Supporting Statement for Paperwork Reduction Act Submissions
Evaluation of the Supportive Services Demonstration
(OMB# xxxx-xxxx)

B. Collections of Information Employing Statistical Methods

1. **Describe (including a numerical estimate) the potential respondent universe and any sampling or other respondent selection methods to be used. Data on the number of entities (e.g., establishments, State and local government units, households, or persons) in the universe covered by the collection and in the corresponding sample are to be provided in tabular form for the universe as a whole and for each of the strata in the proposed sample. Indicate expected response rates for the collection as a whole. If the collection had been conducted previously, include the actual response rate achieved during the last collection.**

Evaluation Overview

The Supportive Services Demonstration (SSD) evaluation has two components: a *process study*, to document how treatment group properties implemented the Integrated Wellness in Supportive Housing (IWISH) program and how property staff, residents, and caregivers responded to it; and an *impact study*, to measure the effect of IWISH on key outcomes related to residents' use of healthcare services and housing stability.

The process study will focus on the 40 IWISH (treatment) properties and the 40 active control properties. The main data sources for the process study are those included in this Information Collection Request (ICR): questionnaires, interviews, and focus groups with program staff, residents, and caregivers. These data collection activities do not employ statistical methods. The study team will select respondents purposively. We will supplement these data collected directly by the study team with data collected by the IWISH properties, administrative data collected by the U.S. Department of Housing and Urban Development (HUD), and public use data.

The impact evaluation will analyze administrative data obtained for residents of all three demonstration groups—treatment, active control, and passive control. The main data sources for the impact study are Medicare Fee-For-Service claims, Medicaid Fee-For-Service claims, Medicare and Medicaid encounter data, HUD administrative data, and public use data to characterize the community. These data sources are not subject to the Paperwork Reduction Act (PRA) and are therefore not part of this ICR. They will be used to estimate the impact of the IWISH model on healthcare utilization, housing exits, and transfers to nursing homes and other long-term care settings. The impact of IWISH is the difference between the average outcomes among residents at IWISH properties and the average outcomes among similar residents in the control groups, estimated using experimental and quasi-experimental analysis methods. The community data will be used to ensure the treatment and control groups are evenly matched on community characteristics and for contextual analysis.

We will submit a second ICR in early 2020 to cover follow-up data collection to be conducted in summer 2020. We expect the follow-up data collection to consist of final questionnaires with IWISH and active control properties and interviews with service provider partners.

All of the data collection in this ICR will be done by Abt Associates and its subcontractor L&M Policy Research. The identification of respondents for each data collection activity is described below.

Selection of SSD Properties

HUD designed the SSD as a cluster-randomized controlled trial to allow rigorous measurement of the impact of housing-based supportive services on health outcomes, healthcare utilization, transitions to higher levels of care, and housing stability among HUD-assisted low-income elderly households in HUD-assisted Office of Multifamily Housing properties.

Using cluster randomization, HUD assigned eligible properties to one treatment and two control groups, in which 40 properties implement the IWISH model (the treatment) and 84 similar properties conduct business as usual. Significantly different outcomes for residents of the treatment versus the control properties will provide evidence that the IWISH model is achieving its aim.

Selection of properties to participate in the SSD began in January 2016 when HUD published a Notice of Funding Availability (NOFA) announcing the availability of $15 million in funds for the Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing and inviting owners of eligible federally assisted multifamily properties to apply.[1]

HUD received more than 700 applications in response to the SSD NOFA. The NOFA stated that HUD expected to constrain the demonstration to a select number of states based on the pool of applicants and property characteristics. After screening all applications for eligibility, HUD ranked states for the demonstration based on three factors: the number of properties with and without a current service coordinator; the rate of county-level fee-for-service enrollment among Medicare beneficiaries; and the number of initiatives funded by the Centers for Medicare & Medicaid Services (CMS) to improve care coordination for elderly persons. In each case, a higher number gave a state a greater chance of being selected for the demonstration.

Based on the rankings, HUD selected seven states (California, Illinois, Massachusetts, Maryland, Michigan, New Jersey, and South Carolina) and identified 185 properties across states as eligible for random assignment. HUD determined that it could fund up to 40 properties to implement the demonstration approach (treatment sites) and limited the

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[1]   https://www.hud.gov/sites/documents/2015SSDEMO-NOFA.PDF

demonstration to seven states in order not to spread the treatment sites too thinly and to permit a sufficient number of control sites in each state.

