HAMPDEN COUNTY CONTINUUM OF CARE

Board of Directors

Holyoke Community College
303 Homestead Ave., Holyoke, MA

September 19, 2014, 9:00 am – 10:00 am

Minutes

Present: Karen Dean (Hampden County Sheriff's Department), Doreen Fadus (Mercy Hospital), Charlie Knight (Rainville), Bill Miller (FOH), Dave Ferenz (HRU/Lighthouse), Lizzy Ortiz (City of Springfield), Jerry Ray (Mental Health Association), Lauren Voyer (HAP Housing), Steve Huntley (Valley Opportunity Council), Dawn DiStefano (YWCA), Marianne Polmetier (River Valley Counseling Center), Gerry McCafferty (City of Springfield), Pamela Schwartz (Western Massachusetts Network to End Homelessness), Shannon Barry (Springfield Public Schools), Maria Perez (New North Citizens Council), Alicia Zoeller (Holyoke),Kathleen Lingenberg (Chicopee), Mary Walachy (Davis Foundation).

Absent: Jennifer Lucca (Samaritan Inn), Mike Suzor (Springfield Technical Community College), Kathryn Buckley-Brawner (Catholic Charities), Sylvia deHaas Phillips (United Way of Pioneer Valley), John Roberson (CHD), Alvina Brevard (Mass Department of Housing and Community Development), Charly Oliva (Springfield Veterans Services Dept.), Diana McLean (Westfield), Ronn Johnson (MLK Jr. Family Services), Charlotte Dickerson, Christina Densmore (Arise), Paul Bailey (Springfield Partners for Community Action), Steve Trueman (Regional Employment Board).

1. **Welcome and Introductions**

Gerry McCafferty welcomed Board members and members introduced themselves to the group.

2. **Review of Minutes**

The Board reviewed the minutes of the June 20, 2014 meeting. Jerry Ray noted the need for a correction on page 3—the number of permanent supportive housing units at Annie's House will be 13, not 15. Charlie Knight made a motion to approve, which was seconded by Mary Walachy. The Board voted unanimously to approve the minutes.

3. **CoC Policies and Procedures: Coordinated Assessment**

Gerry provided background on the topic of coordinated assessment. A summary of that background, which was distributed at the meeting, is attached. Gerry reminded the Board that it considered the VI-SPDAT as an assessment tool at the June 2014 meeting, and did not make a decision, but decided to learn more about that tool. Since that meeting, Friends of the Homeless and Eliot Community Services have piloted the tool and reported their experiences back to the

Individual Services Committee. After the reports of the pilots and discussion, the Individual Services Committee recommends use of the VI-SPDAT as a required screening tool for permanent supportive housing placements.

There were two issues that have been raised about the VI-SPDAT. The first is the fact that some people may not have the ability or willingness to answer the questions, which may lead to people being characterized as not having high service needs when in fact they do have high service needs. The Individual Services Committee believes that this concern can be met through our REACH committees, which enable multiple providers to talk about a particular person's needs and decide to overrule the tool in some cases. The second concern is the intrusiveness of the questions of the VI-SPDAT. The response to this concern is first, when a person is being considered for PSH, there is a need to know about sensitive issues such as substance abuse and mental health. At the same time, individuals may decline to answer any particular questions, or decline to do the VI-SPDAT at all.

Gerry has met with two of the three CoC-funded providers of PSH for families, and these providers endorse use of the VI-SPDAT.

Charlie Knight made a motion that the CoC adopt the VI-SPDAT as a required screen for CoC-funded PSH. Maria Perez seconded the motion.

Discussion:

A number of questions were raised about the particulars of use of the VI-SPDAT, and Gerry indicated that her expectation is that the CoC will begin crafting policies and procedures as it is using the tool and understanding its use. In particular, the CoC is not, at this time, mandating scores that will lead to particular placements, or whether there is an expectation of reevaluation with the tool at some regular interval. In her summary, Gerry had mentioned assessment at two points—"front-door" and "back-door" and was asked for Clarification. Gerry explained that she was trying to differentiate because she does not want the CoC work to conflict with what is being done at the state level. The state has been focused on "front-door" assessment, which screens for whether a person experiencing a housing crisis is in need of shelter or if needs can be met through prevention or diversion assistance. In contrast, our CoC is considering use of the VI-SPDAT as "back-door" assessment, which refers to assessment of people already in shelter, with the goal of determining the intervention that is most appropriate. In particular, the "back-door" screen is useful for determining which people are in need of the service-rich intervention of permanent supportive housing.

There was some discussion about the potential fair housing issues that may arise with the use of the tool. There was discussion about how clear guidelines, applied uniformly, as well as a coordinated waiting list, should prevent fair housing violations. One provider with some recent fair housing experience noted that one place that programs need to be cautious is where family composition changes—for example, from single household to household with children. Even if a

program is designed only to serve single individuals, this does not by itself allow a refusal to serve an ongoing client who becomes a family household.

The Board voted unanimously to approve the motion to adopt the VI-SPDAT.

In the discussion of the VI-SPDAT, Gerry referenced HUD's new recommendations for prioritization of permanent supportive housing, which requires a way to distinguish between severe service needs and service needs that are not severe. The recommended prioritization is as follows:

Priority 1: Homeless one year or longer, with severe service needs

Priority 2: Homeless one year or longer, without severe service needs

Priority 3: Homeless 3+ times in the last 4 years with severe service needs

Priority 4: Homeless 3+ times in the last 4 years without severe service needs

The Board will be considering HUD's recommendations regarding prioritization at a later Board meeting.

4. FY2014 CoC Competition

Gerry reported that the CoC Competition NOFA was released September 16, 2014. CoC responses to HUD are due October 30, and the local competition to be included in the CoC application must be concluded by October 20, 2014.

Gerry explained that the CoC established a process last year in which individual projects submitted applications to the CoC Scoring and Ranking Committee. The Committee ranked all projects, and applied CoC priorities to determine final ranking. Ranking of projects is critical, because HUD uses a funding formula in which it agrees to fund the full amount of need, minus 2%, as Tier 1 projects. In addition, the CoC may submit Tier 2 projects, which make up the remaining 2% of funding, but anything in Tier 2 is at risk of loss of funding. Tier 2 is funded based on the CoC score in the FY2013 competition and the amount of HUD funds available. The CoC must also decide whether to include a planning grant, in an amount up to $44,000, in either Tier 1 or Tier 2.

This year HUD has made available a Permanent Supportive housing Bonus, which may be used to fund a project that serves 100% chronically homeless individuals or families. The CoC is eligible for a Permanent Supportive Housing Bonus award of $530,189. *[Note: this is a clarification of what was presented at the meeting, and has been confirmed by HUD.]*

Gerry provided two handouts, attached: a list of projects up for renewal and their renewal funding amounts, and a chart indicating the factors the CoC Scoring and Ranking Committee will

need to consider in making its determination. These factors are: 1) the importance to the CoC of a planning grant; 2) preference to cut all programs a small amount or top eliminate lowest-scoring programs; 3) if there is a need to cut program budgets, whether to cut across the board or only cut lowest-scoring projects; and 4) whether to allow new projects to compete against existing projects, as we have in past years.

After some questions and discussion, Kathleen Lingenberg made a motion that the CoC Scoring and Ranking Committee consider the following points in making funding decisions: 1. Planning is important (but at the same time may be funded locally—Gerry will quickly explore local funding); 2. The highest scoring programs should be fully protected against budget cuts, and lowest scoring projects may be put at risk for elimination or budget cuts; and 3. If there is a need for budget cuts to make amounts balance, cuts should only be made to the lowest scoring programs. Mary Walachy seconded the motion, and it passed unanimously.

