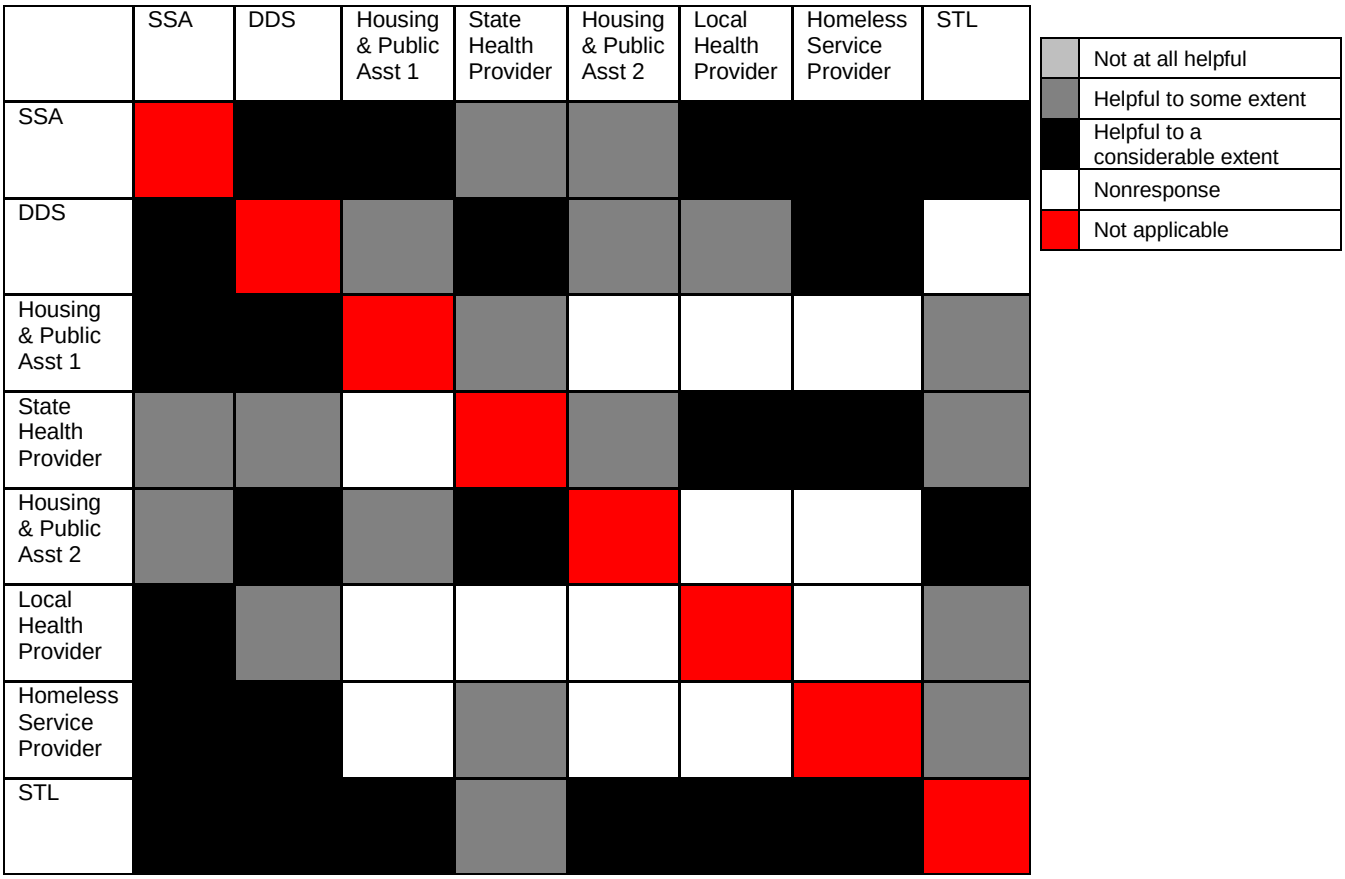
Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year Every month or two Every week or two More than once a week

Note: STL-State SOAR Lead

Source: Social Network Survey from SOAR stakeholders.

Figure C.10. Agency perceptions of the helpfulness of others to the SOAR effort in Site 5

