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Making Permanent Supportive Housing Work in Rural America:

Understanding the Barriers to and Strategies for Implementing Permanent Supportive Housing in Rural Continuums of Care

THE HOUSING INITIATIVE AT PENN
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Executive Summary

Homelessness is increasing across the country, including in America's small towns and rural communities. Between 2018 and 2024, the rural homeless population increased by more than 25 percent. The largest increases were among people experiencing chronic homelessness without shelter. A more robust response in rural areas is needed to meet the needs of this population. Permanent supportive housing (PSH), an intervention that pairs long-term affordable housing alongside voluntary supportive services, has been demonstrated to be effective in keeping highly vulnerable people stably housed. Beginning in the 2000s, the Department of Housing and Urban Development (HUD) adopted PSH as a key strategy in responding to chronic homelessness across the country. However, this model was developed in urban settings, and little evaluative or practice-oriented research has been conducted to understand the implementation of PSH outside of urban areas.

This report draws on 45 semi-structured interviews with rural stakeholders and new analysis of HUD administrative and American Community Survey data, to better understand rural homelessness and the role PSH currently plays in addressing it. The report identifies barriers rural organizations face in implementing PSH and examines strategies to overcome them.

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Key Findings

- **On average, rural areas have lower rates of documented homelessness, less robust homelessness response systems, and fewer PSH beds compared to urban and suburban areas.** In January 2024, over 123,000 people, 16% of all those nationally, were identified as experiencing homelessness in rural Continuums of Care (CoCs). Of this population, 44% were experiencing unsheltered homelessness, a rate higher than in urban and suburban locales. In rural CoCs, about 1 in 4 year-round beds for people experiencing homelessness are dedicated to PSH compared to about 1 in 3 elsewhere.
- **The ability of rural communities to develop and operate PSH is constrained by the underdeveloped capacity of local organizations and low density of people, housing, services, and infrastructure.** These factors make PSH more difficult to implement in rural than urban areas.
- **High capital requirements make single-site PSH projects in rural areas cost-prohibitive.** Most available capital support is not structured for scattered-site PSH, which is much more common than single-site PSH in rural areas.
- **Undercounts of chronic homelessness in rural areas can erode community support for establishing PSH.** These undercounts occur due to large distances and few staff to conduct Point-In-Time counts and restrictive HUD definitions.
- **Funding to support PSH development is often inaccessible in rural communities.** Funding sources are often technically complex to access for CoCs operating at small scales and with limited organizational capacity.
- **Shortages of affordable rental housing in rural areas create delays in placing tenants into PSH.** Affordable housing shortages led to higher rents, fewer suitable units for rent, and stricter tenant eligibility criteria.
- **Program restrictions on the use of rental assistance subsidies limit the pool of potential units suitable for rural PSH.** Rental subsidies are essential to make PSH rents affordable, but they have strict requirements on reasonable rents and housing quality inspections.
- **Underdeveloped and thinly distributed support services infrastructure combined with limited transportation options reduces access to essential services in rural areas.** These factors make consistent, regular support services difficult to deliver.
- **Insufficient long-term funding for supportive services that is burdensome to access compromises frequency and quality of service delivery, especially case management.** Rural service providers incur additional costs due to large distances between clients and higher caseloads.

Recommendations

- **Provide flexible, long-term funding to address rural homelessness.** HUD should continue flexible funding opportunities for PSH that are responsive to the additional costs of operating in rural settings and include a proportion of funds dedicated to expand rural organizational capacity. States governments should expand funding opportunities for PSH that are accessible to rural communities, especially given expected federal funding cuts.
- **Reduce administrative requirements to obtain and maintain PSH funding.** Federal, state, and local agencies and organizations involved in the funding or implementation should reduce administrative requirements and streamline processes.
- **Create evidence on and provide support for rural PSH implementation.** Researchers should conduct evaluative and practice-oriented research to better understand rural PSH program success, essential intervention components, and cost-effective implementation. Opportunities for peer learning and support, as well as technical assistance should be sustained and expanded by HUD or other philanthropic and research stakeholders

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Introduction

The United States is a large country comprised of populous cities and suburban enclaves, small towns, and wide-open spaces that stretch across mountain ranges, arid plains, river deltas, and rugged coastlines. Across these landscapes, increasing numbers of Americans are becoming homeless as housing costs rise. This is true not only in America's big cities, where homelessness has long been recognized as a significant issue, but also in its smaller towns and rural communities. Between 2018 and 2024, the rural homeless population has increased by more than 25% (de Sousa & Henry, 2024)[1]. In January 2024, over 123,000 people, 16% of those nationally, were identified as experiencing homelessness in rural Continuums of Care (CoCs). Unsheltered chronic homelessness is the primary driver of this rise in rural homelessness. More than 40% of people experiencing homelessness in rural areas are unsheltered, a disproportionately high rate relative to urban and suburban locales. As unsheltered homelessness increases in rural areas, a more robust response to meet the needs of this population is required.

Permanent supportive housing (PSH), an approach to responding to homelessness that combines permanent affordable housing and voluntary supportive services, has been repeatedly shown to be highly effective at keeping some of the most vulnerable people, particularly those with disabilities who have had multiple experiences of homelessness, stably housed (Peng et al., 2020). Beginning in the early 2000s, HUD began to provide funding for PSH as a key strategy in responding to chronic homelessness. Implementing PSH often involves cross-sector collaboration and can be administratively intensive. Marshaling the necessary resources and community support to establish a PSH project can be highly challenging, especially for organizations with smaller budgets and limited capacity. Even once in place, administering the housing subsidies on which PSH depends can be difficult, particularly in an environment where affordable housing is in short supply. Finally, coordinating and providing ongoing, high-quality supportive services that are critical to the intervention's success often requires creative strategies and persistent advocates.

1 All original data work in this report includes data from CoCs in the 50 U.S. states and the District of Columbia; U.S. territories are excluded.

While these implementation challenges exist in various forms across communities nationwide, the ways in which they manifest in rural communities are defined by the features of these places. On average, rural areas tend to access fewer federal resources, both absolutely and per capita, to assist people experiencing homelessness. Many of the typical challenges involved in establishing, operating, and sustaining PSH in an urban setting are exacerbated in rural communities where service providers are tasked with serving small populations spread across vast distances. This report documents the specific ways in which the implementation challenges associated with PSH manifest across rural landscapes as well as some of the strategies that have emerged for overcoming these challenges. The report begins by outlining the core components of PSH and the methods used to investigate rural PSH implementation. The findings present quantitative and spatial data on the geography and prevalence of homelessness in rural areas and the use of PSH in these communities before discussing qualitative findings from interviews with continuum of care (CoC) stakeholders on the barriers to rural PSH implementation. Finally, the report offers recommendations to bolster PSH in rural America.

Background on Permanent Supportive Housing

PSH provides permanently affordable housing integrated with ongoing support services. The intervention is most often used to help stabilize highly vulnerable people experiencing chronic homelessness who face complex and interrelated health problems (**"Definition of Chronic Homelessness"**). To resolve and manage these complex problems, an array of supportive services

across multiple systems, in addition to ongoing housing assistance, is required. PSH programs typically rely on a range of funding sources to provide housing and comprehensive supportive services as residents have very low incomes.

Almost two decades of research demonstrates that PSH is effective at addressing chronic homelessness. A systematic review of 15 studies found PSH significantly increased long-term housing stability compared with usual care (Aubry et al., 2020). Other studies have found that PSH is highly effective in engaging people in treatment for substance use disorders and improving their health (Tsemberis, Gulcur, & Nakae, 2004). However, research on PSH's effectiveness in rural settings is limited. A systematic review of PSH research among people experiencing homelessness with disabilities found no studies evaluating programs in rural areas (Peng et al., 2021). The handful of studies discussing PSH in rural settings do not attempt to directly evaluate the intervention's impact on homelessness (Marshall et al., 2022; Henwood, Melekis & Stefancic, 2014; Stefancic et al., 2013). Program effectiveness is contingent upon faithful delivery of the core components of the intervention (known as "high-fidelity implementation"). An understanding of the extent to which PSH is operating in rural areas and the degree of fidelity to the program model is, therefore, an essential first step to ensuring rural PSH is effective at addressing chronic homelessness.

In this report, we find that people involved in the implementation of homeless programs use the term "permanent supportive housing" in three distinct, if sometimes overlapping, ways (**"Understanding PSH"**). First, the term is used to refer to the holistic approach to supporting vulnerable populations through the integration of social services and housing that emerged in the 1960s after the federal government began to "deinstitutionalize" people with serious mental illness (Padgett, 2024). Second, the term PSH is used in reference to an evidence-based intervention that combines permanent housing with supportive services for people with disabilities who are experiencing or at risk of experiencing homelessness. Supportive housing was first defined in the McKinney Homeless Assistance Act in 1987. Third, PSH is a program model that serves people experiencing homelessness under the "Housing First" model that emphasizes the provision of safe and affordable housing without preconditions, accompanied by voluntary supportive services. The "Housing First" model was created by Sam Tsembris in the Pathways to Housing program in 1992 and served as the foundation for subsequent

Definition of Chronic Homelessness

HUD defines "chronically homeless" as a person who:

a) is homeless and lives in a place not meant for human habitation, a safe haven, or emergency shelter;

b) has been homeless or living in a place not meant for human habitation, safe haven, or emergency shelter for at least one year or on at least four separate occasions in the last three years; and

c) diagnosed with substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments due to brain injury, or chronic physical illness or disability.