Kathleen made a second motion that would allow application for new projects only in the Permanent Supportive Housing Bonus competition; that is, for this year, new projects would not be able to replace existing projects. Pamela Schwarz seconded the motion, which passed unanimously.

Gerry provided the Board with the proposed CoC Application Ranking and Scoring Process 2014 and asked for written comments to be sent to her by email by Friday. A final version of this document must be published Monday in order to give sufficient and timely guidance to FY2014 applicants.

The meeting adjourned. It was followed by the CoC Annual Meeting; notes from this meeting follow.

HAMPDEN COUNTY CONTINUUM OF CARE

Overview of Coordinated Assessment: VI-SPDAT

What Is Coordinated Assessment?

Coordinated assessment is the use of a common tool for assessing the needs of people seeking homelessness assistance. Community-wide use of common assessment leads to decision-making about referrals that is based on consistent criteria of a household's needs and a comprehensive understanding of each program's requirements, target populations, and available openings and services.

The goal of coordinated assessment is to better match people experiencing homelessness to the most appropriate types of housing assistance based on an assessment of the needs of households.

HUD requires that Continuums of Care create systems of coordinated assessment for all programs funded by CoC and Emergency Solutions Grants (ESG).

When Does Coordinated Assessment Take Place?

Locally, we have been talking about two key components of coordinated assessment: 1) Front-door assessment, which determines a household's initial need for diversion, rapid rehousing, shelter, or another intervention; and 2) Back-door assessment, which determines appropriate placement for permanent supportive housing. While a long-term goal is to have all assessment completed as early as possible, the goal of back-door assessment is to assist with prioritization for and proper placement into permanent supportive housing for people with chronic homelessness and/or high service needs. At this time, the Hampden County CoC is focused on implementing coordinated assessment in order to determine appropriateness for a permanent supportive housing placement.

What is the VI-SPDAT?

The Vulnerability index-Service Prioritization Decision Assistance Tool (VI-SPDAT) is a coordinated assessment tool in use by hundreds of communities across the country. It brings together two pre-existing tools. The Vulnerability Index is rooted in leading medical research and helps determine the chronicity and medical vulnerability of homeless individuals. The Service Prioritization Decision Assistance Tool (SPDAT) is an intake and case management tool based on a wide body of social science research and extensive field testing. The VI-SPDAT was a key tool used by the 100,000 Homes campaign, which recently met its goal of housing 100,000 chronically homeless individuals.

Why Should We Choose the VI-SPDAT As Our Coordinated Assessment Tool?

Communities around the country are struggling to implement coordinated assessment and a number are creating new tools. Based on our CoC's research, the VI-SPDAT appears to be the only widely-used tool created based on research and extensively field-tested. Locally, Friends of the Homelessness and Eliot have piloted the VI-SPDAT and found that the tool's assessment is reliable—that is, it tends to document what they see as a person's needs. At this time, the VI-SPDAT appears to be the best tool available and is mentioned by HUD as meeting CoC requirements.

MA-504 Springfield/Hampden County FY2014 CoC Program Awards

						Population Served	# units/beds
MA-504	City of Springfield / Catholic Charities - RRH	Springfield	New	$47,148	RRH	Families (non-EA eligible)	2 units/8 beds
MA-504	City of Springfield / CHD Family-Centered PSH	Springfield	New	$519,818	RRH	Families	10 units/25 beds
MA-504	City of Springfield / FOH - Worthington House Campus	Springfield	Renewal	$22,679	PSH	Individuals	32 units/beds
MA-504	City of Springfield / Gandara - SHINE Program	Springfield	Renewal	$189,235	TH	Youth 18-24	8 units/beds
MA-504	City of Springfield / HAP - Rapid Rehousing	Springfield	Renewal	$31,713	RRH	Families	2 units/12 beds
MA-504	City of Springfield / HAP - Rapid Rehousing 2	Springfield	Renewal	$103,516	RRH	Families	8 units/25 beds
MA-504	City of Springfield / HAP - Turning Point	Springfield	Renewal	$57,270	PSH	Families headed by youth 18-24	9 units/21 beds
MA-504	City of Springfield / HMIS	Springfield	Renewal	$29,732	HMIS	n/a	
MA-504	City of Springfield / HMIS Expansion	Springfield	Renewal	$32,260	HMIS	n/a	
MA-504	City of Springfield / HRU - Next Step	Springfield	Renewal	$281,784	PSH	Individuals	22 units/beds
MA-504	City of Springfield / HRU - Next Step 2	Springfield	New	$103,843	PSH	Individuals	5 units/beds
MA-504	City of Springfield / MHA - Annie's House	Springfield	New	$228,752	PSH	Individuals	13 units/beds
MA-504	City of Springfield / MHA - Leahy House	Springfield	Renewal	$97,847	PSH	Individuals	5 units/beds
MA-504	City of Springfield / MHA - S+C SRA 48	Springfield	Renewal	$452,798	PSH	Individuals	48 units/beds
MA-504	City of Springfield / MHA - Safe Havens	Springfield	New	$98,536	PSH	Individuals	5 units/beds
MA-504	City of Springfield / MLKFS - Project Permanence	Springfield	Renewal	$142,431	PSH	Families	8 units/25 beds
MA-504	City of Springfield / Open Pantry - Tranquility House	Springfield	Renewal	$38,854	PSH	Individuals	8 units/beds
MA-504	City of Springfield / RVCC - HIV/AIDS Residential Support	Springfield	Renewal	$173,654	PSH	Individuals/Families	13 units/20 beds
MA-504	City of Springfield / RVCC - HIV/AIDS S+C TRA 7	Springfield	Renewal	$66,551	PSH	Individuals	7 units/beds
MA-504	City of Springfield / SMOC - Bowdoin Street	Springfield	Renewal	$21,594	PSH	Individuals	13 units/beds
MA-504	City of Springfield / VOC - Scattered Site Family Supportive Housing	Springfield	Renewal	$120,567	PSH	Families	8 units/20 beds
MA-504	City of Springfield / WHA - Domus - Reed House	Springfield	Renewal	$35,952	PSH	Individuals	8 units/beds

HAMPDEN COUNTY CONTINUUM OF CARE

FY2014 Grant Competition

Factors to consider:

1. How important to us is a one-year planning grant?
2. Do we prefer to cut program budgets, or cut one or more programs completely?
3. If we cut budgets, should we cut across the board or only cut the lowest-scoring projects?
4. Will we allow new projects to compete with existing to be placed in Tier 1 or 2?

Possible Scenarios for FY2014 Submission

	Tier 1	Tier 2	What Is Cut/Not Included	Pros	Cons
1.	Fully fund programs that rank highest	Lowest ranking programs with total cost of $50,090	Planning Grant	Likely that all programs funded at current levels	Lowest-scoring program(s) placed at risk
2.	Fully fund projects that rank highest	Planning Grant	1 or more programs with total renewal cost of $50,090		Lowest-scoring program(s) will not be funded
3.	Fund all programs with 2% cuts across the board	Planning grant	All programs cut 2%	All programs funded; likely to get planning grant	All programs receive cuts, regardless of score or ability to sustain cuts
4.	Fund all programs—highest scoring programs are fully funded, and lower-scoring programs incur budget cuts	Planning grant	Budget reductions for lower-scoring projects	All programs funded; only lower-ranking projects incur budget cuts; likely to get planning grant	Lowest-ranking programs receive cuts
5.	Planning grant plus fully funded programs that rank highest	Lowest ranking programs with total cost of $50,090	Lowest scoring program(s)	Planning grant and best programs will be funded	Lowest ranking programs will not be funded
6.	Planning grant plus programs with grant reductions	Lowest ranking program(s) with total cost of $50,090		All programs and planning grant funded	All programs receive cuts; lowest ranked program at risk

HAMPDEN COUNTY CONTINUUM OF CARE

Annual Meeting

Holyoke Community College
303 Homestead Ave., Holyoke, MA

September 19, 2014, 10:00 am – 11:30 am

Minutes

1. **Welcome and Introductions**

   Gerry McCafferty welcomed the CoC membership and members introduced themselves.