HUD randomly assigned properties to three groups: a treatment group that received grant funding to hire the RWD and WN and implement the demonstration; an active control group that did not receive funding for implementation but received an incentive for participating in the evaluation; and a passive control group that received neither an implementation grant nor an incentive.

The final demonstration sample includes 124 properties: 40 in the treatment group, 40 in the active control group, and 44 in the passive control group. At the time of random assignment, the treatment and control properties were found to be well balanced across the key characteristics that were available to HUD at the time and of significance to the evaluation.

The process study data collection that is the subject of this ICR will be limited to the treatment and the active control properties, as the owners of these properties entered into cooperative agreements with HUD that require their participation in evaluation activities. Prior to starting data collection, we will reach out to the Authorized Organization Representative of these properties to preview the evaluation activities and to identify a staff member (most likely the property manager) who will serve as the main point of contact for the study. HUD has a contractual relationship with the passive control properties governing their receipt and use of housing assistance funds, but no cooperative agreement regarding the demonstration. Therefore there is no expectation that passive control properties will participate actively in the demonstration though the evaluation will analyze administrative data for residents of these properties.

Identification of Respondents for Initial Questionnaire

In order to minimize respondent burden, we opted to limit the questionnaire to one primary respondent per property at each of the 40 treatment and 40 active control sites. For the treatment properties, we selected the Resident Wellness Directors (RWDs) to be the primary respondents because they work full-time at the properties and are the main point of contact for the IWISH demonstration. For the active control properties, we will conduct the questionnaire with the service coordinator if the property has one, as many of the questions concern service coordination activities. For the active control properties that do not have a service coordinator, we will conduct the questionnaire with the property manager. Although the plan is to conduct the questionnaire with one respondent per property, we have built time into the burden estimates for consultation with other staff as needed.

Identification of Respondents for Interviews

We expect to conduct interviews with all relevant property staff at the 40 treatment and 40 active control sites. At the treatment properties, the relevant staff are the RWDs, WNs, and housing property staff. At the active control properties, the relevant staff are the service coordinator (if the property has one) and the housing property staff.

Identification of Properties for Focus Groups

We plan to conduct a total of 24 focus groups: 18 focus groups at 12 treatment properties and six focus groups at six active control properties. Across all the properties, we are seeking a diversity of perspectives.

Treatment Properties

We plan to use the following criteria to identify 12 treatment properties for focus groups:

- **Geographic Location:** Because residents' experiences of IWISH may vary by state, and in order to have representation from each of the states in the study, we plan to hold at least one focus group with IWISH participants in each of the seven study states.

- **Health Resources:** The level of health resources in the community could affect how IWISH is implemented (particularly with respect to partnerships) and how residents experience IWISH. We plan to use the health component of the American Association of Retired Persons (AARP) Livability Index as a proxy for the level of health resources in the community. The health component of the AARP index includes two measures of healthcare quality (patient satisfaction and preventable hospitalization rate), one measure of access to healthcare (healthcare professional shortage areas), and three measures of healthy behaviors (access to exercise opportunities, obesity prevalence, and smoking prevalence). The demonstration properties are located in communities with scores on the health component of the AARP index that range from 17 to 90, with an average of 58. We plan to designate communities with a score of 43 or below (more than one standard deviation below the average score) as "low resource" communities, communities with a score between 44 and 72 (within one standard deviation of the average score) as "average resource" communities, and communities with a score of 73 and higher (more than one standard deviation above the average score) as "high resource" communities. Using these definitions, 8 of the treatment properties are in low resource communities, 25 are in medium resource communities, and 7 are in high resource communities. We will try to hold at least two focus groups in each community type.

- **Prior Service Coordination:** At the time of random assignment, 33 of the 40 treatment properties had service coordinators prior to IWISH. We plan to conduct at least two focus groups at properties that did not have service coordinators prior to IWISH.

- **Age of property (PRAC vs. non-PRAC):** Of the 40 treatment properties, 24 were developed before 1991, under the original Section 202 program, and 16 were developed in 1991 or later under the Section 202 PRAC program. We want to conduct focus groups at some older properties because they may have different

features that affect residents' experience of IWISH. We plan to conduct at least three focus groups at pre-PRAC properties.

- **Size category:** Of the 40 treatment properties, 75 percent have 50 to 115 units, 18 percent have 116 to 215 units, and 8 percent have more than 215 units. We plan to have at least one property in each size category (small, medium, and large) in the focus group sample, as the IWISH program could be implemented or experienced differently at smaller versus larger properties.