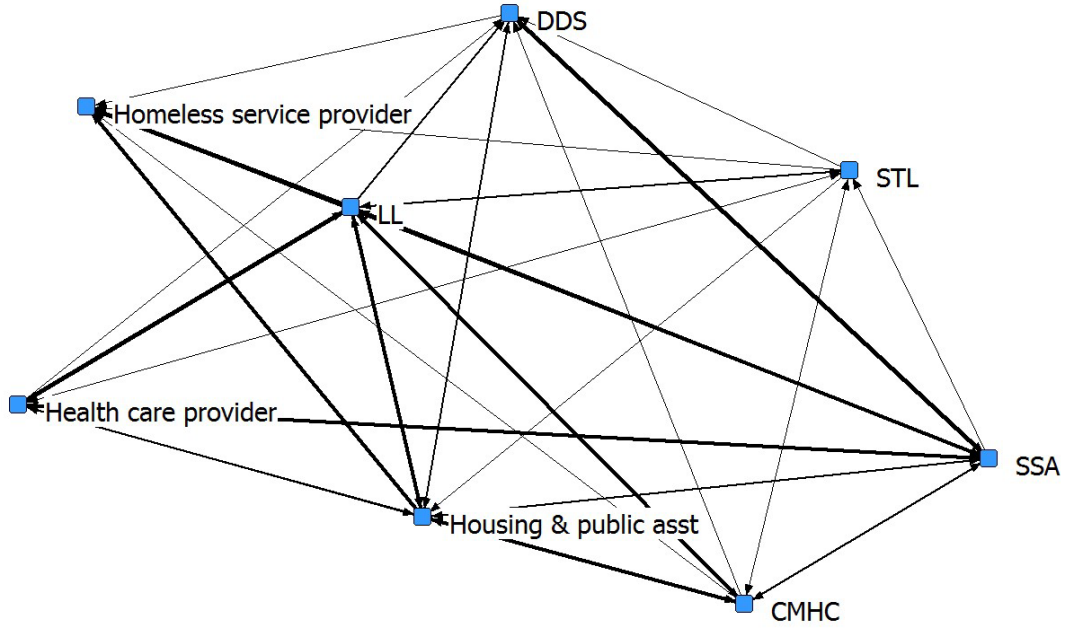


Note: STL-State SOAR Lead

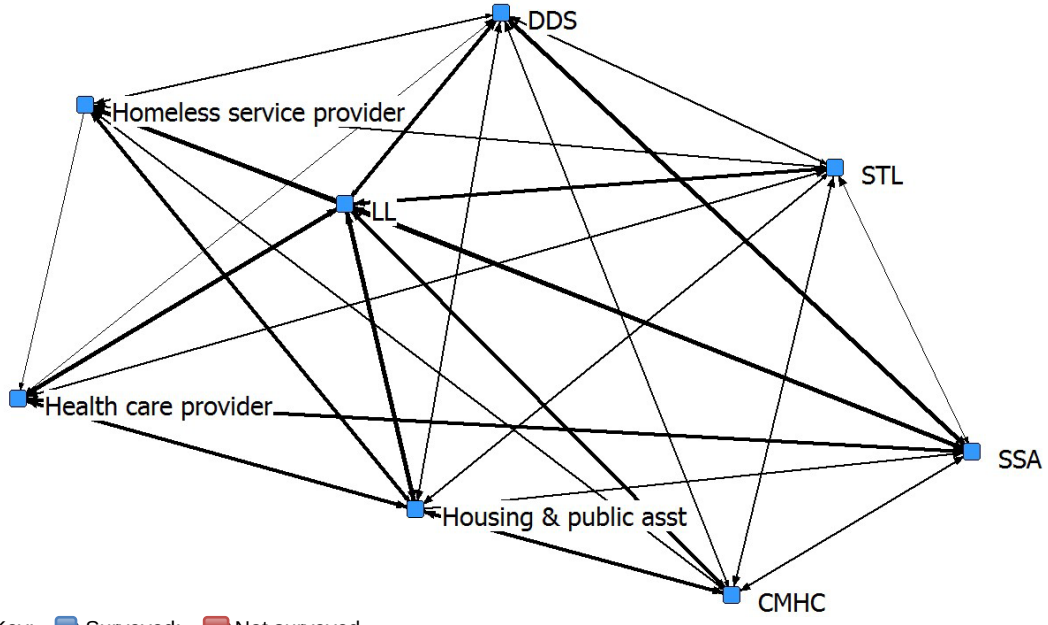
Source: Social Network Survey from SOAR stakeholders.

Figure C.11. Social network survey of communication before and after SOAR in Site 6