Understanding PSH

Supportive housing can be understood in three ways, as:

1) An approach to supporting vulnerable populations through the integration of support services and housing;
2) An evidence-based intervention combining permanent affordable housing with support services for chronically homeless individuals;
3) A program model serving people experiencing homelessness according to "Housing First" principles.

PSH programs across the country (Tsemberis & Eisenberg, 2000). Today, much of the funding for PSH comes from HUD, which stipulates specific criteria for determining persons and activities eligible for federal funding.

The US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration has developed and defined several core components of PSH based on rigorous research (SAMHSA, 2010) ("**Core Components of PSH**"). Regarding housing, PSH requires tenants to have similar choices in their housing and living arrangements that other individuals at their income level might have. Tenant preferences over their neighborhood, proximity to amenities (e.g., transportation, shops, and recreation), and building and unit type should be taken into consideration. Once a tenant selects a housing unit, it should be without limits to duration of stay, meet minimum quality standards, be integrated within a local community to the extent possible, and cost the tenant no more than 30% of their income. Tenants also occupy the housing with full tenancy rights, meaning they have the same rental protections as other renters, including control over their living space and limits to landlord or property owner entry.

Core Components of PSH

SAMHSA identifies several essential components of PSH:

- Housing choice
- Integrated, permanently affordable housing
- Full tenancy rights
- Separation of housing and services
- Flexible, voluntary support services

A crucial component that differentiates PSH from residential treatment facilities is the functional separation of housing provision from support services (Tsai, Mares & Rosenheck, 2010). To avoid feelings of coercion, it is recommended that property management and supportive service staff are provided by different organizations or, at the very least, different staff members whose roles do not overlap (SAMHSA, 2010). Consistent with a "Housing First" approach, PSH offers a place to live rather than a place to be treated (Leff et al., 2009). Further, a tenant's housing is not conditional on their participation in any service (Tsemberis, 1999). Support services are voluntary, flexible to the needs and preferences of the tenant, and multi-disciplinary in that they address a broad range of needs from mental health treatment to public assistance access.

Methods

In this report, we explore three primary research questions: 1) What is the scope and geography of rural homelessness and PSH in the United States? 2) What barriers do rural CoCs face in implementing PSH? 3) What strategies could rural CoCs and service providers, local and state governments, and HUD adopt to overcome these challenges to PSH implementation? To do this and to situate our findings within the existing policy landscape we draw on the existing literature on PSH and rural service provision, analyze publicly available HUD data on homelessness and PSH, and conduct semi-structured interviews with 45 CoC stakeholders.

Spatial Data Collection and Analysis

To understand the scope and geography of rural homelessness and PSH, we gathered and joined four publicly available data sources to identify geographical variation across CoCs (**Table 1**). To join datasets at different geographic units of analysis (Census tract and CoC), we conducted a spatial join between 2020 Census tracts intersected with 2024 CoC boundaries. In most cases, CoC boundaries lined up with county boundaries, which neatly contain tracts. However, there are some CoCs that contain only portions of counties. In these cases, and where Census tracts were divided

Table 1. Data sources for quantitative and spatial analyses

Data Source	Year	Geography	Indicators
American Community Survey, five-year estimates; Census Bureau	2020	Census Tract	Population-level data, poverty rate, racial and ethnic characteristics, benefit take up rates
Continuums of Care Boundaries, Housing and Urban Development	2024	Continuum of Care	Boundaries of CoCs, geographic classification
Housing Inventory Count, Housing and Urban Development	2024	Continuum of Care	Availability of PSH beds
Point in Time Count, Housing and Urban Development	2024	Continuum of Care	Number of people experiencing sheltered, unsheltered, and chronic homelessness

between two or more CoCs, Census tracts were assigned to the CoC in which at least 50% of the land mass was contained. The resulting dataset provided a relational crosswalk table between CoC boundaries and Census tracts. To ensure accuracy, the coordinate reference systems of both layers were standardized prior to the joining of the datasets.

CoCs that fall within the 50 states and District of Columbia were included in the quantitative and spatial analyses. CoCs that coordinate services in US territories were excluded. The spatial join, tables, and maps in this report were created in RStudio. The spatial join between Census tracts and CoCs is publicly available through the Housing Initiative at Penn's GitHub repository: https://github.com/housinginitiative/coc_to_tract_crosswalk.

Interview Data Collection and Analysis

Between February 2024 and March 2025, the research team conducted semi-structured interviews with 45 individuals involved in the development, operation, and management of PSH in rural communities. To recruit interviewees, we employed a mixed sampling strategy to ensure our findings represented the majority of rural CoCs in the country and incorporated perspectives from a diverse set of professional roles and organizations involved in multiple stages of rural PSH implementation. We began recruitment by focusing on leaders at CoC collaborative applicant organizations, ensuring our sample represented wide variation in CoC geographic location, number of PSH units, and number of people experiencing (chronic) homelessness. Contact information was obtained through public information posted on HUD's website about the collaborative applicant organization. When contact information was out-of-date, we visited the collaborative applicant organization's website and contacted someone on their leadership team. During this initial round of data collection, we used snowball sampling by asking interviewees to identify key PSH stakeholders and organizations participating in their CoC or region. In the later stages of data collection, we focused on interviewing leaders of rural CoCs that better represented the "average" rural CoC.

Interviewees represented a broad range of organizations, including CoC Collaborative Applicants ("**CoC Collaborative Applicant**"), nonprofit service providers, local, state, and federal governments, advocacy groups, and housing developers. Of the 34 organizations representing

CoC Collaborative Applicant

The Collaborative Applicant is the organization responsible for applying for funds to plan and coordinate a CoC's response to homelessness. In practice, the organization is usually a non-profit or government agency involved in serving people experiencing homelessness. The Collaborative Applicant also supports other organizations in applying for HUD funds.

a specific CoC, interviewees represented 31 rural CoCs in 29 states and across all major regions of the country (**Table 2**). Overall, the interview sample included representatives from rural CoCs that cover 59% of the population living in rural CoCs nationwide. Homelessness in general occurs at a slightly lower rate in the rural CoCs in our sample than in rural CoCs overall, as does chronic homelessness. Even though sampled CoCs have lower rates of documented homelessness relative to rural CoCs more generally, they have roughly the same number of PSH units in proportion to the total population, suggesting that CoCs in the sample had marginally more capacity to meet the needs of their communities relative to rural CoCs as a whole. Interviews provided insight into the barriers faced by rural CoCs in establishing, operating, and sustaining PSH programs as well as the successful models of rural implementation of PSH. Interviews lasted for about 60 minutes, with a range of 29 minutes to 71 minutes. Interviews were audio-recorded with participant consent, professionally transcribed using a paid transcription service, and uploaded to qualitative data analysis software. Every 10 interviews, the research team wrote analytic memos to synthesize emerging themes and made modifications to the interview guide to explore emerging topics and avoid data saturation.

Qualitative analysis proceeded in two main stages. First, qualitative data were condensed through a flexible coding approach that involved applying broad index codes to group similar interview topics (Deterding & Waters, 2021). Next, guided by the study's overarching research questions, a narrower set of analytic codes were applied within each index. Throughout this process, the research team met regularly to ensure consensus on the definition and scope of each code. Based on the final analytic codes, key themes were extracted.

Table 2. Breakdown of interviewees by organization type and region

		Frequency	Percent
Organization type	Local or state government	10	22.2%
	Nonprofit service provider or homelessness coalition	18	40.0%
	Housing authority	5	11.1%
	Philanthropic foundation	2	4.4%
	Advocacy organization	7	15.6%
	Nonprofit housing developer	2	4.4%
	HUD/federal government	1	2.2%
Region	Northeast	7	15.6%
	South	11	24.4%
	Midwest	13	28.9%
	West	9	20.0%
	Nationwide	5	11.1%