2. **CoC Annual Report**

   Gerry presented an Annual Report on the CoC, which includes data that we have on meeting performance measurement standards, as well as data regarding the CoC's response to chronic and veteran homelessness. A copy of the report is attached.

3. **Report on High End Utilizers Grant**

   Doreen Fadus reported on the outcomes of the High End Utilizers Grant, an initiative led by Mercy Hospital and funded by Blue Cross/Blue Shield. The initiative, a collaboration of hospitals in the region, identified homeless high service utilizers in the area, and provided them with intense and focused case management support, with the goal of improved health outcomes and reduced hospitalizations. The initiative has been very successful, with large health cost savings. A copy of Doreen's presentation is attached.

4. **Governance Charter review and vote on proposed update**

   As required by the CoC Governance Charter, the CoC undertook an annual review of the Charter. In the review, one section was identified for proposed revision. The 2013 Governance Charter, Section 6.3.2 provides "The officers shall be elected by the Hampden County CoC Members annually, at the Annual Meeting."

5. **Election of 2014-2015 Board of Directors**

   The membership reviewed a proposed slate of directors to be considered for three-year terms starting September 2014. After a motion from Steve Huntley, seconded by Charlie Knight, the members unanimously approved the proposed directors. The newly-elected members are:

   Lauren Voyer, Hap Housing

Kathleen Buckley-Brawner, Catholic Charities
Diana McClean, City of Westfield
Ann Lentini, Domus, Inc.
Pamela Schwartz, Western Massachusetts Network to End Homelessness
Shannon Barry, Springfield School Department, McKinney-Vento Liaison

In addition, invitations are being extended to the following:

Annamarie Golden, Baystate
Lynn Ostrowski, Health New England
Katie Zobel, Community Foundation of Western Massachusetts
Representative of Affiliated Chambers of Commerce of Greater Springfield

Thinking Outside of the Emergency Room:
A Collaborative Response to the Overuse of Emergency Rooms in Western Massachusetts