Before SOAR



After SOAR



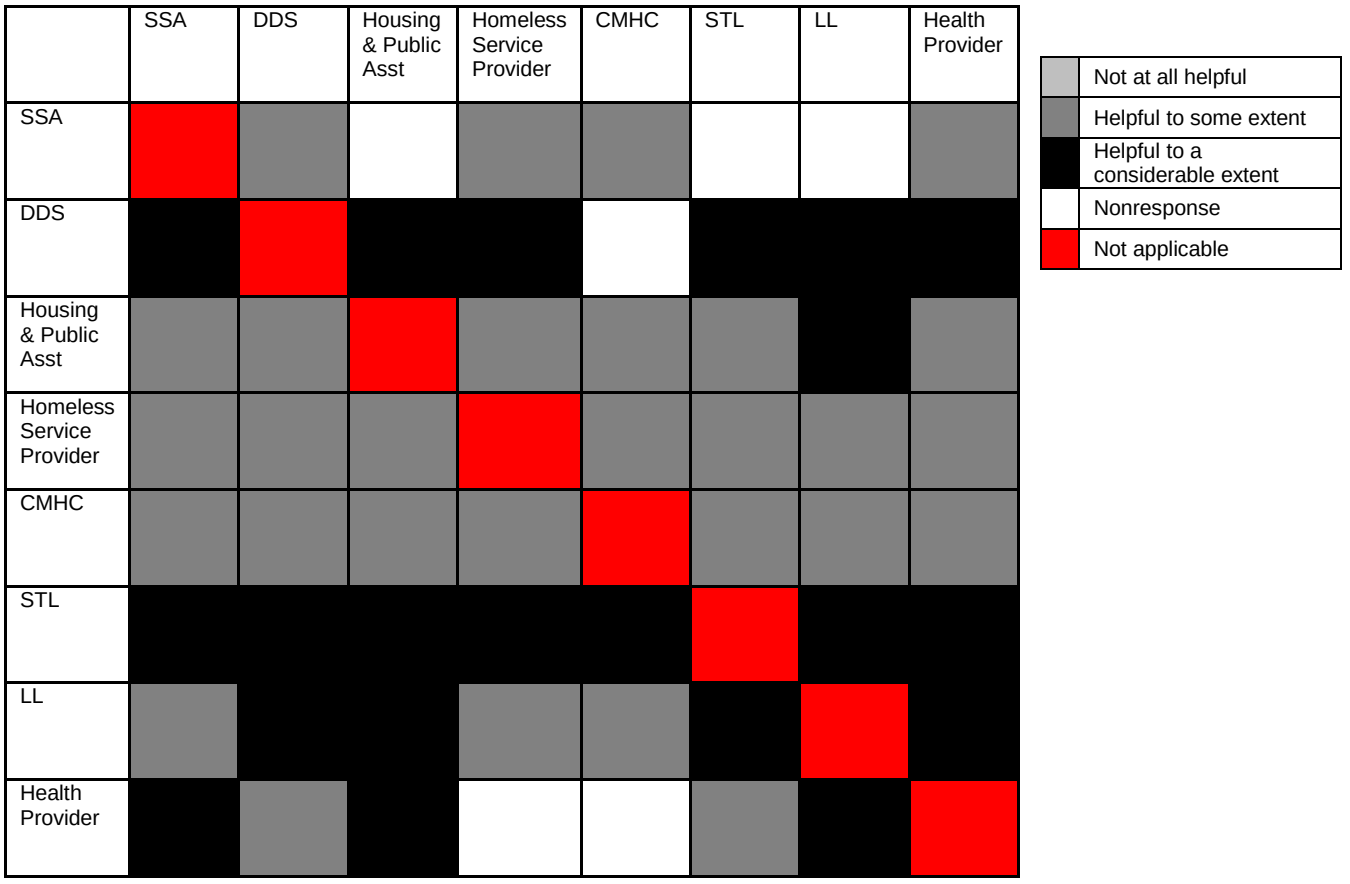
Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year Every month or two Every week or two More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

Figure C.12. Agency perceptions of the helpfulness of others to the SOAR effort in Site 6

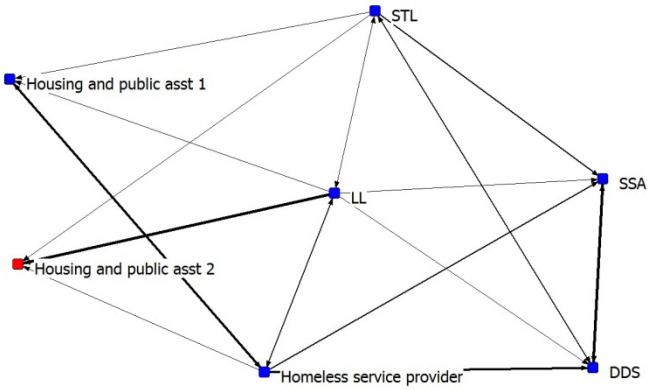


Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

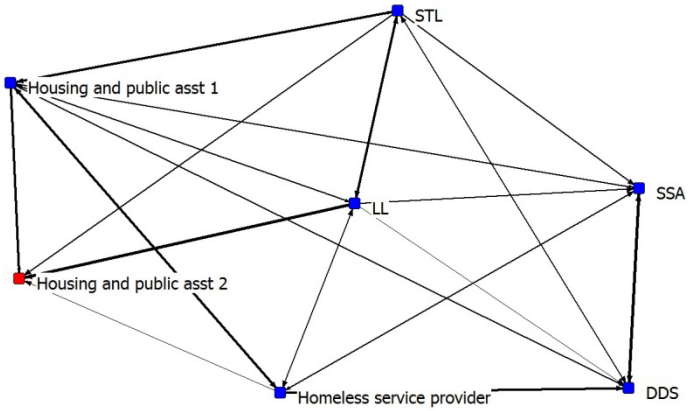
Source: Social Network Survey from SOAR stakeholders.