Findings

The Geography of Rural Homelessness

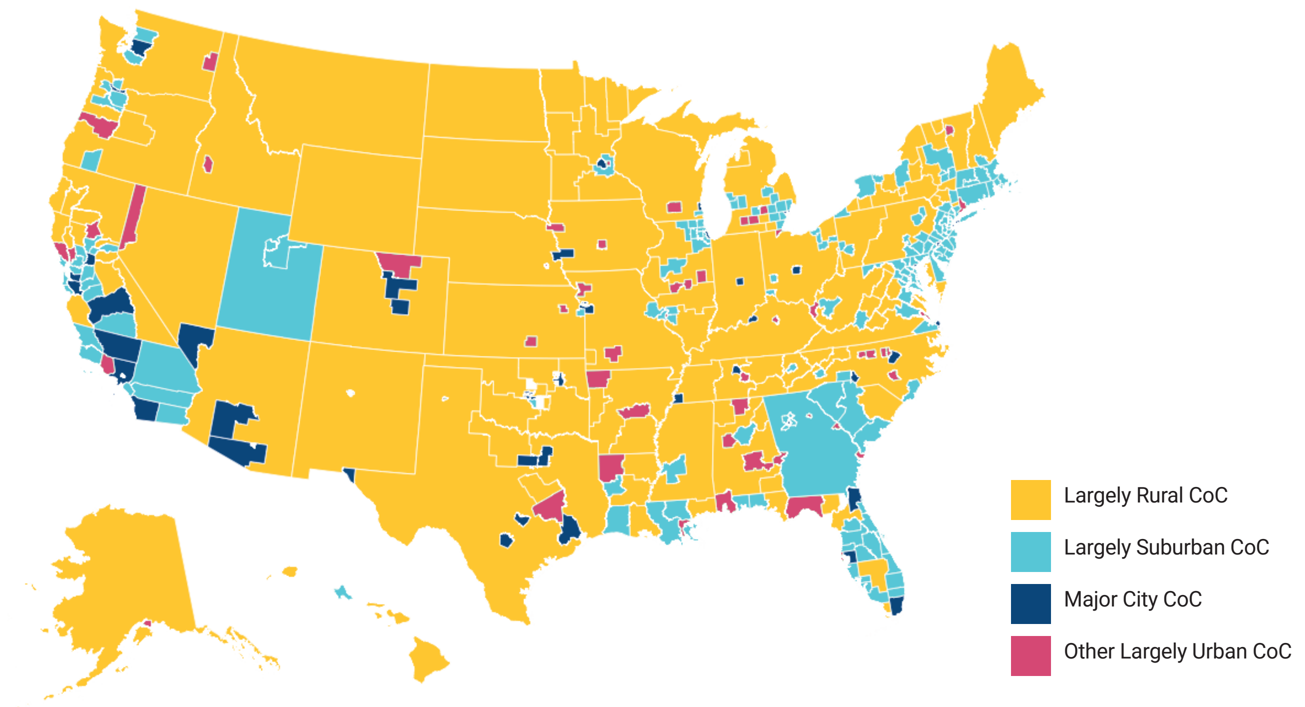
Understanding Rural Continuums of Care

Continuums of Care (CoCs) are local or regional administrative bodies comprising governments, nonprofits, and other organizations responsible for coordinating resources and services to address homelessness within a specific geographic area. First established 30 years ago and codified in 2009 in the HEARTH Act, the CoC system was envisioned to promote a more unified response to homelessness at the local level. The organization that leads each CoC (known as the "**Collaborative Applicant**") must submit a plan for a community-level homelessness response alongside their applications for program funding from HUD. Additionally, CoCs are tasked with establishing and maintaining a unified record-keeping system (through the Homeless Management Information System) to track and prioritize assistance for people seeking support through service providers connected to the CoC. Finally, CoCs are responsible for collecting data about the prevalence of homelessness in their service area through an annual Point-in-Time (PIT) count.

Across the country, there are 381 CoCs. The CoCs are classified by HUD into four geographic groups: 48 "Major City," 61 "Other Largely Urban," 164 "Largely Suburban," and 108 "Largely Rural" CoCs. Our study focuses on the 108 CoCs classified as "Largely Rural," which we refer to as "rural CoCs."[2] Together, rural CoCs coordinate services across approximately 85% of the country's landmass and for about 30% of the population. While rural CoCs are spread throughout the country, CoCs classified as Major City, Other Largely Urban, and Largely Suburban tend to be concentrated along the coasts and in the Midwest (**Figure 1**). In large metropolitan areas, CoCs generally map neatly onto other administrative boundaries, such as city and county

2 While CoCs classified by HUD as Largely Rural sometimes include smaller urban and suburban areas, the majority of residents in these CoCs live in areas defined as rural.

Figure 1. Geographic Classification of Continuums of Care in the United States



Data Source: HUD CoC 2024 Boundary File

government jurisdictions. For instance, the Major City CoC that represents Philadelphia has the same boundaries as the city, county, and school district. By contrast, many rural CoCs encompass tens, if not hundreds, of other administrative boundaries. For example, Texas' Balance of State CoC represents 215 counties.

Rural CoCs encompass geographically, economically, and culturally diverse areas, with a great deal of variation occurring both within and between CoCs (**Table 3**). The total population of rural CoCs ranges from over 11 million people in the Texas Balance of State CoC to under 34,000 in the CoC serving Alpine, Inyo, and Mono Counties in east-central California. Likewise, the density of these CoCs varies from less than one person per square mile in Alaska's Balance of State CoC to 222 people per square mile in the CoC that coordinates services in Mississippi's Jackson County.

On average, poverty occurs at a similar rate in rural CoCs as compared to Major City and Other Largely Urban CoCs. However, renters in rural CoCs are less likely to be rent-burdened relative to renters in other markets, and there tend to be considerably more vacant units than in other areas. In 38 rural CoCs, less than 40% of renting households are cost burdened, yet in 10 rural CoCs, more than 50% of renters are cost burdened. Twenty-four rural CoCs, primarily located in the South, have vacancy rates exceeding 20%, and one, the Wyoming State CoC, has a vacancy rate of 44%. Other rural CoCs face much tighter housing markets—a sign of the variation in the housing landscape across rural communities. Likewise, a similar proportion of households access SNAP benefits or other public assistance in rural CoCs relative to their counterparts in major cities (**Table 3**).

The Prevalence of Rural Homelessness and PSH

In January 2024, over 123,000 people in rural CoCs were identified as experiencing homelessness. This figure represents about 16% of people identified as experiencing homelessness nationally. Of this population, 44% were experiencing unsheltered homelessness in rural areas, a disproportionate

Table 3. Average and range of geographical and demographic characteristics by CoC type

		Largely Rural CoC	Largely Suburban CoC	Other Largely Urban CoC	Major City CoC
Number of CoCs		108	164	61	48
Total population	median	427,214	548,236	321,122	1,140,958
	range	33,667-11,502,075	64,973-7,384,993	97,299-960,565	457,066-9,055,673
People per square mile	median	61	529	452	1,603
	range	1-222	18-15,066	65-16,610	110-28,239
People in poverty (%)	median	14%	11%	13%	14%
	range	7-26%	4-21%	7-26%	7-32%
Rent burdened renter households (%)	median	41%	47%	47%	49%
	range	31-57%	37-61%	35-60%	36-60%
Vacant housing units (%)	median	15%	7%	9%	8%
	range	7-44%	3-41%	4-19%	4-22%
Households receiving cash public assistance or food stamps in the past year (%)	median	14%	12%	12%	14%
	range	6-22%	3-33%	4-22%	7-39%

Data Source: American Community Survey 5-Year Data (2023)

amount compared to urban and suburban locales. While Major City CoCs have the highest rates of homelessness on average, they also have larger homelessness response systems, as measured by the number of shelter beds (**Table 4**). In contrast, rural CoCs have the lowest rates of homelessness but also the smallest homelessness response systems on average. Planning grants are generally awarded as a proportion of total funds from HUD, so CoCs that receive less funding from HUD also receive less support for the coordination of activities.

On average, 11 per 10,000 people are identified as experiencing homelessness in rural CoCs, ranging from 2 per 10,000 people in West Virginia's Balance of State CoC and Wyoming's Statewide CoC to 161 per 10,000 people in Alaska's Balance of State CoC. On average, 16% of those identified as homeless are classified as chronically homeless in rural CoCs, ranging from under 5% in 12 rural CoCs (mostly in the Midwest) to over 40% in Tennessee's Appalachian Regional CoC and the North Dakota Statewide CoC.

Among all homeless housing tracked in the annual Housing Inventory Count, a smaller proportion of beds are dedicated to PSH in rural CoCs relative to other CoCs. In rural CoCs, about 1 in 4 (24%) year-round beds for people experiencing homelessness are dedicated to PSH. In Major City, Other Largely Urban, and Largely Suburban CoCs, the proportion is at least 1 in 3 (37%, 34%, and 33%, respectively). Eighteen rural CoCs, most in the South or Southwest, have fewer than one PSH bed per 10,000 people.

Table 4. Average and range of homeless population characteristics by CoC type

		Largely Rural CoC	Largely Suburban CoC	Other Largely Urban CoC	Major City CoC
Total people experiencing homelessness	median	561	702	579	2,921
	range	56-10,081	55-11,552	86-3,085	311-140,134
Rate of homelessness per 10,000 people	median	11	12	17	26.5
	range	2-161	1-109	3-8	5-164
Proportion of homeless population unsheltered	median	38%	22%	27%	34%
	range	0-100%	0-91%	2-74%	2-73%
Proportion of homeless population classified as chronic	median	16%	18%	22%	24%
	range	0-46%	0-64%	3-68%	3-51%
Shelter beds per 10,000 people*	median	8	8	14	17
	range	0-58	1-105	18-688	4-132
PSH beds per 10,000 people	median	4	7	11	17
	range	0-65	0-46	0-58	2-176
Proportion of all beds that are PSH**	median	24%	34%	33%	37%
	range	0-76%	0-70%	0-80%	8-67%

Data Source: American Community Survey 5-Year Data (2023), HUD's Point-in-Time Count Estimates (2024), and HUD's Housing Inventory Count (2024)

* While CoCs classified by HUD as Largely Rural sometimes include smaller urban and suburban areas, the majority of residents in these CoCs live in areas defined as rural.

** PSH as a proportion of Emergency Shelter, Transitional Housing, Save Haven, Rapid Rehousing, PSH, and other units tracked in HUD's Housing Inventory Count defined as rural.