- **Willingness of the site to accommodate focus groups:** Although the Abt team will handle most of organizing and conducting the focus groups, we will need the support of the property manager and IWISH staff in order for the focus groups to be successful. As described below, we plan to hold the focus groups at the property and may need some assistance from property staff in recruiting focus group participants.

- **Non-English speakers:** We hope to conduct some focus groups with non-English speakers at properties with a high proportion of residents with limited English proficiency (LEP). We have the capacity within the evaluation team to conduct focus groups in English and Spanish and could bring in other language resources as needed. At this time, we do not have information on which properties have a large share of LEP residents, but we will be asking about LEP on the initial questionnaire and so will be able to take language into account in selecting focus group sites.

We will distribute the 18 focus groups across these 12 properties as follows: six properties have one focus group with IWISH participants; three properties have one focus group with IWISH participants and one focus group with residents who did not choose to enroll in IWISH; and three properties have one focus group with IWISH participants and one focus group with the caregivers of IWISH participants.

We will use PHL data on enrollment levels to select the three treatment properties where we will hold focus groups with residents not enrolled in IWISH. We will rank the 12 properties targeted for focus groups according to the percentage of residents enrolled in IWISH and will select three properties in the bottom third in terms of enrollment for the non-enrollee focus groups.

Active Control Properties

We plan to use the following criteria to identify six active control properties for focus groups:

- **Service Coordinator:** We plan to hold focus groups only in those properties that have had on-site service coordinators for the entire demonstration period (i.e., since at least October 2017). The reason for this restriction is that properties with service coordinators will be most comparable to those in the IWISH group in terms of what they offer residents and thus will provide the most relevant insight for the study's research questions.

- **Health Resources:** We plan to hold at least one focus group in each of the health resource categories (low resource, medium resource, and high resource) described above in the context of the treatment sites.

- **Geographic location:** In order to have some geographic diversity, we plan to hold focus groups in at least four of the seven states in the demonstration.

At each of the 6 active control group properties selected, we will hold one focus group with residents.

Identification of Respondents for Focus Groups

Focus Groups with IWISH Participants

The starting point for identifying IWISH participants for focus groups is the Population Health Logistics (PHL) data system that all IWISH properties will use to collect and store health and service information on IWISH participants. The PHL data collection is covered under ICR 201702-2528-001 and the consent process for IWISH participants covers the transfer of PHL data to the evaluation team.

We will use the PHL data to identify all the individuals enrolled in IWISH at the 12 focus group properties. We will then apply the following restrictions to ensure that the residents selected for the focus group have sufficient history with the property and are of the correct age to provide relevant information for answering the process study's research questions:

- **IWISH Enrollment.** Residents must have been enrolled in IWISH for at least 6 months prior to the focus group. For example, if the focus group is planned for July 2019, we would limit the sampling universe to participants who enrolled on or before January 1, 2019. This restriction is to ensure that residents have some experience with the IWISH program.

- **Residency.** Residents must have been living at the property for at least one year before the start of the demonstration on October 1, 2017. In other words, we would exclude any residents who moved in after October 1, 2016. This restriction is in place to ensure that focus groups participants have a point of comparison to IWISH.

- **Age.** Residents must be aged 62 or over as the start of the demonstration in October 2017. The demonstration is targeted to people aged 62 and over and this is the focus of the evaluation.

- **Language.** If we learn through the initial questionnaire with the RWD and through the PHL data that there is a large share of non-English speakers at the property, we may determine that we will hold a non-English focus group at that property. In that case, we will restrict the sample to speakers of the selected language. Otherwise we will not apply any language restrictions. If the focus group is to be held in English and a resident is not able to consent to the focus group (as described below) because

of language issues, then he or she will likely be excluded from the group, as is the case for others who are unable to consent.

Focus Groups with Residents Not Enrolled in IWISH

To select residents for the non-enrollee focus groups we will cross reference the HUD Tenant Rental Assistance Certification System (TRACS) data on the residents at the property against the list of individuals enrolled in IWISH as documented in the PHL. We will then apply restrictions so that the residents are not enrolled in IWISH, have sufficient history with the property, and are of the correct age to provide relevant information for answering the process study's research questions. Other than non-IWISH enrollment, the restrictions are the same as for the IWISH participant focus groups. The restrictions are:

- **IWISH enrollment.** Residents cannot have been enrolled in IWISH at any time since the start of the demonstration.