Figure C.13. Social network survey of communication before and after SOAR in Site 7

Before SOAR



After SOAR



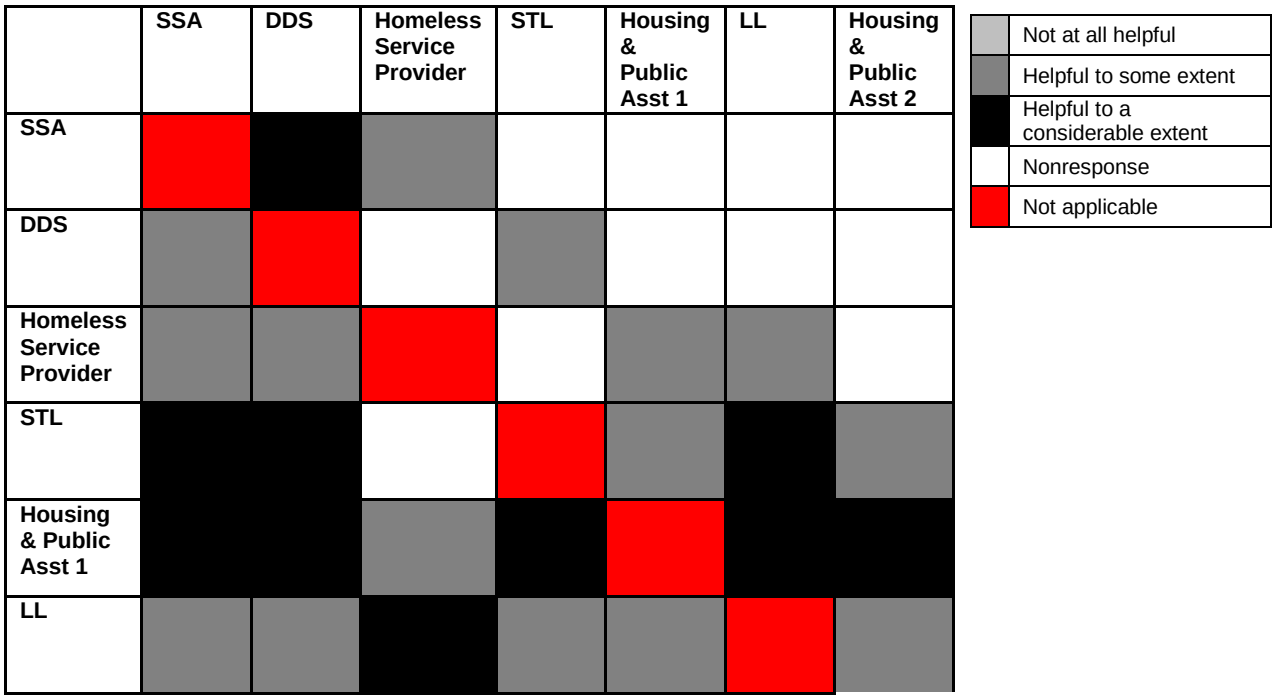
Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year Every month or two Every week or two More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead

Source: Social Network Survey from SOAR stakeholders.

Figure C.14. Agency perceptions of the helpfulness of others to the SOAR effort in Site 7

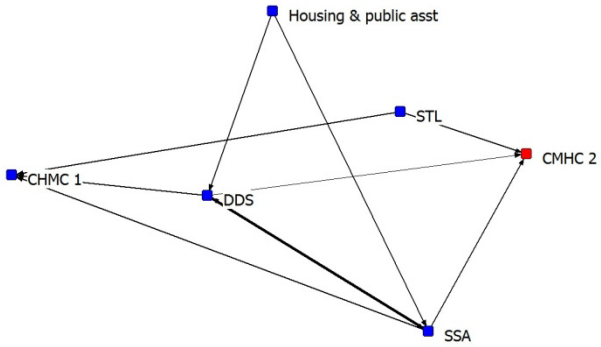


Note: STL-State SOAR Lead, LL-Local SOAR Lead

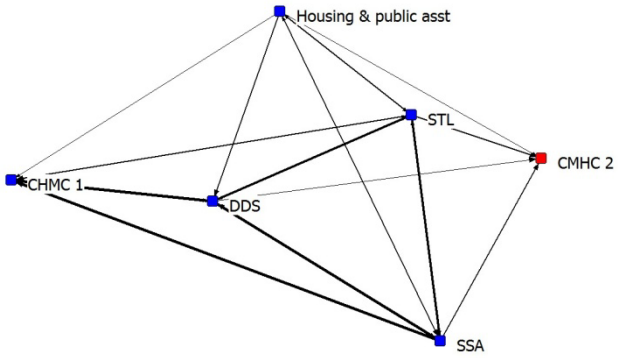
Source: Social Network Survey from SOAR stakeholders.