Barriers to Rural PSH Implementation: Key Findings

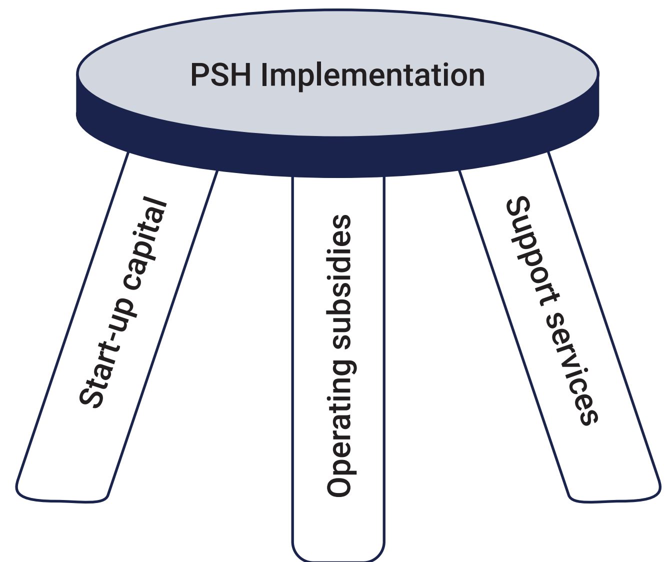
The Importance of Organizational Capacity and Density in Homelessness Response

The implementation of PSH is often referred to as a three-legged stool, requiring start-up capital and funding for building or acquiring housing units, operating subsidies to cover rent and property maintenance, and supportive services to address tenant needs (**Figure 2**). To effectively implement a high-fidelity PSH project, all three legs of the stool must be securely funded, efficiently operated, and consistently delivered. During interviews, two overarching themes repeatedly arose during the discussion of implementation barriers: organizational capacity—the financial resources, staff time and expertise, trusted leadership, and effective partnerships that an organization can use to create and operate PSH programs—and density—the concentration of people, housing, services, physical infrastructure, and other amenities in a geographic area. Organizations with higher capacity operating in higher-density areas tended to have greater success in implementing PSH than organizations with limited capacity in very low-density areas. Interviewees described limited organizational capacity and the lack of density, intrinsic to rural areas, as fundamental challenges to providing PSH at virtually every phase of implementation and across each aspect of the intervention.

CoCs play a crucial role in linking communities to the resources available through HUD to support responses to homelessness, such as PSH. At the CoC level, capacity gaps create difficulties in documenting homelessness, building expertise in PSH as a strategy, and securing long-term support for PSH. A lack of organizational capacity is very often the result of a lack of resources. For CoCs, especially in rural areas, HUD is the primary, and sometimes only, provider of resources. The maximum amount of funding a CoC is eligible for is determined either based on the population and poverty rate (alongside other indicators of housing insecurity) or on the funds required to maintain existing programs within the CoC, whichever is greater. However, even as funding allocations vary, some of the key obligations of CoCs remain constant regardless of organizational capacity or location density. Many of these key obligations are much more time-consuming and complex to complete. For example, conducting the HUD-mandated annual Point-in-Time count to enumerate the homeless population and region-wide Coordinated Entry system to assess client need and match them with appropriate services is more challenging across vast geographic areas in low-density rural regions. Fundamentally, there is a mismatch between the scale of a rural CoC's work—multi-county, regional, and even state—and the scale of their resources—often only one or two full-time staff. One technical assistance provider put it this way:

> *"How would less than one person carry out a PIT count, do training and capacity building for providers, make sure that folks are getting monitored, make sure they have support? It's just so many things that it's like it doesn't really make sense that one person could carry all of those things out."*

Figure 2. Three-legged stool of PSH implementation



A very small staff was typical of almost all the rural CoCs we interviewed. Even in the rare rural CoCs with adequate staffing, CoC stakeholders still faced challenges related to the low density of people, housing, and other social and medical service providers in rural areas. The high vulnerability and complex problems facing many PSH residents can require high-intensity case management. One common model, Assertive Community Treatment, requires a multidisciplinary team of psychiatrists, health specialists, nurses, peer support workers, and case managers, highly accessible services delivered at home or nearby, 24-hour crisis management, and low staff-to-client ratios. In areas with limited service infrastructure, very few of these components are likely to be implemented with fidelity. The following sentiment shared by a rural service provider was supported by many other interviewees:

> *"Housing first was built for areas that have services that can be wrapped around. And if you put somebody outside of any city, they ain't going to get wrapped. They're just not. And even in [a hub community], it's hard for us to wrap around with services because there are some things that just don't exist here."*

The core components of PSH related to housing are also highly difficult to implement in regions lacking enough affordable and accessible housing. Developing and securing housing units for PSH in remote areas and often across vast distances is particularly costly on a per-unit or per-resident basis. Rapid placement of clients in affordable housing, while offering a choice over housing type and neighborhood, was rarely achieved in rural PSH. Small towns often do not contain enough affordable rental housing stock that meets basic habitability standards and is managed by landlords willing to rent to PSH residents to allow clients to have meaningful choice.

Throughout the report, we highlight the specific ways in which both limited organizational capacity and lack of density in housing, services, and physical infrastructure serve as barriers to implementing PSH. The remaining findings are structured according to the three fundamental aspects of PSH implementation.

Barriers to Implementation: Start-Up Capital and Funding

Finding 1: High capital requirements make single-site PSH projects in rural areas cost-prohibitive

For start-up of single-site PSH projects, major costs include financing or capital costs for development. Though research has repeatedly demonstrated that PSH is cost-effective, its benefits are not as easy to identify and measure (National Academies of Sciences, Engineering, and Medicine, 2018). Benefits like reductions in emergency room visits, legal proceedings, jail stays, and shelter stays can be tricky to monetize. A 2021 review of 17 PSH programs in the United States found that for every $1 spent on PSH, $1.80 was generated in benefits (Jacob et al., 2022). These benefits are also rarely accrued by the organizations investing in or implementing PSH projects. However, interviewees asserted that making the case for the cost-effectiveness of PSH in rural settings was more complicated and depended on the model proposed.

Several interviewees simply stated that the high capital requirements for single-site PSH were prohibitive for all but the largest rural organizations. The coordinator of a large rural CoC in the South explained:

> *"We don't fund new construction just because it's too expensive...The amount of money that we're distributing is not, or that we can apply for, it's not large enough to build new permanent supportive housing. So the expansion that we've seen has honestly mostly been through Rapid Rehousing."*

Practically, available capital support is structured for either new multi-unit buildings or the rehabilitation of existing buildings. This type of funding can be useful in constructing purpose-built PSH buildings where units are specifically geared towards PSH tenants and on-site supportive services. Such buildings have some advantages for PSH programs; gathering PSH residents together in one place can mean they offer one another support, delivering supportive services requires no travel and can be available more frequently, and

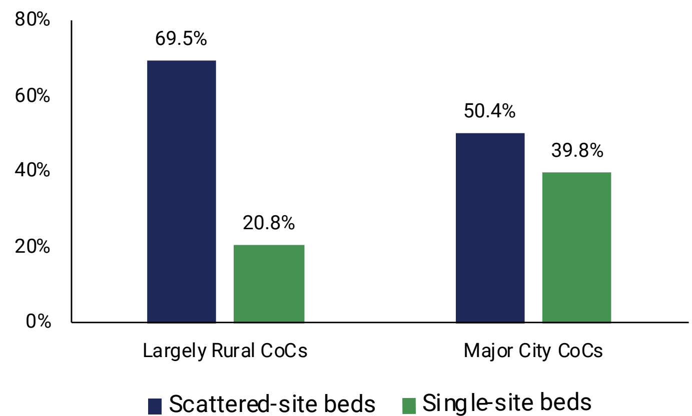
buildings and units can be constructed with the needs of this population in mind, such as using trauma-informed building design (Bollo & Donofrio, 2022).

Nationally, the Low-Income Housing Tax Credit (LIHTC) program is the largest source of affordable housing. It supports the acquisition, rehabilitation, and new construction of affordable housing through the issuance of tax credits. Though scattered site projects are eligible under LIHTC, some interviewees identified rural PSH projects as too small to be competitive for tax credits or to benefit from economies of scale. When calculated on a per-resident basis, the cost to construct and maintain rural PSH units is higher due to the smaller-scale buildings accommodating fewer individuals. Higher costs are also attributable to less developed rural infrastructure. One technical assistance provider we spoke to summarized the challenges with new rural PSH projects as the:

> *"Lack of funding and the scarcity of developers, the complexity of the land infrastructure and the limited infrastructure between transportation and just getting electrical systems and piping and plumbing and all of those systems to rural communities without there. It's really expensive. So, it's like that requires, I think, a lot more resources."*

Despite these financial barriers to establishing new, single-site PSH projects, rural CoCs were still able to offer PSH, often through a scattered-site model in which individual or small numbers of units are rented from private landlords. In single-site PSH, buildings include multiple PSH units and are generally developed with some public support. Every rural CoC coordinator we spoke with had more scattered-site than single-site PSH units in their rural region. This finding is supported by our analysis of HUD data, which shows that 69.5% of PSH beds are in scattered-site models in Largely Rural CoCs compared to 50.4% in Major City CoCs (**Figure 3**). Notably, a substantial minority (one in three, approximately) of rural PSH units still are single-site. Many of these units are likely in "hub communities" where essential services are centralized and density is considerably higher.

Figure 3. Proportion of PSH beds in scattered- or single-site models for all Largely Rural and Major City CoCs



Data Source: HUD's Housing Inventory Count (2024)

The emphasis on scattered-site PSH avoided the high initial capital costs of constructing, rehabilitating, or acquiring larger buildings but led to a different set of problems in leveraging existing housing stock. Interviewees frequently discussed struggling with the limited availability of affordable housing, securing willing landlords to rent to PSH tenants, and using housing vouchers that pay too little to secure decent housing. Conditions in rural areas clearly favor scattered-site PSH, but the statistics suggest that some rural CoCs have succeed in establishing single-site PSH projects.