- **Residency.** Residents must have been living at the property for at least one year before the start of the demonstration on October 1, 2017.

- **Age.** Residents must be aged 62 or over as the start of the demonstration in October 2017.

- **Language.** Unless we determine that one of the groups will be conducted in a language other than English, we will not apply any language restrictions.

Focus Groups with Caregivers of IWISH Participants

The caregivers we are targeting for the focus groups are the informal caregivers of IWISH participants, not paid caregivers. Most will be friends and family members of IWISH participants. We will limit the focus groups to the caregivers of residents who have been enrolled in IWISH for at least six months, were living at the property for at least a year before the start of the demonstration and are aged 62 or over.

Focus Groups with Residents of Active Control Properties

The starting point for identifying participants in the active control group focus groups is the HUD TRACS data on the residents at the property. We will then apply the following restrictions to ensure that residents have sufficient history with the property and are of the correct age to be comparable to participants in focus groups at the treatment sites:

- **Residency.** Residents must have been living at the property for at least one year before the start of the demonstration on October 1, 2017.

- **Age.** Residents must be aged 62 or over as the start of the demonstration in October 2017.

- **Language.** Unless we determine that one of the groups will be conducted in a language other than English, we will not apply any language restrictions.

2. **Describe the procedures for the collection of information including:**

- **Statistical methodology for stratification and sample selection,**
- **Estimation procedure,**
- **Degree of accuracy needed for the purpose described in the justification,**
- **Unusual problems requiring specialized sampling procedures, and**
- **Any use of periodic (less frequent than annual) data collection cycles to reduce burden.**

Statistical Methods

Process Study. The data collection covered by this submission is intended to provide qualitative information to support a process study of the implementation of the SSD. The process study will qualitatively describe how IWISH was implemented at the treatment sites and how it was experienced by program staff, participants, and their caregivers, as well as how the IWISH implementation compares to the typical service coordination provided at HUD multifamily properties serving older adults.

The questionnaire respondents are chosen because they are the most relevant individuals at each site for providing the information requested in the questionnaire. The in-depth interview respondents constitute the full universe of relevant individuals at each of the study properties.

Focus group participants are limited in number and are not intended to represent all respondent types. Rather, the focus groups are designed to serve two main purposes: to provide more in-depth information on the range of experiences of residents and caregivers with IWISH and traditional service coordination and to gather additional information as an adjunct to the study's quantitative data collection to help interpret the results of the study's outcomes and impact analysis. We will not draw statistical inferences from the qualitative data covered in this ICR submission; instead, the analysis of administrative data (described below) will provide the main evidence of program outcomes and impacts.

Impact Study. Prior to engagement with Abt, HUD, designed a cluster-randomized controlled evaluation and randomly assigned eligible properties to treatment and control groups to support the evaluation. The number of demonstration treatment and active control sites was limited to 40 based on preliminary power analyses and budgetary constraints. The random assignment was designed and conducted to facilitate an impact evaluation such that causal inferences can be made.

To support the impact analysis, the study team will use linked HUD and Medicare and state Medicaid administrative data for HUD-assisted residents of the 40 treatment properties, the 40 active control properties, and the 44 passive control properties. The team will analyze approximately five years of person-level administrative data—two years of data prior to the start of the demonstration (October 2015 – September 2017) and three years of data covering the duration of the demonstration (October 2017 – September 2020).

To estimate the impact of IWISH on resident outcomes, the study team will conduct an intent-to-treat (ITT) analysis by comparing outcomes of residents in the treatment group and to those of residents in the active and passive control group properties, which will be pooled into one control group. The study team calculated minimum detectable effect size (MDES)[2] for the main impact analysis—the intent-to-treat (or ITT) analysis—for the following outcomes:

- **Days of unplanned hospitalizations.** The minimum detectable difference is 30.4 days of hospitalization per 1,000 resident months (or a 21 percent difference).

- **Primary care visits.** The minimum detectable difference is 59.6 visits per 1,000 resident months (or a 9 percent difference).

- **Housing exits.** The minimum detectable difference in the probability of housing exit is two percentage points. The minimum detectable difference in the probability of transferring to a nursing home is one percentage point.

In addition to the main impact analyses, the study team will conduct additional exploratory analysis of key outcomes to examine: non-linear trends in the cumulative effect of IWISH on healthcare utilization and spending during the demonstration; potential heterogeneity of the treatment effect across important subgroups of individuals; and the extent to which sample attrition due to deaths might bias the estimated impact of IWISH on utilization and spending.