Figure C.15. Social network survey of communication before and after SOAR in Site 8

Before SOAR



After SOAR



Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

Figure C.16. Agency perceptions of the helpfulness of others to the SOAR effort in Site 8

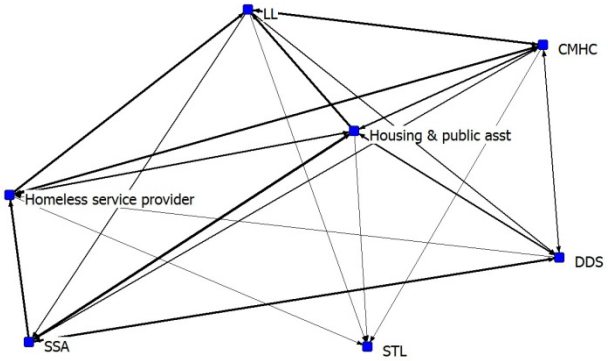
Not at all helpful
Helpful to some extent
Helpful to a considerable extent
Nonresponse
Not applicable

Note: STL-State SOAR Lead, CMHC-Community Mental Health Center

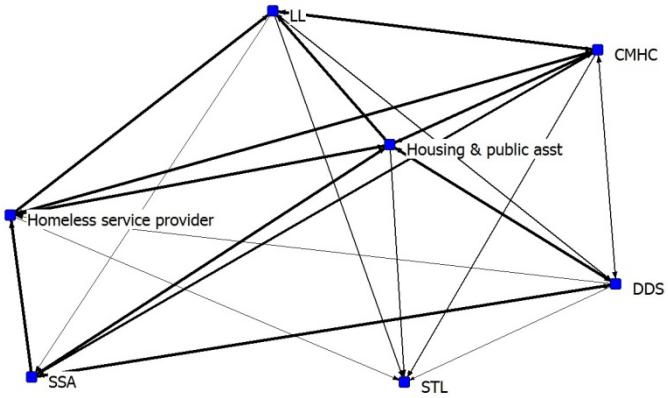
Source: Social Network Survey from SOAR stakeholders.

Figure C.17. Social network survey of communication before and after SOAR in Site 9

Before SOAR



After SOAR



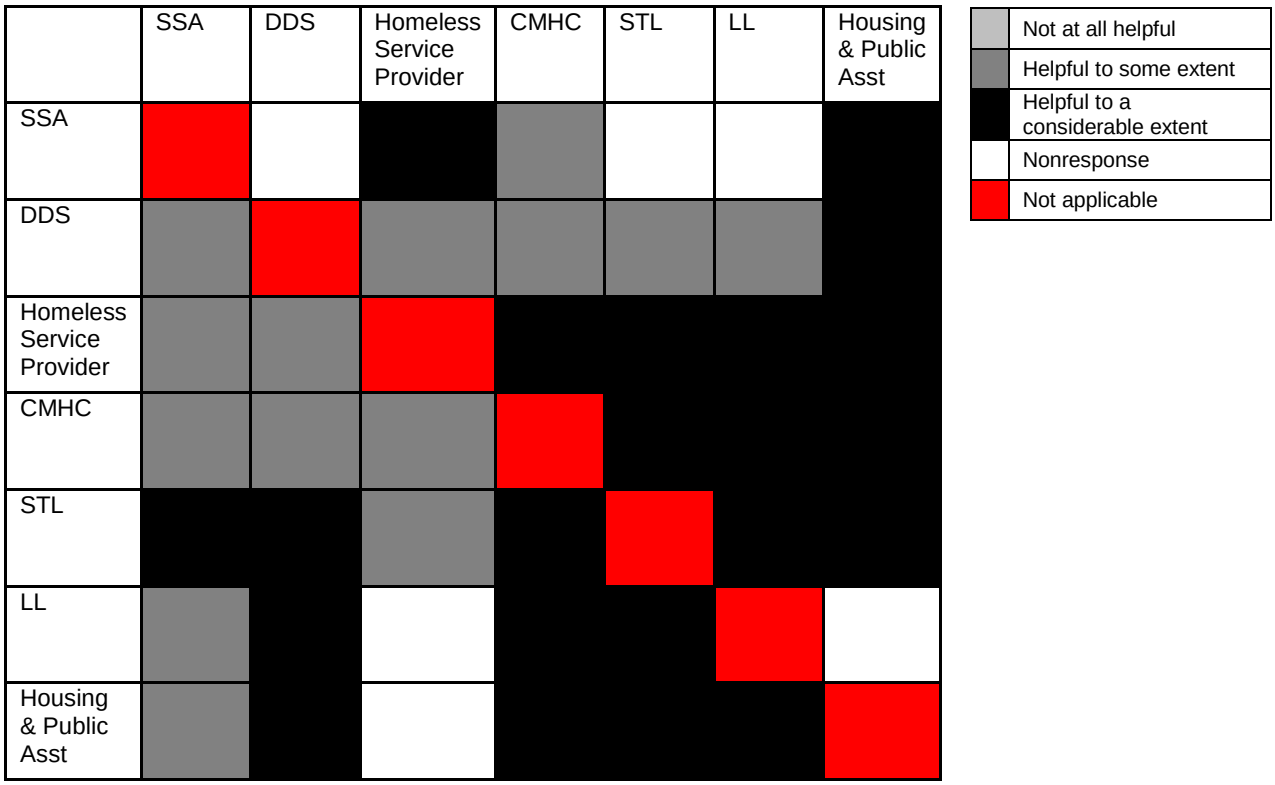
Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year Every month or two Every week or two More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

Figure C.18. Agency perceptions of the helpfulness of others to the SOAR effort in Site 9