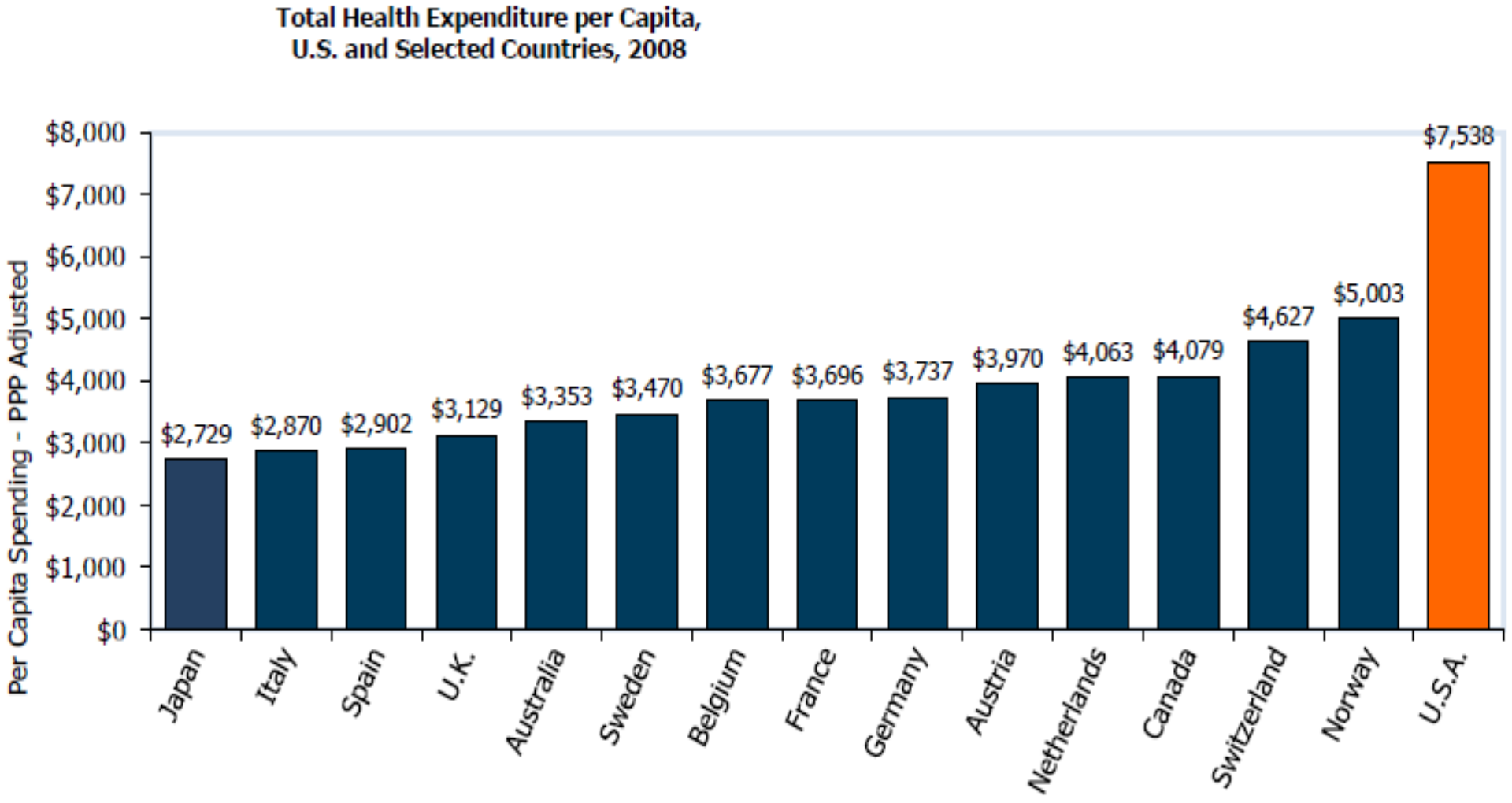
New Orleans
May 28, 2014

Doreen Fadus, MEd
Mercy Medical Center, Springfield, MA

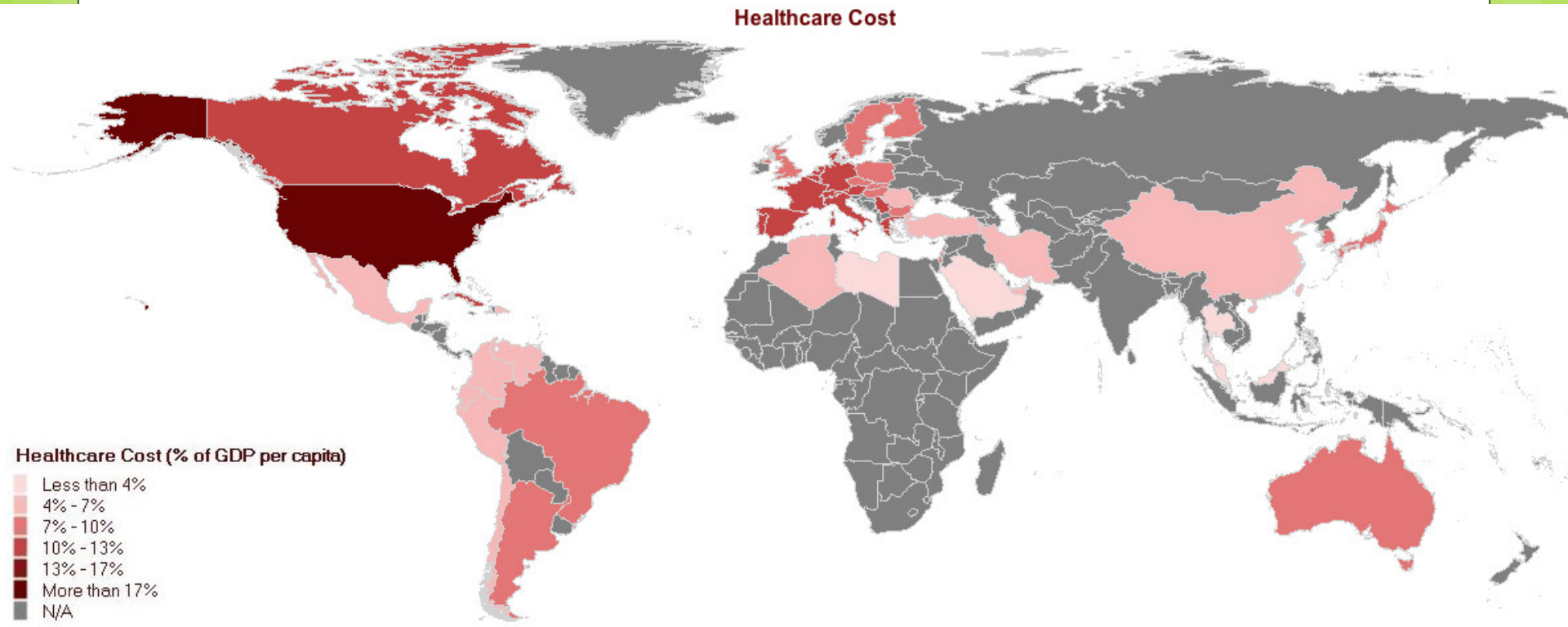
Sheila Mammen, PhD
University of Massachusetts Amherst

The Challenge and the Opportunity

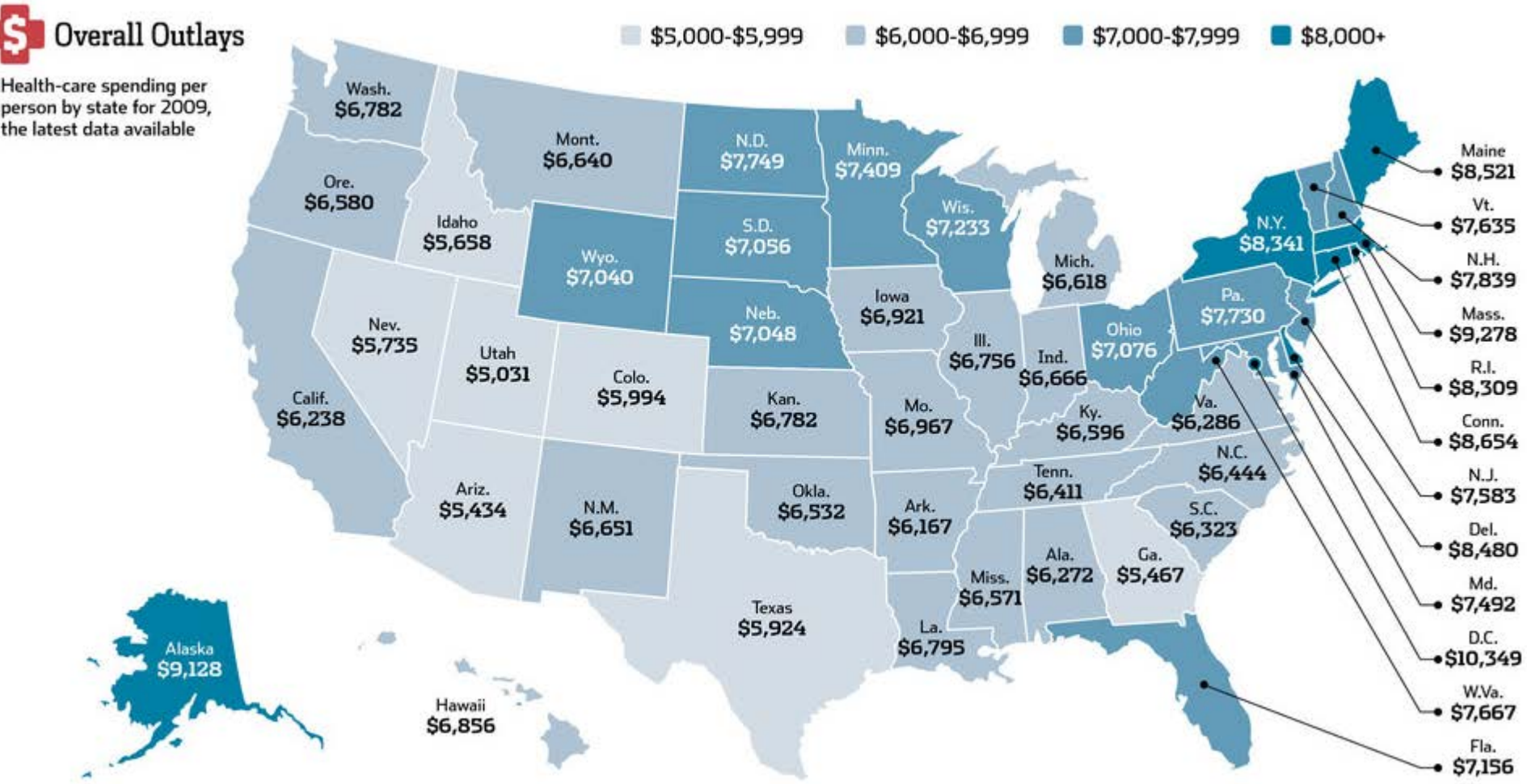
The United States Spends More on Health Care than Any Other Developed Nation



Healthcare Cost as % of GDP per Capita (2013)



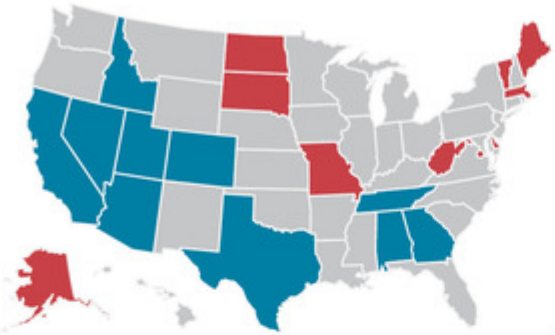
A break-down of health care spending state-by-state (2009)



Hospital Care

- Hospital care is spending for services provided in hospitals, including outpatient care, operating-room fees and services of resident physicians.