Sampling of Participants for Focus Groups

Resident Focus Groups. After identifying appropriate potential resident participants at both treatment and active control sites, we will ask the RWD, service coordinator, or property manager (as appropriate) to review the resulting list for ability to participate in a 90-minute focus group. We will then invite a random sample of the remaining residents to participate in the focus groups and screen interested residents for their cognitive ability to participate. We will obtain written consent from focus group participants at the start of the focus group.

For focus groups with resident participants, the target size for these focus groups is eight participants, though we expect that we may need to pick a sample of 20 residents for each focus group to allow for declines and people who are not able to consent. The evaluation team determined that eight participants is an appropriate size for the focus groups after consulting the research literature on interviewing and conducting focus groups with older adults and seeking input from Abt Associates' staff with a background in clinical care for older adults. Two key resources were Barrett and Kirk (2000)[3] and Beuscher and Grando (2009).[4] The size of the group is a primary concern for focus groups with the elderly and disabled because of slower response times and the greater likelihood of distractions. Larger

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2   Based on the minimum effect sizes detectable 80 percent of the time when rejecting the null hypothesis at the 95 percent significance level ($p<0.05$), and assuming an intra-cluster correlation of 0.01.

3   Barrett, J., & Kirk, S. (2000). Running focus groups with elderly and disabled elderly participants. *Applied Ergonomics,* 31(6), 621-629.

focus groups are challenging for participants who are hard of hearing, as we expect many of our participants to be. Also, older people tend to take some time to recall memories and can be distracted by what others say. A smaller group allows all respondents to have time to speak and respond to questions and to each other.

Caregiver Focus Groups. After identifying appropriate potential caregiver respondents at treatment sites, we will invite a random sample to participate. Our preferred approach for identifying caregivers is to use the PHL system. If the PHL data do not contain information on caregivers, we would ask the residents that we recruit for participating in the IWISH focus group at that property whether they would be willing to provide information on the focus group to their caregiver. We would then mail the resident the introductory letter to provide to their caregiver and interested caregivers would contact the study team. If neither of these options is successful, we would ask the RWD to identify caregivers who might be willing to participate. We plan to hold the caregiver focus groups toward the end of the data collection period so that we can build on what we learn from the earlier site visits and focus groups and design the best approach for recruiting caregivers.

The target size for the caregiver focus group is 10 participants, though we expect that we may need to pick a sample of 20 caregivers for each focus group to allow for declines. Focus groups with non-elderly, non-disabled adults typically range in size from 10 to 12 participants. The evaluation team selected the lower end of this range because we anticipate that many of the caregivers may be older adults and may benefit from a smaller group size as discussed above.

Number of Focus Groups. The number of focus groups planned for this study was determined considering the total resources available for the study and the relative importance to the study's research questions of the data that could be obtained from each focus group type. Overall, based on Abt Associates' experience conducting focus groups for other research studies, the evaluation team believes that 24 focus groups are sufficient to meet the goals of the focus group data collection, which are to provide information on the range of experiences of residents and their caregivers and to provide context for interpreting the study's outcome and impact analysis.

The study design allocates the largest share of focus groups (12 of the 24) to focus groups with IWISH participants. This allocation reflects the importance to the process study of exploring participants' experiences with IWISH and the study team's expectation that IWISH participants will have diverse experiences with the program. We have allocated six of the 24 focus groups to residents of non-IWISH properties because a secondary goal of the process study is to understand how the experiences of IWISH participants differ from those of residents of the non-IWISH control properties. Two other areas of interest for the process study that are less central to the main question of IWISH implementation are the experiences of IWISH participants' caregivers and the reasons that some residents of IWISH properties

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4   Beuscher, L., & Grando, V. T. (2009). Challenges in Conducting Qualitative Research with Individuals with Dementia. *Research in Gerontological Nursing*, 2(1), 6-11.

chose not to participate in IWISH. We have allocated three focus groups to each of these populations.

The number of focus groups for each population type reflects the relative importance of that population's experiences to the process study's research questions and the study team's expectations for the diversity of views among each group based on the study team's expertise in conducting similar qualitative research. The study also has a budget limitation on the total number of focus groups that can be conducted.