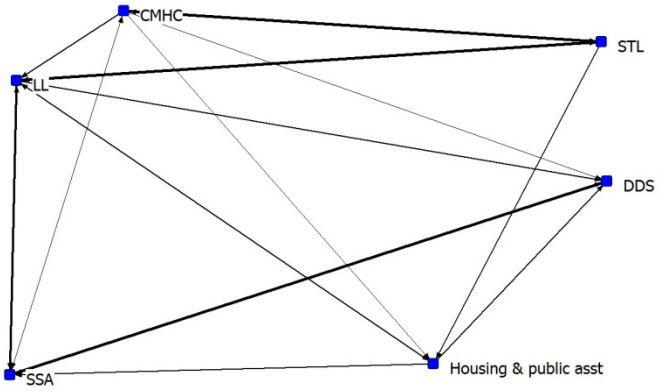


Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

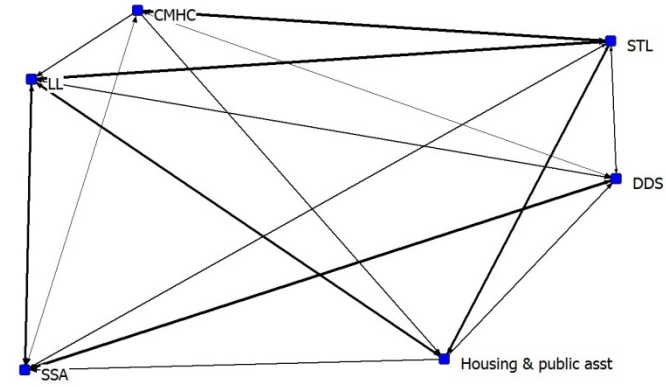
Source: Social Network Survey from SOAR stakeholders.

Figure C.19. Social network survey of communication before and after SOAR in Site 10

Before SOAR



After SOAR



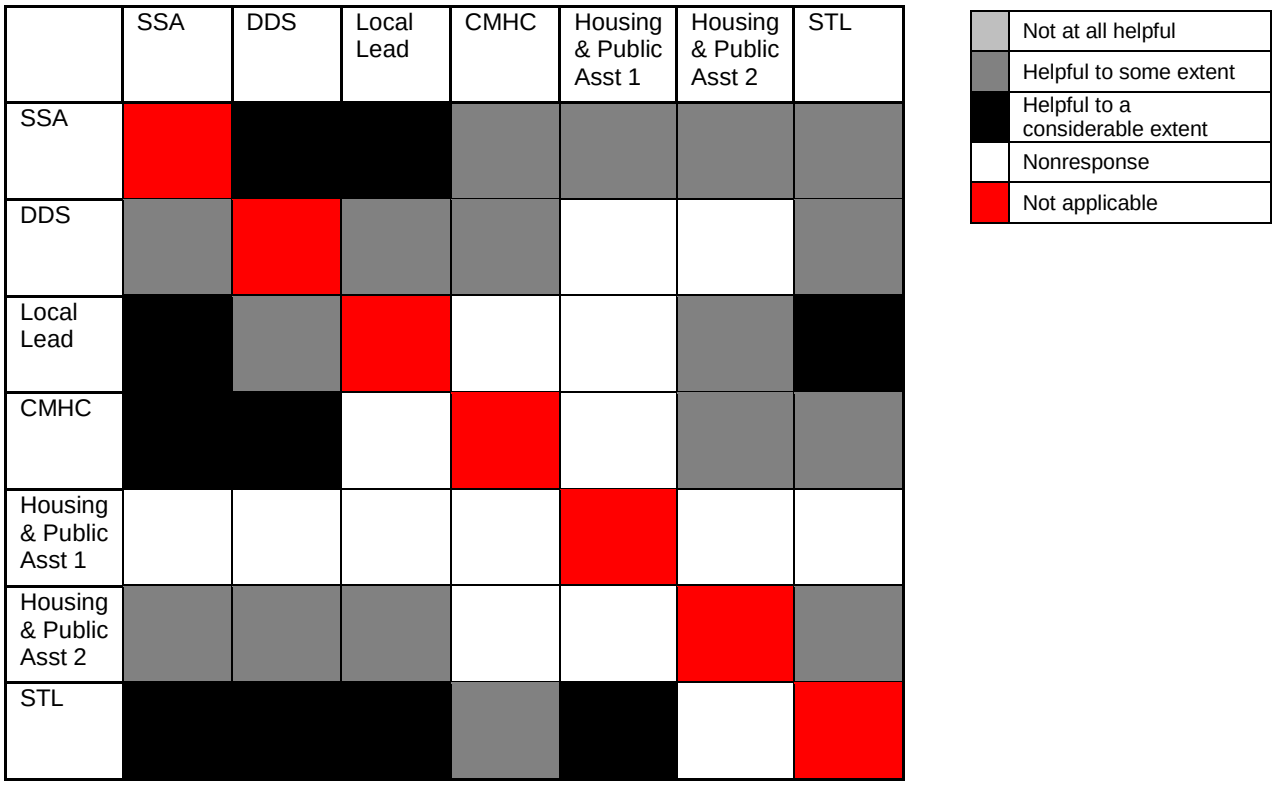
Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year Every month or two Every week or two More than once a week

Note: STL-State SOAR Lead, CMHC-Community Mental Health Center

Source: Social Network Survey from SOAR stakeholders.