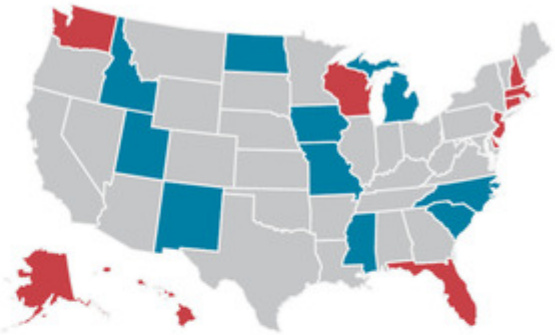
Highest		Lowest	
D.C.	$4,948	Utah	$1,830
Alaska	3,879	Ga.	1,922
Mass.	3,505	Nev.	1,949
Vt.	3,408	Ariz.	1,977
Maine	3,268	Calif.	2,077
N.D.	3,183	Ala.	2,111
S.D.	3,147	Idaho	2,115
Mo.	3,143	Texas	2,138
Del.	3,109	Conn.	2,150
W.Va.	3,073	Tenn.	2,160



Physician and Clinical Services

- Physician and clinical services is treatments in health professionals' establishments.

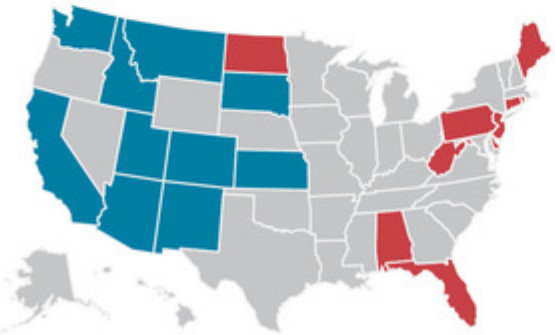
Highest		Lowest	
Alaska	$2,570	Utah	$1,189
Mass.	2,078	Mo.	1,277
N.J.	2,049	Idaho	1,287
Del.	1,978	N.D.	1,306
Conn.	1,952	Mich.	1,366
Fla.	1,950	Iowa	1,381
Wis.	1,879	Miss.	1,391
Hawaii	1,873	S.C.	1,399
N.H.	1,863	N.C.	1,401
Wash.	1,842	N.M.	1,440



Prescription Drugs and Other Nondurables

- Prescription drugs and other nondurable medical products include over-the-counter drugs such as cough and allergy medications and medical sundries such as surgical dressings or thermometers.

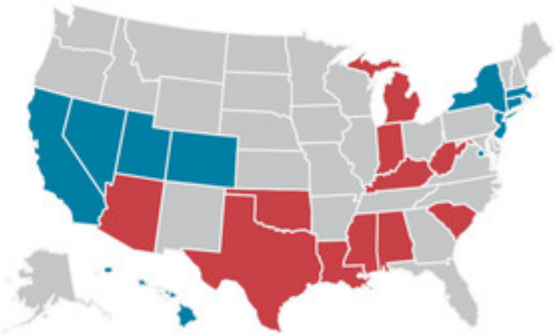
Highest		Lowest	
Conn.	$1,269	Colo.	$690
R.I.	1,230	Mont.	733
Del.	1,219	Idaho	739
Fla.	1,213	Utah	741
N.D.	1,185	S.D.	768
Ala.	1,179	Calif.	786
W.Va	1,175	N.M.	791
N.J.	1,171	Ariz.	804
Maine	1,126	Wash.	807
Pa.	1,113	Kan.	822



Obesity

- Obesity is 2011 rate among adults calculated from respondents' self-reported weight and height.

Highest		Lowest	
Miss.	34.9%	Colo.	20.7%
La.	33.4	Hawaii	21.8
W.Va.	32.4	Mass.	22.7
Ala.	32.0	D.C.	23.7
Mich.	31.3	N.J.	23.7
Okla.	31.1	Calif.	23.8
Ariz.	30.9	Utah	24.4
Ind.	30.8	Conn.	24.5
S.C.	30.8	Nev.	24.5
Ky.	30.4	N.Y.	24.5
Texas	30.4		



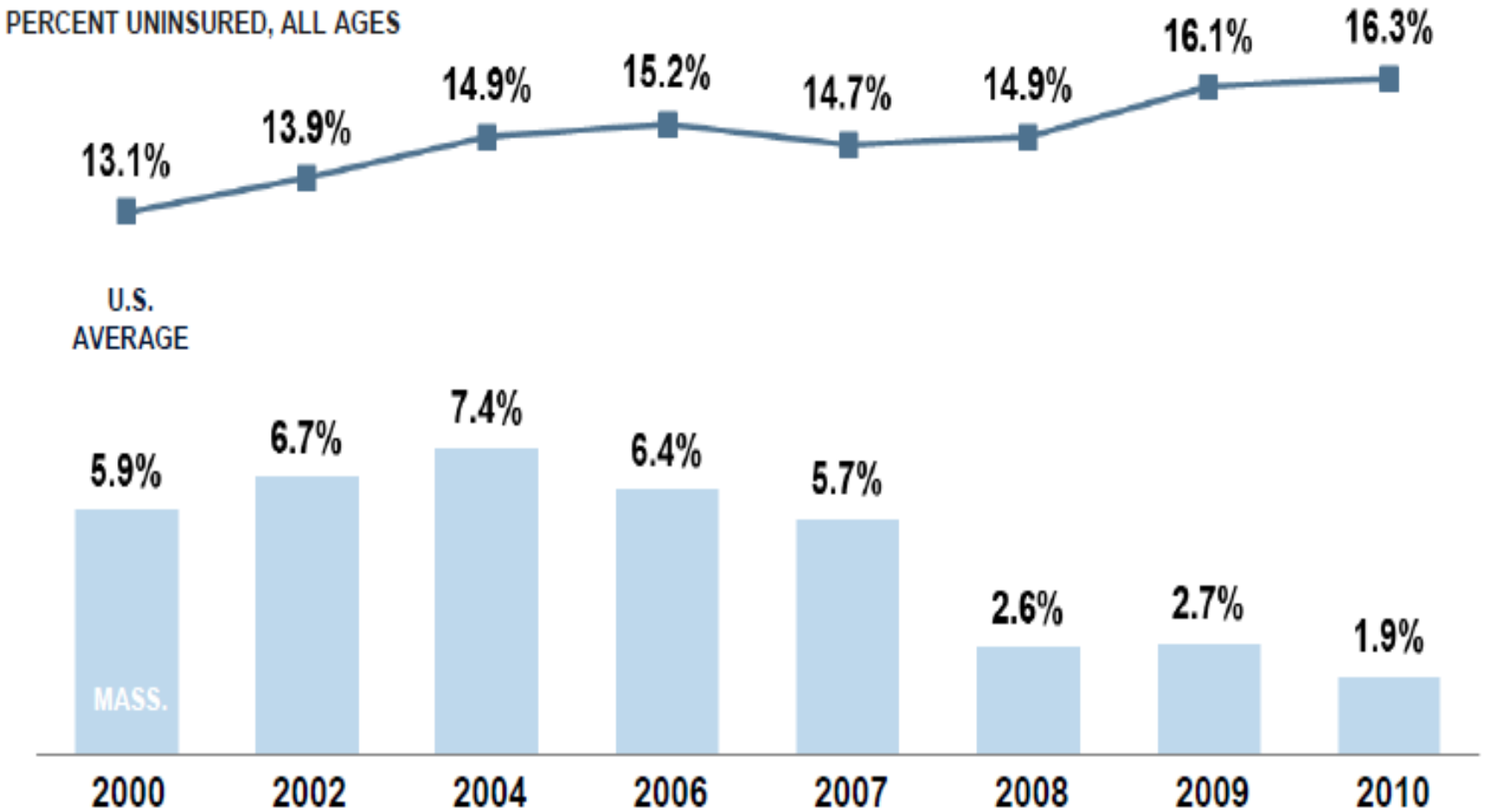
Note: All spending figures are per capita in 2009.