Finding 2: Undercounts of chronic homelessness erode community support for establishing PSH

As the facilitator of a region's coordinated response to homelessness, the CoC must collect accurate data about the scope and scale of homelessness. HUD mandates that all CoCs conduct an annual PIT count that calculates the number of people experiencing homelessness within a CoC's boundaries on a single night in January. Interviewees found that the PIT count was highly challenging to complete in rural areas for two reasons. First, in urban areas, homelessness tends to occur in highly visible spaces, such as emergency homeless shelters in densely populated locations and in large encampments in public spaces. By comparison, in rural areas,

homelessness more commonly occurs in "hidden" settings, such as vehicles parked in remote locations, abandoned buildings, and other temporary shelters on private land.

Formal services, such as emergency homeless shelters or drop-in centers, serve as points of congregation and are a primary method for counting the number of people experiencing homelessness. However, homeless shelters and services tend to be concentrated in high-population, inner-city areas and are therefore sparse in rural areas (Lee & Farrell, 2005). Many CoCs rely on volunteers or professional survey enumerators to help conduct PIT counts. In major cities, hundreds of volunteers or paid staff can be mobilized leading to coverage of every single road, encampment, and shelter where people experiencing homelessness may be living. In rural CoCs, many of which encompass several counties and large distances between them, significant undercounts of the homeless population are almost a certainty. One report on rural homelessness in Southern Oregon projected that their PIT count underestimated "by half or more the number of rural unhoused" (Akins, 2023). Yet, it is remarkable that rural CoCs are consistently able to conduct PIT counts with such limited formal and informal capacity.

Second, chronic homelessness is more difficult to identify and document according to HUD definitions in rural areas. To be considered chronically homeless and therefore eligible for PSH, an individual must have been living in a place not meant for human habitation, often defined as a shelter or outdoors, for at least one year or on at least four separate occasions in the last three years ("**Definition of Chronic Homelessness**"). Research suggests that the willingness in some rural communities to "take care of their own" may lead to the shuttling of people experiencing homelessness between places to stay that do not count in the formal definition of chronic homelessness, such as a neighbor's couch or a church member's garage (Patton, 1988). This transience is most common in winter months when sleeping unsheltered is too hazardous. HUD's definition of homelessness also does not include "doubling-up" in which people live in temporary situations in the home of a friend or family member or in overcrowded homes. The former coordinator for a rural CoC in the Midwest explained the difficulty of applying the HUD definition of chronic homelessness in rural areas:

> *"A lot of our homelessness is invisible and, at least for HUD purposes, isn't considered homelessness because since there's no place else to go, they are couch hopping and staying with other people and they've got 10 people in a one- or two-bedroom apartment and evading landlords at that point in time. So by our standards we know that they don't have a home, but they're doing what they can to survive. But, by HUD standards and definitions, they don't qualify as homeless for a lot of purposes."*

In these situations, each temporary move into a "doubled-up" situation breaks the string of continuous homelessness that HUD uses as a benchmark to allocate resources. Further, the lack of shelter, minimal street outreach, and reduced participation in regional HMIS of some remote or low-capacity shelters make episodes of, or breaks in, homelessness very difficult to prove. Without meeting the definition of chronic homelessness with supporting documentation, the CoC has difficulties classifying the person as chronically homeless and therefore cannot qualify the individual for PSH funds. Through persistence and sometimes creativity, many rural CoCs and service providers ultimately find ways to identify chronic homelessness, but the mismatch between how rural homelessness is experienced and defined also plays a key role in reducing its visibility. This lack of visibility can in turn make it difficult to build support for homeless response interventions in rural areas.

The implications of challenges in conducting accurate PIT counts for rural CoCs is that estimates of homelessness are more likely to be undercounts than in other urban areas. These undercounts reinforce the perception that homelessness is not a problem and PSH projects are unnecessary.

Community resistance against homeless shelters and services can also be redoubled when there is a sense that homelessness is not an issue in the community or that, if it is, it is driven by transience rather than originating in the communities themselves. While the need to overcome community opposition to establish and protect PSH projects is not a uniquely rural issue (Wagoner, Lomeli & Sundby, 2023), some interviewees contended that rural PSH opposition was more often driven by ignorance of housing hardship. Without recognition of homelessness as a problem, interviewees emphasized that rural "Not in My Backyard" (NIMBY) attitudes often prevailed.

Some interviewees felt that NIMBY attitudes could scupper PSH projects more easily in rural areas compared to cities as many towns had never allowed any form of homelessness response, such as emergency shelters or drop-in centers. In some other rural places, these services exist but function independently of HUD's CoC funding and data systems. As one interviewee conveyed:

> *"We have very good [participation in the CoC], but not a hundred percent. And we also have some parts of our CoC where there isn't even shelter. And we also don't have street outreach. So people have experiences of homelessness that are just not really getting documented and are not within the system we're mostly using."*

Other interviewees communicated that smaller communities also facilitated more opportunities for influential local champions to garner support for PSH projects and overcome community resistance. Though this meant a few stakeholders had outsized influence over local programs, the support of even one powerful local politician who believed in PSH and was able to secure consistent resources could make the difference between chronic homelessness being a major or a minor problem in the community.

Finding 3: Organizational capacity is underdeveloped in many rural CoCs, limiting the ability of these communities to develop PSH

A lack of visibility and public understanding of homelessness as an issue within rural communities can make developing responses difficult; however, even in places where homelessness is recognized as an issue requiring public action, developing an understanding of the role PSH might play can prove challenging. Interviewees working in rural communities frequently expressed a sense of overwhelm regarding the prospect of establishing PSH. There have been various efforts to build capacity and expertise to expand access to PSH, although full engagement with these programs can be challenging for teams with limited staff capacity to begin with. Some communities have taken an incremental approach to developing and expanding capacity over time.

Rural CoC leaders described rural service providers as not feeling "equipped to develop, create a PSH project in their communities because it can be challenging" and not having "the expertise to work with a [chronically homeless] population and to establish something of permanence." While the limited capacity of smaller communities often poses challenges to establishing PSH, some interviewees remarked on how the small scale of their communities allowed them to operate in the context of less bureaucratic red tape when establishing PSH.

Nationally, various efforts are underway to demystify the process of establishing PSH and to support communities actively developing PSH. The Corporation for Supportive Housing is a leader in this area and operates statewide institutes to support developers and service providers in several states, including New York, Indiana, Ohio, and Oregon, in developing new PSH projects. Participation in these programs is often incentivized through preferred access to state funding for program participants. However, despite being statewide, many institutes have difficulty engaging rural providers, and much of the PSH developed through these programs is situated in more urban settings. Interviewees attributed minimal rural participation to two primary factors: the first being that small rural providers often

lack the staff time to devote to capacity building efforts, and second, a mismatch between the material being presented and the on-the-ground realities in many rural communities.

Several years ago, before funding cuts ended the program, several organizations providing technical assistance around PSH partnered to run a rural-specific curriculum at their training institutes. A key lesson from that training was often rural organizations were far from ready to establish PSH projects, but rather needed more basic training around organizational leadership and collaboration prior to engagement with an institute. Some training institutes were reluctant to support rural communities until they were fully prepared to establish a PSH project. Yet, as one of the leaders of the training institutes highlighted:

> *"What we were finding out is that oftentimes in rural communities you had to build that readiness…Organizational leadership and collaboration readiness, they're really important to have success to change the systems, coupled with these other things, but we can build a pipeline of readiness to get in [the training institute]."*

From this perspective, rural organizations need additional support to level the playing field before taking advantage of PSH-specific training. Building the capacity to undertake technically complex projects, especially those that may not be part of their original mission, takes time and resources. One administrator of a rural Southwestern CoC described their success in building capacity through an "incremental approach" that first introduced communities in rural areas to the CoC system and HUD funding, including for PSH. Initially, some providers in rural counties were unfamiliar with the concept of a CoC, having previously operated independently. The CoC administrator described supporting these communities to begin to operate within the CoC framework, specifically by providing funds to undertake some planning and coordination activities. Additionally, the CoC leadership worked with these communities to apply for and manage state funds, which are less technically complex than the funding available through HUD, to expand their services and build expertise in applying for and managing grants. As this rural CoC administrator asserted,

> *"PSH is a whole area of learning for some of these communities. Some of them don't know how to do that. What would they propose? What are we looking for?"*

Similarly, the director of a small PSH provider in the Midwest described how the organization has incrementally developed capacity to meet the community's needs over the last fifteen years. While the organization was initially established with the narrow focus of developing affordable housing, as homelessness became increasingly visible to providers and the extent of services required to stabilize these households became apparent, the organization expanded its scope to include providing increasingly complex assistance to people experiencing homelessness. This work began with funding to support families, and, later, a non-congregate shelter was built with community support. Recently, this organization received HUD funds to develop a PSH project. While homelessness services and developing and operating PSH were outside the original scope of the organization, the organization organically grew over time to respond to the demands of the community. The director put it this way,

> *"If I would known back then what we were going to do today, I would've ran for the hills... What we do well, is to identify needs as they come along, and we address them as we need to, and then we see more and more success with our families."*

Finding 4: Funding to support PSH development is often inaccessible rural communities

A resource-intensive intervention, securing and braiding together funds to provide permanent housing alongside supportive services, is highly challenging. Again, staff capacity is often

overextended in small CoCs, with individual staff tasked with multiple responsibilities, each of which might have a dedicated staff member to manage in larger CoCs. In particular, the lack of dedicated staff with expertise in identifying funding opportunities and applying for grants often made pursuing additional resources to establish complex projects out of reach for many rural CoCs. Many rural CoC administrators also felt the HUD funding system was especially complex, even for those who had been in their role for more than a decade. A regular sentiment was that maintaining compliance often took precedence over housing people.