Figure C.20. Agency perceptions of the helpfulness of others to the SOAR effort in Site 10

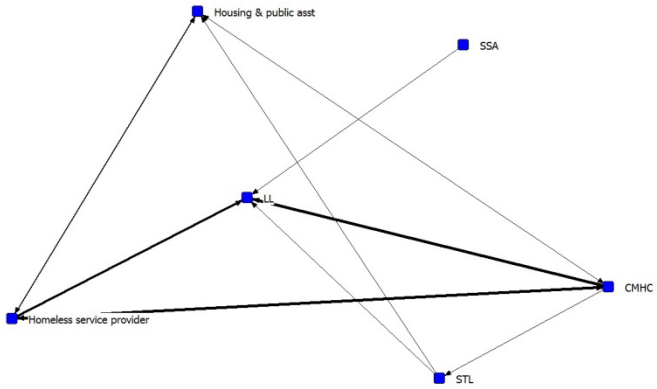


Note: STL-State SOAR Lead, CMHC-Community Mental Health Center

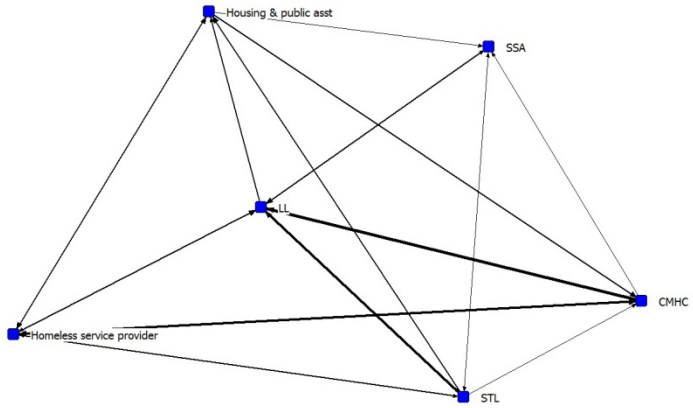
Source: Social Network Survey from SOAR stakeholders.

Figure C.21. Social network survey of communication before and after SOAR in Site 11

Before SOAR



After SOAR

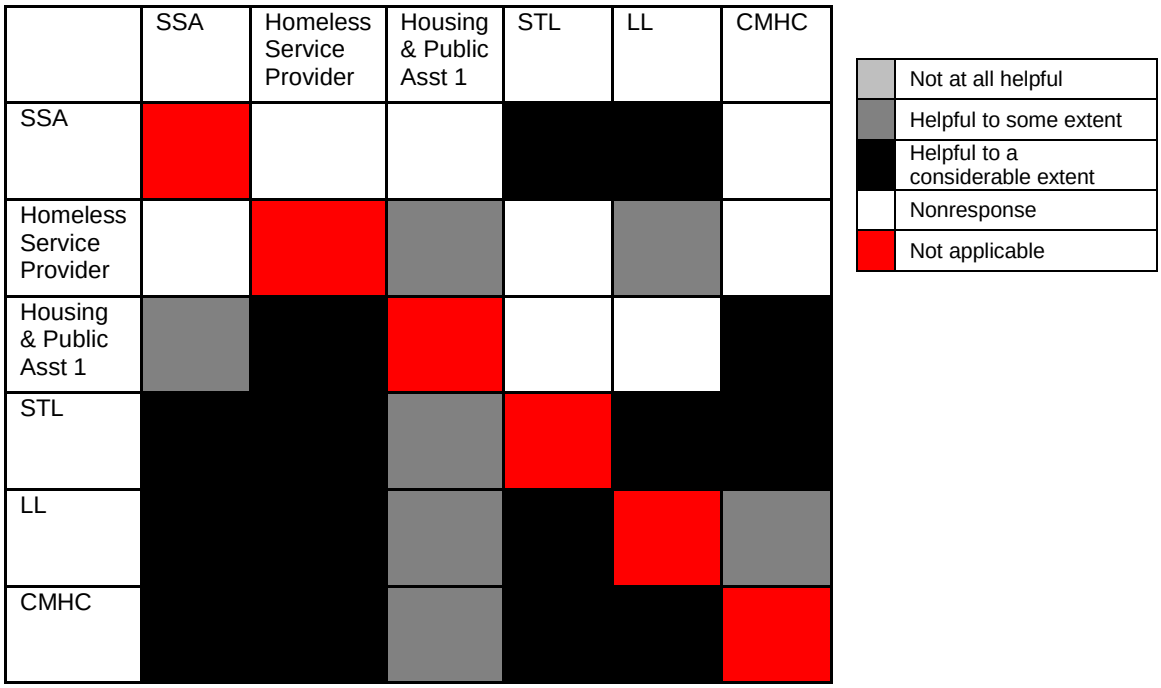


Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center
Source: Social Network Survey from SOAR stakeholders.