Sources: Centers for Medicare and Medicaid Services (spending data); Census Bureau (population); Centers for Disease Control and Prevention (obesity)

The Wall Street Journal

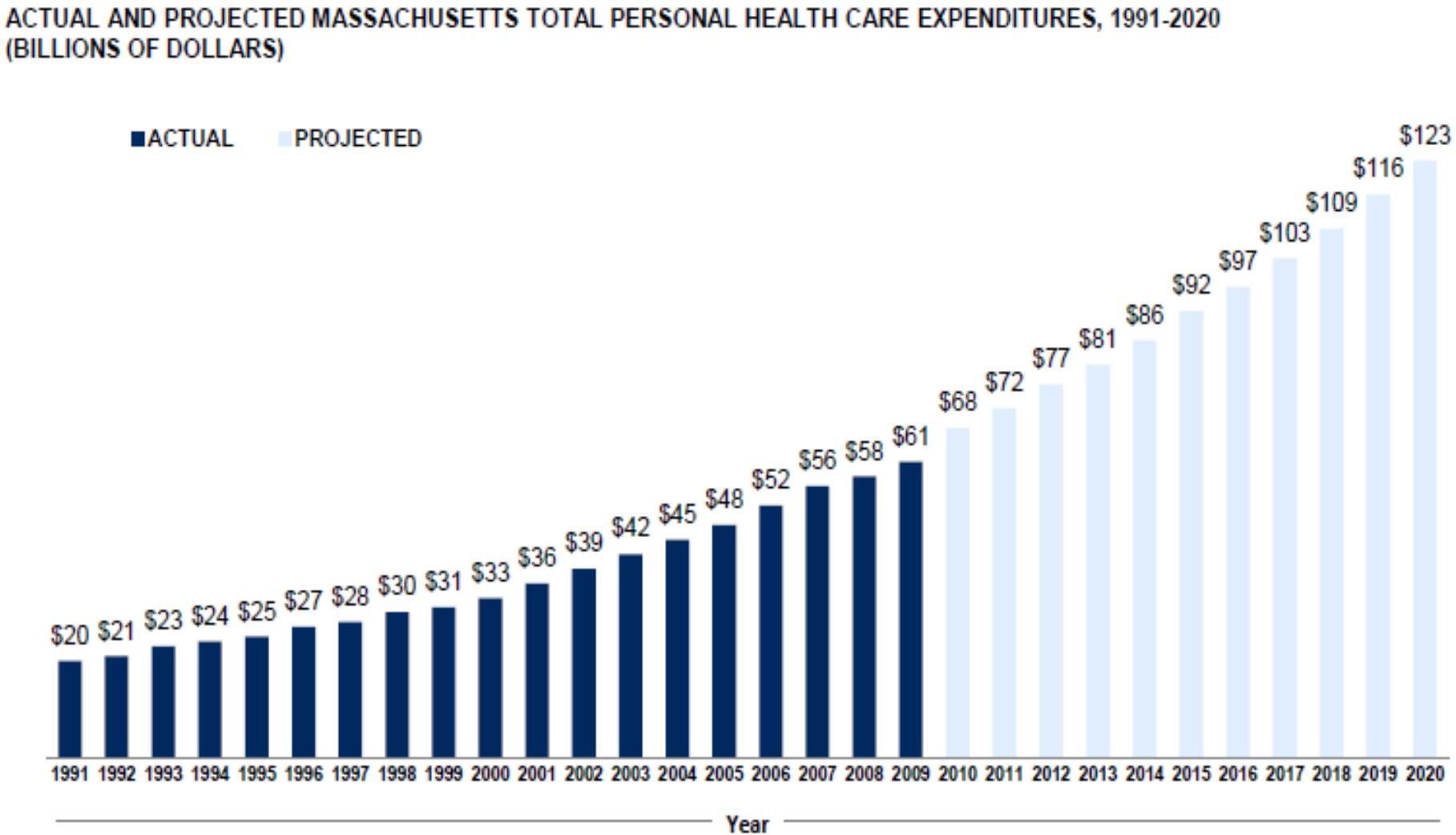
How We Got Here

MASSACHUSETTS NOW HAS THE LOWEST RATE OF UNINSURANCE IN THE COUNTRY

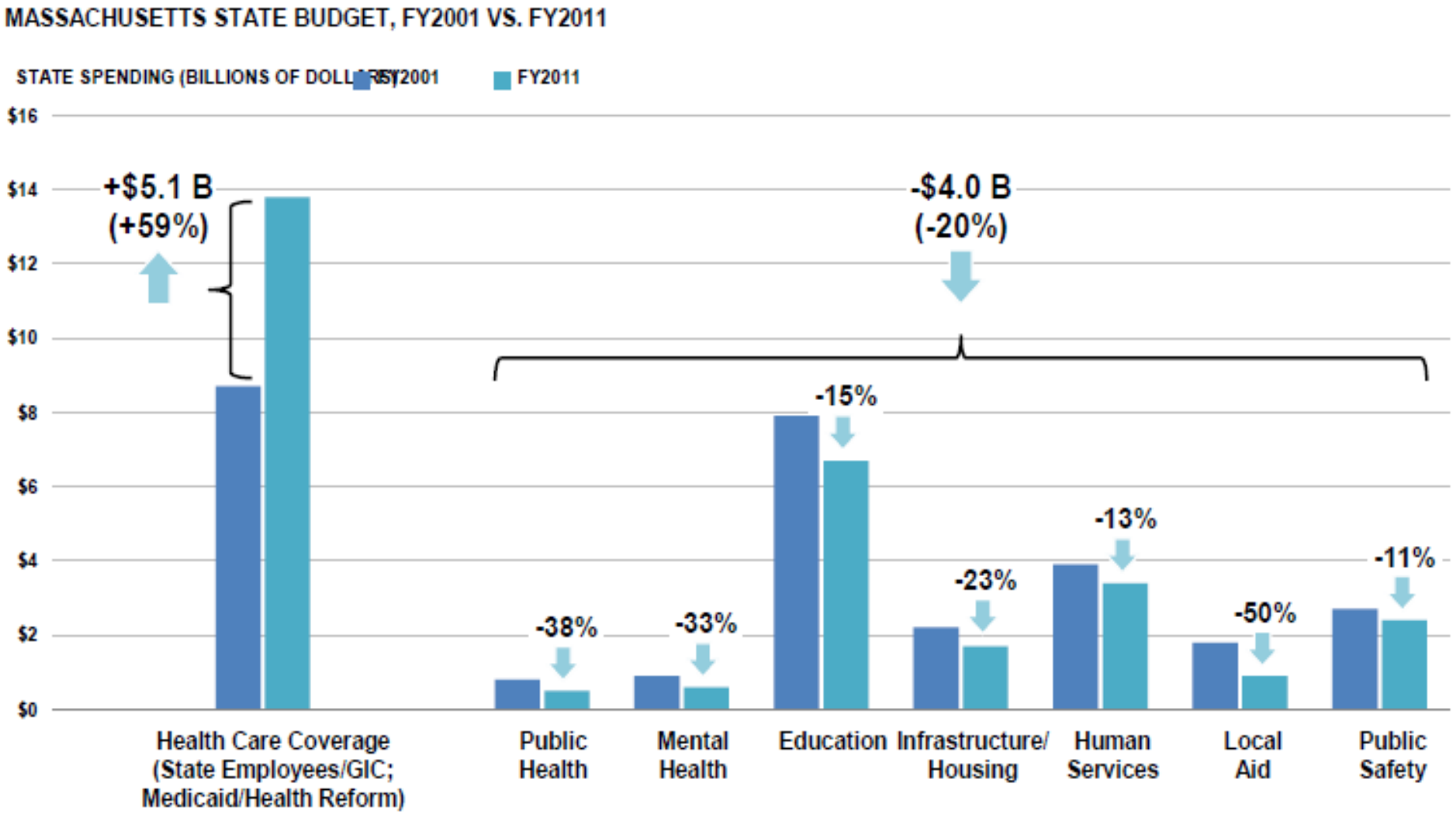


The Challenge and the Opportunity

Total Health Spending Will Double from 2009 to 2020



Increasing Costs of Health Care Squeeze Out Other Public Spending



SOURCE: Massachusetts Budget and Policy Center Budget Browser.

"Start with only two people"

Jeffrey Brenner, MD
Camden (NJ) Coalition of Healthcare Providers

Found a better and cheaper way to treat costly patients through collaborative care by using data to map "hot spots" of health care high-utilizers.

Making Health Care Affordable: Preserving Access and Improving Value

Making Health Care Affordable provides **up to three-year grants** for initiatives that demonstrate substantive cost containment while maintaining or improving access and quality of care. Moderating the growth of health care spending is critical to sustaining the grains that Massachusetts has made in access and coverage since 2006. This program supports the development, expansion, testing, and measurement of the impact of affordability strategies among Massachusetts health care organizations in order to ensure the sustainability of these gains.

Funded by Blue Cross Blue Shield Foundation of MA

Mercy Hospital	Springfield
Brockton Neighborhood Health Center	Brockton
Holyoke Health Center	Holyoke
Steppingstone	Fall River
Brookline Community Mental Health Center	Brookline
Judge Baker Children's Center	Boston
Alliance Foundation for Community Health	Somerville
VNA of Greater Lowell	Lowell
Community Healthlink, Inc.	Worcester
Lynn Community Health Center	Lynn
Boston Medical Center	Boston
Greater Lawrence Family Health Center	Lawrence

Special Community Health Outreach to Redirect Homeless High-End Utilizers of Hospital Emergency Departments into Primary Care and Case Management, 2012-2015

- ***Goal:*** To contain health care costs by redirecting homeless persons who are high end utilizers of hospital emergency rooms to primary care and intensive case management in cases of non-emergent care and chronic conditions

- ***Funding Source:*** Blue Cross and Blue Shield of Massachusetts Foundation

- ***Principal Investigator:*** Doreen Fadus, Mercy Medical Center, Springfield, MA