3. **Describe methods to maximize response rates and to deal with issues of non-response. The accuracy and reliability of information collected must be shown to be adequate for intended uses. For collections based on sampling, a special justification must be provided for any collection that will not yield "reliable" data that can be generalized to the universe studied.**

We expect a 95 percent or better response rate from the staff at treatment and active control properties, because these properties have entered into cooperative agreements with HUD that require their participation in evaluation activities.

Based on past experience and the focus group literature, we expect a somewhat lower response rate from residents and caregivers invited to participate in the focus groups. The study team's conservative estimate for the percentage of focus group participants who will pass the cognitive screen and agree to participate is 50 percent; of those, we anticipate that 80 percent will attend the focus group. We expect that residents and caregivers will be motivated to participate in the focus groups to share their experiences, but that some will be apprehensive about participating in a group session and others will not pass the cognitive screen. Abt staff will conduct outreach to residents via a combination of mail, phone, email, and will consult with RWD, service coordinator, and property manager to get their input on the outreach approach. We will allow residents to bring their caregivers to the resident focus group if they choose to, which may make some residents more willing to participate.

All focus group participants[5] will receive a $40 gift card. The incentive amount is consistent with other studies of comparable populations and burdens.

4. **Describe any tests of procedures or methods to be undertaken. Testing is encouraged as an effective means of refining collections of information to minimize burden and improve utility. Tests must be approved if they call for answers to identical questions from 10 or more respondents. A proposed test or set of tests may be submitted for approval separately or in combination with the main collection of information.**

Initial Questionnaire

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[5] If a resident chooses to bring a caregiver to one of the resident focus groups, the resident will receive a gift card but not the caregiver. Caregivers who participate in the caregiver focus groups, where the caregiver is the target respondent, will receive a gift card.

We pretested the questionnaire with three treatment properties and four active control properties in September 2018 and plan to conduct another two pretests in early October 2018. We plan to spread the remaining interviews over October, November, and December. We plan to pretest the questionnaire first in paper form and then again after programming it into the online survey tool *Confirmit*, once finalized and approved by OMB.

The respondents to the seven pretest questionnaires unanimously said that the questions were clear and easy to follow. The respondents said they appreciated receiving the questions related to property staffing, programs, and partners in advance. The length of the pretest interviews were consistent with the study team's burden estimate of 45 minutes to an hour for the interview itself: four of the seven interviews lasted about 45 minutes, two interviews lasted about half an hour, and one interview lasted just over an hour. The estimated additional 30 minutes for scheduling and preparing for the questionnaire was also consistent with the pretest findings.

Site Visits and Interviews

We plan to conduct two site visits in March 2019 to test the procedures and approach. One of the site visits will be with a treatment property and one with an active control property. In addition, after an initial round of interviews with active control sites, we will compare the interview summaries from the interviews conducted in person to those conducted by telephone to identify any differences in the completeness of the information or the perceived level of candor from respondents. If we find significant differences, we will develop a plan to address them.

Focus Groups

We plan to schedule two focus groups with IWISH participants in advance of the others so that they can serve as a test of the procedures and protocol. After these first two groups are complete, the site visit team will meet to debrief. Depending on what we learn, we may propose modifications to the facilitator guide or the recruitment process that could be applied to the other categories of focus groups as well as the remaining groups of IWISH respondents. HUD's Contracting Officer's Representative will participate in Abt's debriefing meeting and will review any proposed modifications.

5. **Provide the name and telephone number of individuals consulted on statistical aspects of the design and the name of the agency unit, contractor(s), grantee(s), or other person(s) who will actually collect and/or analyze the information for the agency.**

HUD has contracted with Abt Associates to conduct the data collection. The data collection procedures will be similar to those used in other studies conducted by Abt Associates. The HUD Contracting Officer's Representative (COR) reviewed all the procedures and had them reviewed by other subject matter experts at HUD. If there are any questions about this submission, please call either the HUD COR, Leah Lozier (202-402-3013) or the Abt

Associates co-Principal Investigators, Gretchen Locke (617-349-2373) and Sara Galantowicz (617-520-2510).

In addition, Abt Associates and HUD have established an Expert Panel to review the evaluation design, progress, and findings, to maximize the rigor of the evaluation and its value to multiple stakeholders. The full membership of the panel is presented in Part A of this ICR. The following panelists have focused on the statistical aspects of the study's design:

- Partha Deb, PhD, Professor of Economics, Hunter College, City University of New York.
- Kosuke Imai, PhD, Professor of Politics and Director of Program in Statistics and Machine Learning, Princeton University.