> *"The complexity of the HUD system is really difficult, I think, for smaller CoCs and for rural areas to navigate. I spend much of my time working with individual agencies on trying to understand their annual performance reports, on dealing with getting reports into HUD, of dealing with the rules and the regulations, as opposed to housing people."*

Several rural CoC administrators believed they were disadvantaged in national grants competitions as they had to compete with their urban counterparts who not only had dedicated staff to write complex funding applications but that both urban and rural CoCs were assessed on the same criteria. For example, points in the grants application scoring system could be awarded for partnerships with organizations specializing in helping specific subpopulations of people experiencing homelessness. However, interviewees told us that these organizations simply did not exist in their area. These rural CoCs believed their applications suffered because award criteria were impossible to meet in their region. An individual who provided technical assistance on PSH pointed out that in rural areas:

> *"You can't match programming to certain cultural competencies or certain areas of representation... You're not necessarily just going to be able to say, "Oh, we already have 100 nonprofits and now we're going to try to bring some more into our effort when you only have a handful of partners that maybe even exist to begin with."*

Another interviewee further explained how the scarcity of rural service infrastructure meant funder expectations were unrealistic:

> *"But I can't reference the five DEI-focused organizations here. I can't talk about all of our great partnerships we have with the culturally-specific organizations because they don't exist. There's definitely not an organization that I can partner with that exclusively focuses on unhoused folks who are African-American. So I think that the expectations being developed…come with added challenges for rural areas."*

There is some research to support the perception that better-funded CoCs are more likely to be successful in grant applications. A study seeking to uncover the factors explaining HUD CoC grant allocations concluded that local capacity was associated with higher funding allocations while need was negatively associated (Lee, 2021). Several rural CoC leaders acknowledged that funding for capacity-building was rarely available, even when the projects themselves were funded. Some of these organizations who successfully obtained funding found their staffing stretched thin because additional funding was often attached to additional compliance requirements. New funding was very frequently earmarked for specific purposes and could not be used to hire or train additional staff. This "capacity strain" was commonly cited as a disincentive to pursue additional funding, especially those sources known to place stringent compliance requirements on recipients.

In 2022, HUD responded to some of these criticisms by issuing a Special Notice of Funding Opportunity (SNOFO) that included funds designated specifically for rural communities. Successful projects were offered three-to-five-year grants rather than the typical one-year term issued through the standard NOFO process. Additionally, the structure of

the SNOFO funds was responsive to limited administrative capacity in rural communities and their lack of density. There were alternative documentation requirements providing greater flexibility, and funds could be used to cover a more diverse set of expenses, including repairs to make PSH habitable, short-term stays in motels or emergency shelters, and food assistance.

Our analysis of the SNOFO awards shows 34 rural CoCs received grants to support their efforts in responding to homelessness.[3] Rural CoCs with relatively larger populations were the most successful at accessing these funds. While CoCs throughout the country were eligible to apply, rural CoCs in the Mountain West and South were less successful than CoCs from other regions in accessing these funds. Rural CoCs that were awarded SNOFO funds had a median population of 833,289 people, nearly twice that of rural CoCs overall. Of the rural CoCs that were awarded Rural Set Aside funds through the SNOFO, 50% received grants to support PSH, with a median value of $1.4 million.

CoCs that received SNOFO funding to specifically support PSH projects had a similar amount of PSH on a per-capita basis relative to rural CoCs overall and had a median population of over one million people, greater than that of both all rural SNOFO awardees and rural CoCs in general. Taken together, this analysis indicates that even as these funds were targeted at rural communities, the application and review processes likely favored applications from CoCs operating with relatively greater administrative capacity and that completing applications to support for PSH may still have been particularly logistically demanding. Nevertheless, the SNOFO represents a significant effort by HUD to respond to some of the organizational capacity challenges faced by rural communities.

3 A total of 38 CoCs received rural set-aside funds; 34 of these were largely rural CoCs. The remaining 4 awards were made to rural areas within CoCs classified in other ways. Our analysis focuses on awards made to rural CoCs.

Barriers to Implementation: Operating Subsidies and Housing Placements

Affordable housing was very often believed by interviewees to be the most important component to PSH and was specifically described as a "basic need" and "necessary to take care of before other things." Rather than allowing people experiencing chronic homelessness to stay on the street, housing provided through PSH can be the first step toward stability and a better life. Rental subsidies are essential in providing housing that is accessible to the very low-income population that is served through PSH programs. Subsidies are used to cover ongoing housing costs in both single-site and scattered-site PSH. These subsides come with restrictions on how they can be used, which poses challenges in rural settings where housing costs have sharply risen in recent years, and where there is less administrative and service provision capacity to assist tenants in using these subsidies.

Regardless of whether PSH is single-site or scattered-site, most programs also rely on ongoing rental subsidies to cover the operating and maintenance costs associated with tenants' housing. We found three primary types of rental subsidies frequently used in rural CoCs: 1) tenant-based assistance, 2) project-based assistance, and 3) sponsor-based assistance. Tenant-based assistance is tied to a specific household and can be used with any private housing unit whose landlord accepts the assistance. Project-based assistance is tied to a specific housing unit when occupied by an eligible household, such as a project-based Section 8 unit. Sponsor-based assistance is tied to a "sponsor", usually a nonprofit organization, that owns or leases housing units and then subleases those units to households participating in their programs; this is the way in which PSH rental subsidies funded by HUD through the CoC program are administered.

Even when funding for rental subsidies is secured, there can be issues in using these subsidies to secure units for PSH tenants. The availability, amount, and form of a rental subsidy influences the type of PSH unit, which in turn impacts the trade-offs and

expenses faced by PSH programs. Here we examine how shortages of rural affordable housing and subsidy program restrictions create delays in placing tenants into PSH.

Finding 5: Shortages of rural affordable housing create delays in placing tenants into PSH

Like urban areas, rural areas face shortages in affordable housing. While housing stock in rural suburbs and non-metropolitan areas is generally not as constrained as in cities, higher-income renters occupy a much larger proportion of the affordable housing stock in rural areas than in urban areas (Alvarez & Steffen, 2023). Between 2020 and 2023, home price growth in rural areas was almost double (36%) that of urban areas (22%) (Hermann & Whitney, 2025). Interviewees also attributed rising housing costs as the cause of recent migration among urban dwellers to rural areas during the COVID-19 pandemic. Some of these properties were now being advertised on short-term accommodation platforms for middle-income households:

> *"In my area, there's a lot of Airbnbs here, and so that super affects housing stock and affordable housing. There's a lot of neighborhoods that are just all Airbnbs, all seasonal rentals, and that's very frustrating because they're there, but they're not available to the people we're trying to get housed."*

Almost every interviewee mentioned the shortage of affordable housing as a pressing challenge in implementing rural PSH. The leader of a rural CoC in the Midwest observed:

> *"The rental markets are tight. Rents have gone up. Landlords can be more picky. People aren't buying houses, so they're staying in their rental.... [These] challenges in the rental market ... are having a direct impact on our ability to get people housed. And definitely on our ability to house them quickly."*

As this interviewee described, affordable housing shortages led to higher rents, fewer suitable units for rent, and stricter tenant eligibility criteria. These consequences create additional work for providers assisting tenants in securing units, as well as in delays in placing eligible individuals into housing, prolonging their chronic homelessness.

Finding 6: Program restrictions on the use of rental assistance subsidies limits the pool of potential units suitable for PSH

Despite their importance to operating PSH, many rental subsidies have strict requirements on their use. The HUD-funded Housing Choice Voucher (HCV) program that includes both tenant-based and project-based rental assistance can only be used with units renting at or below the Fair Market Rent (FMR), which is calculated by HUD at the 40th percentile of regional rents. As rents have increased sharply in recent years, many interviewees expressed frustration that these FMRs have not kept pace with market prices. One advocate who provided technical assistance on PSH to dozens of large rural communities explained:

> *"I don't work in a community right now that isn't feeling the strain of like, "Okay. We got new vouchers," or, "Okay. We got new PSH funding." But where are we going to find the units if it's not project-based and attached to a building that they already have access to? ... There aren't enough units that will meet FMR or rent reasonableness."*

Beyond limitations on rental amounts, rental subsidies often come with additional guidelines, such as requirements for units to pass safety inspections and restrictions on the types of costs they can cover. Many interviewees reported difficulty finding units suitable for PSH that both met affordability guidelines and passed inspections. These restrictions created additional barriers to housing for PSH tenants who already had very low

incomes, limited credit histories, and records of eviction or felony conviction. To further complicate this process, the public housing authorities that administer the Housing Choice Voucher program are highly local organizations whose boundaries rarely overlap with those of CoCs, except in large cities. A single rural CoC may have anywhere from several to upwards of one hundred housing authorities operating within their CoC boundaries. Each housing authority has a different set of eligibility requirements, FMRs, and administrative process that the CoC must navigate. Most urban CoCs are likely to have only one or two housing authorities operate within their boundaries.

The largest source of housing subsidies nationally, the Housing Choice Voucher program, does not legally require housing authorities to prioritize assistance to people experiencing homelessness, only those with low incomes. Where local fair housing protections are not in place, some housing authorities also deny applicants with criminal and eviction histories (Ramsey, 2018). These punitive rules disproportionately affect people experiencing chronic homelessness and may be more common in rural areas where there are fewer pro-tenant advocates and organizations to pressure housing authorities. Nevertheless, under the American Rescue Plan Act 2021, Congress appropriated funding for approximately 70,000 Emergency Housing Vouchers that specifically serve people currently experiencing, at risk of experiencing, or who recently experienced homelessness. Even with higher FMRs and additional funding for housing navigation and landlord incentives, many recipients struggled to use their vouchers, in part due to challenges in coordination between CoCs and housing authorities (Economy, Finnigan & Espinoza, 2023).