Participating Hospitals

Mercy Medical Center, Springfield

Baystate Medical Center, Springfield

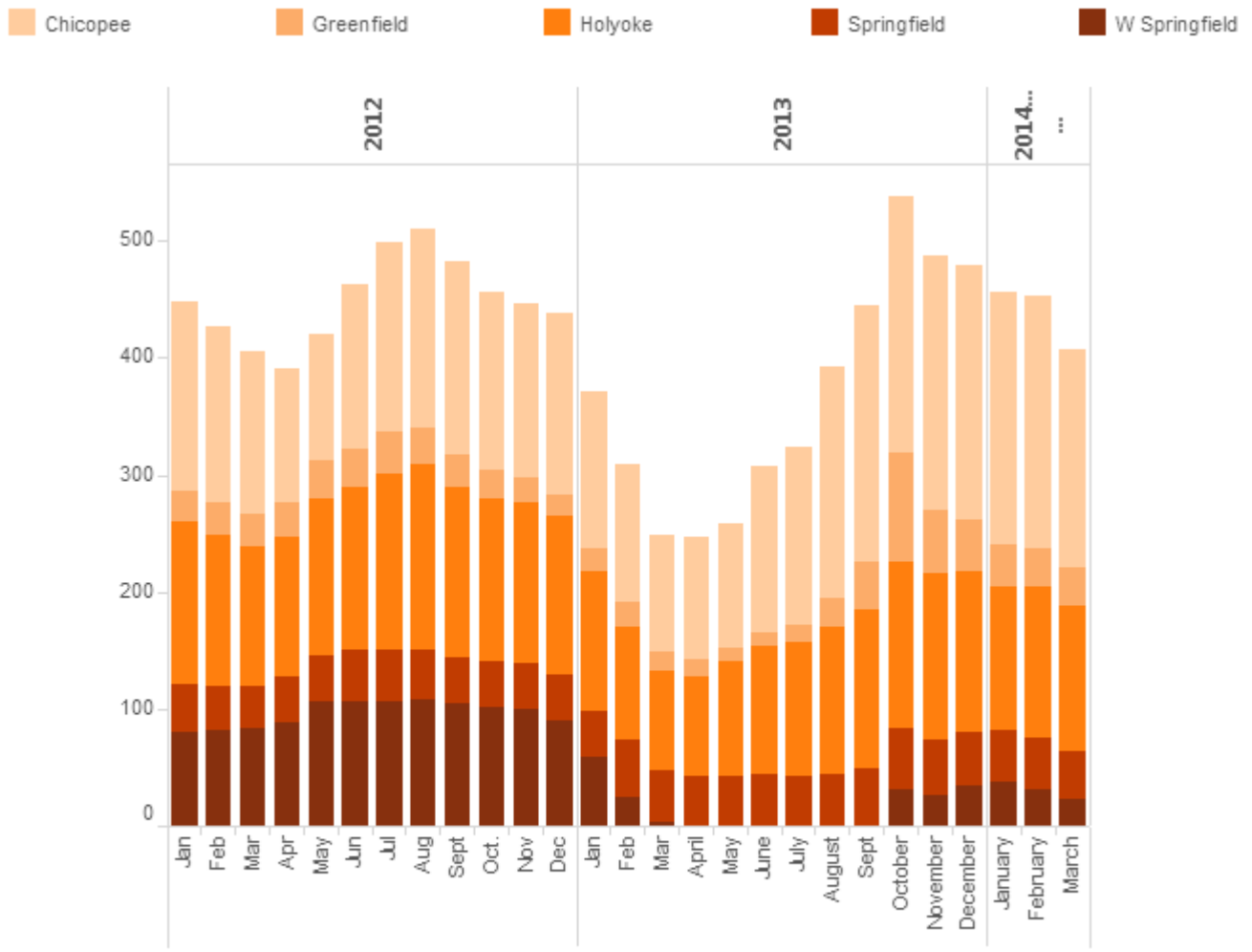
Cooley Dickinson Hospital, Northampton

Holyoke Medical Center, Holyoke

Noble Hospital, Palmer

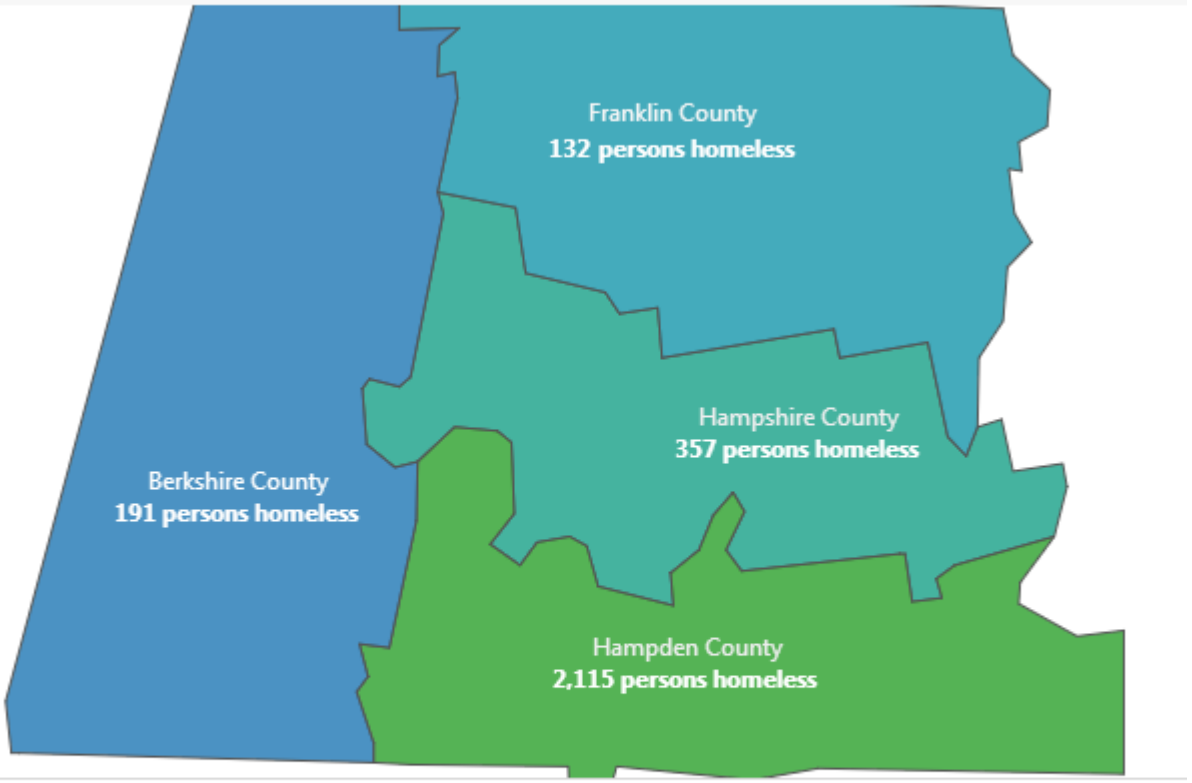
Size of Homeless Population in Western MA

- Source: Western MA network for homelessness
  http://westernmasshousingfirst.org/data/



Western MA families make up a disproportionate share of families placed in hotels/motels statewide.

Regional Point In Time Count Data
January 30th, 2013



2,795 persons homeless across Western Massachusetts

Consisting of **887 individuals** and **1,908 persons** in **633 families**

Individuals Persons in Families

How the Project Works

- Case management based: 1 case manger, 1 social worker
- High end utilizers' needs assessed using prior knowledge & hospital records
- Referrals came from Health Care for Homeless, Western MA interagency meetings, ER, other homeless service providers
- Project staff recruited potential participants at soup kitchens, shelters, streets etc.
- Following initial assessment, services offered to participants as they arrived at Health Care for Homeless.

Survey Questions

- Is client covered by Insurance?
- Does client have a Primary Care Provider?