Figure C.22. Agency perceptions of the helpfulness of others to the SOAR effort in Site 11

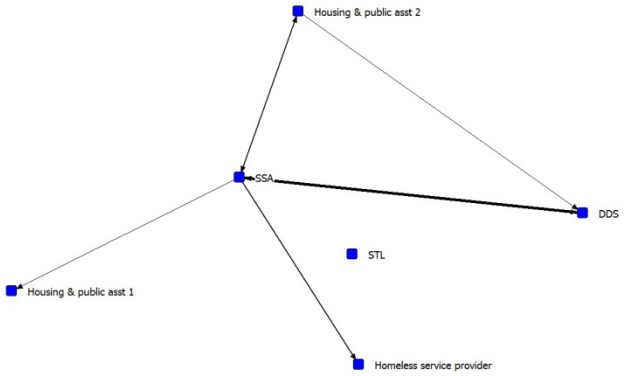


Note: STL-State SOAR Lead, LL-Local SOAR Lead, CMHC-Community Mental Health Center

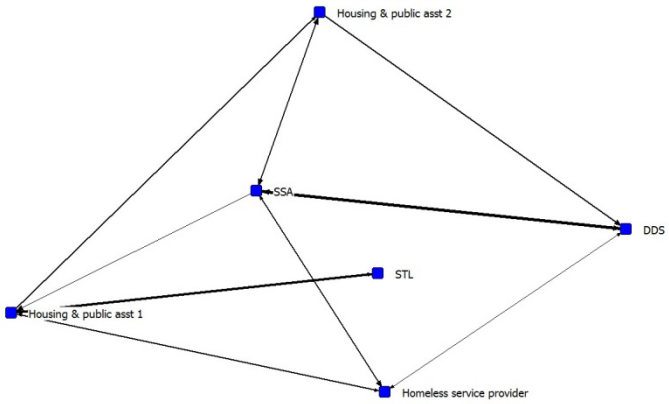
Source: Social Network Survey from SOAR stakeholders.

Figure C.23. Social network survey of communication before and after SOAR in Site 12

Before SOAR



After SOAR



Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead

Source: Social Network Survey from SOAR stakeholders.

Figure C.24. Agency perceptions of the helpfulness of others to the SOAR effort in Site 12

	SSA	DDS	STL	Homeless Service Provider	Housing & Public Asst 1	Housing & Public Asst 2
SSA						
DDS						
STL						
Homeless Service Provider						
Housing & Public Asst 1						
Housing & Public Asst 2						

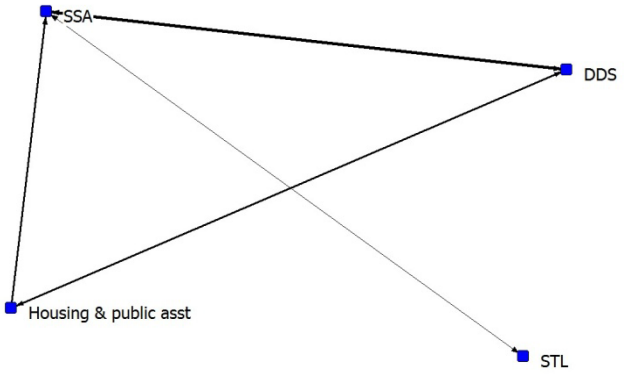
	Not at all helpful
	Helpful to some extent
	Helpful to a considerable extent
	Nonresponse
	Not applicable

Note: STL-State SOAR Lead

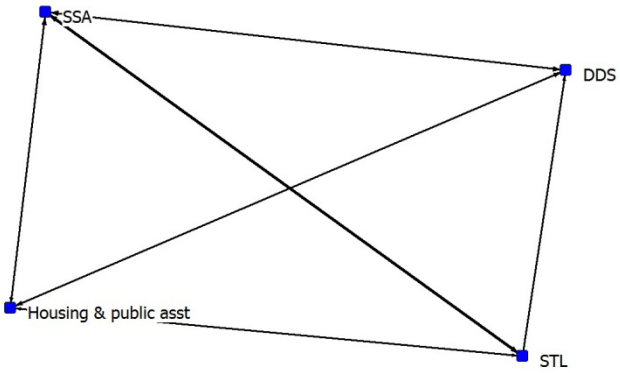
Source: Social Network Survey from SOAR stakeholders.

Figure C.25. Social network survey of communication before and after SOAR in Site 13

Before SOAR



After SOAR



Key: Surveyed; Not surveyed

Communication frequency:
Once or twice a year — Every month or two — Every week or two — More than once a week

Note: STL-State SOAR Lead

Source: Social Network Survey from SOAR stakeholders.

Figure C.26. Agency perceptions of the helpfulness of others to the SOAR effort in Site 13

	SSA	DDS	Housing & Public Asst	STL
SSA				
DDS				
Housing & Public Asst				
STL				

Not at all helpful
Helpful to some extent
Helpful to a considerable extent
Nonresponse
Not applicable

Note: STL-State SOAR Lead

Source: Social Network Survey from SOAR stakeholders.

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