Several interviewees bemoaned their inability to forge closer partnerships with their local housing authorities. They explained that housing authority partnerships were crucial for accessing long-term housing subsidies for residents in PSH. However, CoC leaders felt incentives for housing authorities were not aligned with housing people experiencing homelessness. As one executive director of a rural CoC collaborative applicant in the Midwest explained:

> *"Every grant application… highly recommends that [CoCs] collaborate deeply with your public housing authorities. But on the housing authority side, it is not required that they work with the homeless."*

A couple interviewees who had attempted to develop partnerships with their local housing authorities claimed that the latter's reluctance to engage was because people experiencing homelessness often had difficulty finding appropriate housing due to a poor housing history, little to no income, and problems with substance use and mental illness. Another interviewee disclosed that none of the three housing authorities in their rural region had a "homelessness preference" written into their policies. Though we do not know the extent to which housing authorities in rural areas have preferences for people experiencing homelessness, most major cities have had such preferences written into their rules for more than a decade.

Barriers to Implementation: Supportive Services

Supportive services help program participants obtain and maintain their housing. These services range from case management and life skills training to mental health services and substance use recovery. Engagement with supportive services strongly predicts positive housing stability outcomes in PSH programs (Yuan & Manuel, 2025). However, flexible supportive services adjusted to the needs of tenants are difficult to provide, particularly in rural settings. Providing services is especially resource intensive for PSH providers serving tenants scattered across a large geographic region and, without robust service provision networks, providers often play multiple roles, further constraining capacity. Here we examine

these issues, discussing how underdeveloped and thinly distributed rural support service infrastructure combined with limited transportation options reduces access to essential services. Additionally, we discuss how insufficient and difficult to access long-term funding for supportive services compromises the frequency and quality of service delivery, especially case management.

Finding 7: Underdeveloped and thinly distributed rural support services infrastructure combined with limited transportation options reduces access to essential services

The underdevelopment and thin distribution of support services in rural areas creates numerous barriers to high-fidelity PSH implementation, especially the delivery of supportive services. At best, rural services might be clustered in "hub communities," which function as a central point for a much larger rural region. In places where hub communities did not exist or were too far away from tenants, interviewees reported that service infrastructure was likely to be underdeveloped. As one interviewee located in a small town of a few thousand people in the South explained, the problem extends beyond specialist support services to the provision of basic needs:

> *"You've got a desert of services, really. You cannot get mental health care. The challenges are to make sure that they have access to medical, mental, grocery stores, all of those things that are hard on everybody but are harder if you are vulnerable."*

The thin distribution of supportive service infrastructure in rural areas made consistent, regular support services difficult to deliver consistently in scattered-site PSH, according to interviewees. Consistent weekly visits by case managers, which is considered a PSH best practice, was described as "complicated," "an unrealistic expectation," and "infeasible." Rural case managers were expected to have the same number of clients and contact hours as urban case managers, without acknowledging the large geographic distances between clients and lack of specialist services. The following sentiment shared by a rural service provider and was supported by many other interviewees:

> *"Housing First was built for areas that have services that can be wrapped around. And if you put somebody outside of any city, they ain't going to get wrapped. They're just not. And even in [a hub community], it's hard for us to wrap around with services because there are some things that just don't exist here."*

Some supportive services, such as specialist physical or behavioral healthcare, did not exist within one hundred miles of a rural community's PSH units. Many dedicated rural case managers attempted to fulfill this role, expanding their responsibilities from assisting clients in accessing services to also providing a specialist service themselves or seeking additional funding for it. Rural services providers described becoming a "one stop shop," providing housing, case management, and acting as a food bank as there simply were not agencies to partner with to provide these services. A service provider at a nonprofit in the West described the dilemma that rural PSH staff often faced:

> *"The reality…in rural communities, is that services may not exist or be very accessible in many areas or programs. [We] just don't have the time and capacity to do all of the work it would take to figure out how to bring funding together or how to set up effective referral programs. And so, I think often what that means more so in rural communities probably than in more urban areas, is that your PSH staff may be the only staff assigned to that person and they may only be using one funding source to pay for that staff and have limited capacity to piece together a more holistic array of services because either they don't exist or they don't have the time and wherewithal and capacity to figure out how they would do that as an individual agency."*

The scarcity of support services in rural communities is compounded by the unavailability of reliable transportation options. In cities and suburbs, it is common for PSH residents to receive transportation vouchers or free access to public transit through smart cards to access offsite supportive services. In rural areas, public transportation is not as readily available: 40% of rural counties have no public transportation system (USDA Economic Research Service, 2025). One interviewee working in a rural part of the Midwest highlighted the shortage of public transportation, saying:

> *"Yes, there is a bus system…but it is not quick. So, some towns and boroughs, it may only make one or two stops there in a day. And nothing on the weekends."*

Where public transportation is unavailable or unreliable, private vehicles are essential. However, many PSH residents live on extremely low fixed incomes, making the costs of owning and maintaining a car too expensive. Those with disabilities may be unable to operate a vehicle. Some residents may be able to rely on friends or family to take them to appointments, but the descent into homelessness often results in the exhaustion of social resources (Cook & Hole, 2020). Taxis and newer ride-sharing services also have limited reach in rural communities. A rural service provider in the South described the sparsity of private transportation options:

> *"In some of our rural communities, agencies can't even provide Lyft or Uber vouchers 'cause there are no Lyft or Uber drivers there, so you can't Uber someone to an appointment. [PSH is] that much more challenging in rural communities because the resource scarcity is so much greater."*

Long distances for tenants to travel to the few available service providers is a major barrier to accessing supportive services in rural communities. Once again, case managers often had to fill gaps in transportation access by providing it themselves. In rural communities, case managers likely play an even greater role than in urban areas. Most rural organizations and their case managers are making concerted efforts to make up for shortfalls in services to ensure tenants' needs are met. These efforts demonstrate the dedication, resourcefulness, and flexibility of rural service providers.

Finding 8: Insufficient long-term funding for supportive services that is burdensome to access compromises frequency and quality of service delivery, especially case management

Organizations providing PSH require sufficient financial resources to provide consistent, high-quality supportive services. In addition to making services difficult to access for tenants, interviewees discussed how long distances between individuals in PSH meant it was more costly to provide the same level of services in a rural area compared to a typical urban or suburban area. The heavy reliance of scattered-site PSH in rural areas highlighted this problem, as one rural service provider in a Southern state explained:

> *"In a rural community... the scattered sites are more scattered, so the time and energy it takes for a case manager to successfully bill all of their clients is larger, right? Whereas in a city you might be able to hit 10 or 12 clients at this one apartment building. In a rural community there might be a couple places, but the apartment complexes are just so much smaller. And, probably, the urban and rural caseloads are about the same."*

Funding to provide supportive services is rarely structured to cover the additional costs incurred serving clients in rural areas. Some rural service providers claimed funding for case management was especially low compared to other supportive services. The case manager was perceived to be the crucial service provider who strung together a web of more specialized supportive services to meet the tenant's needs. Without sufficient funding for supportive services, rural CoC leaders indicated

that service delivery suffered. Case managers reported facing a choice between lowering the frequency with which they visited tenants or spending less time with each tenant. As a PSH technical assistance expert summarized:

> *"What we're experiencing and what we're hearing from the housing developers and the property managers who are managing those units, those services are inconsistent. Whether it's capacity, because they can't retain enough staffing to consistently provide the services, or if the reimbursement rates for the services, do they really cover the costs? No matter what the reason is, the outcome is folks in these [rural] locations aren't getting the level of support that they need."*

In addition to the insufficiency of funding, some interviewees asserted that their organization lacked the staffing and resources to secure consistent funding for supportive services. At the state and federal levels, funding for supportive services is rarely awarded for more than two years, and some awards are as short as six months. While these funding periods are for the most part the same for all CoCs and much of this funding is renewable, small rural organizations have less administrative capacity to successfully navigate the renewal process.

Most interviewees communicated that Medicaid was an important source of funding for supportive services provision. As low-income, elderly, and disabled adults qualify for Medicaid, many people experiencing chronic homelessness are eligible. PSH clients may need multiple health services via Medicaid, including psychiatric services, substance use services, and peer support to navigate healthcare systems. We heard from other interviewees that some rural organizations were too small to take advantage of Medicaid as a source of funding. The high costs of obtaining credentials to bill services to Medicaid and determining eligibility for different services made Medicaid a lucrative but sometimes unobtainable funding source for rural service providers.

There is significant state variation in the use of Medicaid. A few interviewees were in states that had not expanded Medicaid access under the Affordable Care Act while others operated in states like Arizona, California, and New York that had obtained waivers to allow for reimbursement of community-based services. Interviewees whose organizations were successful in accessing Medicaid reimbursement stressed that not every person experiencing chronic homelessness has access to, or even qualifies, for Medicaid so it was not a universal solution. Those unable to access Medicaid spoke of needing help to "determine what…services actually could be billed to Medicaid." In some states, interviewees were frustrated that:

> *"The process for getting Medicaid credentialed is…complex because [it is not a priority for] our state leaders and our governor… Public assistance, Medicaid, these are often underfunded programs and understaffed programs."*

In rural areas where Medicaid was a key source of funding, a lack of other consistent sources of funding created perverse incentives to only conduct tasks that were "billable to Medicaid, not because it will serve the clients, but because it's what [we] need to sort of balance the books." Medicaid requirements led case managers to spend roughly equal time with every client rather than prioritizing based on need. The reliance on Medicaid reimbursement meant case managers were left with little flexibility in their client interactions, spending more "energy on the client that needs less attention for the sake of billing," and, more consequentially, spending less time with clients with more pressing needs. Ultimately, residents unable to reliably receive supportive services do not receive the consistent care that is critical to PSH's success in combating chronic homelessness.

Strategies for Successfully Implementing PSH in Rural Areas

Provide Flexible, Long-Term Funding to Address Rural Homelessness

Inadequate funding constrains the ability of rural CoCs and service providers to establish and operate PSH. The cost of providing PSH in rural communities is often particularly high on a per-resident basis due to the small scale of these projects, the distances across which they operate, limited availability of operating subsidies, and thinly distributed service provision networks. Current funding sources often fail to account for these additional costs that emerge in rural settings as well as the fixed administrative costs associated with running these programs.

Expanded funding responsive to the needs of rural communities is not without precedent at the federal level. One example is HUD's Youth Demonstration Program, which supports coordinated community approaches to addressing youth homelessness and has designated funds to support rural communities in particular (Henderson et al., 2020). The most prominent recent example is HUD's 2022 SNOFO to address unsheltered and rural homelessness. Thirty-eight awards were made to rural communities with most of this funding allocated for housing interventions, especially PSH (DuBois, 2024). Many rural CoC leaders expressed that the opportunity to apply for funds specifically committed to supporting rural communities was welcome. Interviewees appreciated having their applications evaluated alongside those from other rural communities, rather than those from large cities with dedicated grant writers, well-developed service infrastructure, and decades of experience in developing PSH projects.

While many interviewees praised the SNOFO's targeting of rural communities, rural CoCs with larger populations tended to be more successful at accessing these funds, suggesting that the award process may have been difficult for the smallest CoCs to apply for and navigate. Even as the SNOFO was designed to limit the administrative load on CoCs and providers, both the application process and the grant management came with fixed administrative costs and no funding to support the work of applying for and overseeing the grant. One technical assistance provider explained:

> *"Anything [CoCs] were going to do related to the strategy or capacity building around this initiative, they were going to be doing it on top of their already limited capacity...Some urban areas would hire like a SNOFO project manager who would coordinate across all their projects and support them, [but] there were zero-dollars attached to the rural SNOFO funding for CoCs and planning grants."*

Given the high need, states should likewise increase funding for PSH to prevent rises in chronic homelessness. As with federal funds, these funds should be designed to be accessible and responsive to the needs of rural communities. Some strategies might include: flexibility in homelessness definitions, documentation, and eligibility requirements; multi-year grant periods; capacity-building set-asides to support staff; and a wider range of eligible activities, such as rent arrears, short-term accommodation, and emergency food or clothing. A variety of strategies are currently being used by states to expand available funding, including Washington state's Mental Illness and Drug Dependency Sales Tax, dedicating portions of State Housing Trust Funds to PSH, state-funded rental assistance programs, and capacity-building institutes that unlock access to funding. However, only some of these funding sources are structurally responsive to the smaller scale of homeless response in rural communities and their limited organizational capacity. Nevada's Supportive Housing Development Fund takes a number of steps to ensure that the program is accessible to a variety of types of communities throughout the state ("**Nevada's Supportive Housing Development Fund**").

Nevada's Supportive Housing Development Fund

The Nevada state legislature established the Supportive Housing Development Fund in 2023 with a $32 million allocation. Designed as a statewide initiative to help people experiencing homelessness with complex barriers to housing, the fund offers grants for supportive services that can be paired with housing finance tools. While not geographically specific, there are a number of elements in how Nevada has structured these funds that make it more accessible to rural communities, including options for 5-year grants, bridge funding for supportive services, and set-asides to build the capacity of housing developers and service providers.

Recommendation 1:

HUD should continue flexible funding opportunities for PSH that are responsive to the additional costs of operating in rural settings and include a proportion of funds to expand organizational capacity.

Recommendation 2:

State governments should expand PSH funding opportunities in ways that are accessible to rural communities.

Reduce Administrative Requirements to Obtain and Maintain PSH Funding

Obtaining funding for PSH and maintaining compliance with various funding sources requires considerable resources. Medicaid frequently plays a critical role in supporting PSH clients. Medicaid eligibility and billing processes could be adapted to decrease the burden experienced by providers in coordinating access support for clients. Medicaid insurance frequently allows residents to access very low- or no-cost healthcare. In some Medicaid waiver states, it can also provide direct housing assistance and other supportive services. Simplifying the process for recertifying eligibility for Medicaid and reducing the frequency with which eligibility must be certified could reduce the administrative costs experienced by providers in coordinating access to Medicaid for their clients. Likewise, loosening billing requirements for Medicaid funds used to cover costs related to social determinates of health may also provide particularly useful in rural communities where organizational capacity is strained.

States can play a major role in reducing the administrative load placed on rural CoCs and service providers by streamlining application processes for state-level PSH funding and assuming greater administrative responsibility for some funding streams. This role might involve lending state administrative capacity to access financing and braid funding for rural PSH projects ("**North Carolina's Back@Home Initiative**"). States more reluctant to

North Carolina's Back@Home Initiative

North Carolina's Department of Health and Human Services runs Back@Home, a collaborative initiative that allows the state to manage much of the administrative work of securing and maintaining compliance with a spectrum of homelessness response services funding across the 79 counties in their Balance of State CoC. This approach allows on-the-ground organizations to focus on providing person-centered care, including Rapid Rehousing and PSH, while funding for this work is managed on the back end.

The approach demonstrated in Back@Home emerged from iterative and progressive capacity-building and learning that began after Hurricane Florence in 2018, when North Carolina's Office of Recovery and Resiliency assumed administrative responsibilities for rehousing displaced households across 28 severely affected counties (Teles et al., 2023).

take a hands-on role in coordinating PSH funding could consolidate and, where possible, standardize requirements for state-level and local-level funding sources to simplify the process for obtaining PSH funding. Other organizations could also play a role, such as housing authorities and large housing providers, by streamlining and reducing requirements while still maintaining compliance. Some agencies are doing this by using fact-specific proxy to document eligibility.

Recommendation 3:

Federal, state, and local agencies and organizations involved in the funding or implementation should reduce administrative requirements and streamline processes.

Create Evidence on and Provide Support for Rural PSH Implementation

Current PSH models and best practices have been developed and studied almost entirely in urban or suburban areas with denser populations and support service networks. These models can be difficult to fully implement in rural settings. One national-level housing advocate articulated the limitations of working from the premise that urban models can be easily transferred to rural settings this way:

> *"If we want [PSH] to work in rural [areas], we can't start with the assumption that the models that we've got can work 80% or 90%... maybe you can only keep 50%. It's a real paradigm shift for a lot of people…. and I think in some instances it means you got to have two different policies."*

Rural service providers often stated the difficulty in implementing PSH according to best practices, especially offering choices over housing type and neighborhood and availability of specialist supportive services, due to limited organizational capacity and lack of density in housing, services, and physical infrastructure. However, one HUD system performance metric suggests that housing outcomes for PSH may be very similar between rural and urban settings. In 2024, HUD reported that the median successful exit rate to permanent housing beyond six months for PSH was 95.3% in Largely Rural CoCs and 96.3% in Major City CoCs. Though these findings are self-reported by CoCs and the product of a rigorous evaluation, they pose questions about whether all PSH best practices defined by SAMHSA are equally important to producing positive housing outcomes. Further evaluative research would provide more rigorous evidence on the extent to which rural PSH programs perform similarly to urban ones and on relative importance of different core components of the intervention.

Practice-oriented research would support deeper understanding of the trade-offs between different approaches to PSH implementation and, ultimately, how to more effectively and cost-efficiently provide low-barrier housing alongside person-centered services in rural settings. This research would provide guidance to rural PSH stakeholders to increase the number and quality of PSH programs and inform the development of an updated set of evidence-informed baseline standards for PSH. The responsibility for funding and coordinating this type of research and information has largely been held by HUD, but the recent removal of some online resources and cuts to technical support indicate a reduced future role. Several interviewees discussed the importance of the online resources, guidebooks, training, and helpdesk made available through HUD Technical Assistance in furthering their understanding of PSH and overcoming barriers to implementation.

Implementing PSH requires expertise in various areas and ongoing problem-solving. Rural CoCs and providers tend to operate at small scales and in relative isolation, and as a result, frequently have expertise in some but not all of the aspects required to successfully implement PSH. Despite these challenges, rural CoC stakeholders are developing on-the-ground strategies for overcoming barriers to implementing PSH. In some cases, the small scale

of interventions in rural communities allowed for creativity and flexibility in problem-solving. Rural communities have taken a variety of approaches, including establishing flexible funds for landlord incentives, utilizing satellite offices and telehealth in targeted settings, and leveraging community skills and strengths. Documenting promising practices in rural communities and creating opportunities for peer-learning and support could expand the organizational capacity to provide PSH in rural CoCs.

Recommendation 4:

Researchers should conduct evaluative and practice-oriented research to better understand rural PSH program success, essential intervention components, and cost-effective implementation.

Recommendation 5:

Opportunities for peer learning and support, as well as technical assistance, should be sustained and expanded by HUD or other philanthropic and research stakeholders.

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