- Would you recommend this program to a friend or family member?
- Self-assessment of health status
- Where did participant stay the night before?
- Was participant ever housed?
- How did participant get to the Emergency Department for the last visit?
- What is the participant’s general means of transportation?

SURVEY QUESTIONS *(Cont.)*

- Is the participant currently working for pay (including under the table pay)?
  IF YES, what is the occupation & place of employment?
  IF NO, what was the last source of employment?
  IF NO, during the past 30 days, has the participant made specific efforts to find work?
  IF NO, which category best describes the participant's current situation?

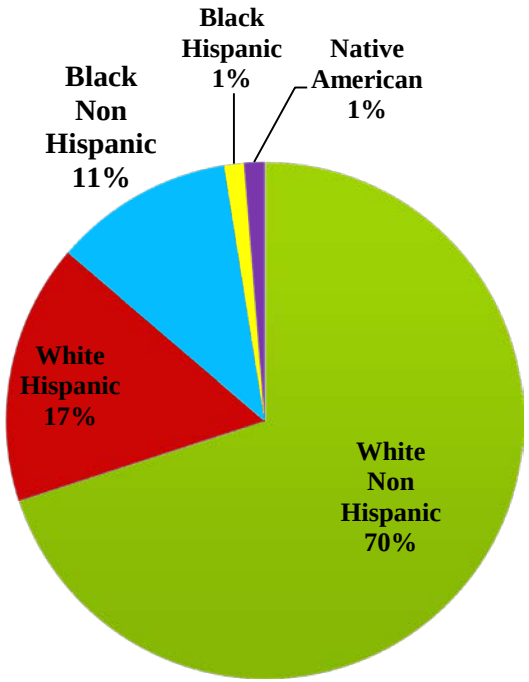
- During the past 12 months has the participant received assistance from any public assistance programs? If NOT, why not?

- In the last 12 months, has the participant received any in-kind assistance?

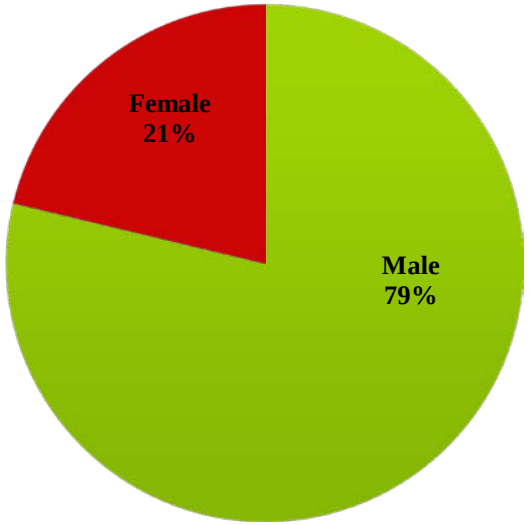
- What is the participant's monthly income?

Overall Demographics of Program Participants N=80

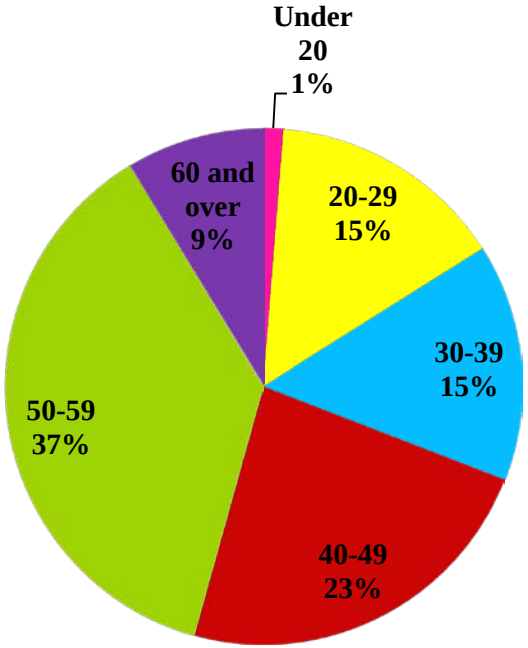
Race/Ethnicity



Gender



Age



Update on Participants…April 1, 2014

Total clients enrolled as of April 1, ‘14: 81

- **# of clients enrolled at least 12 months as of April 1, ‘14: 50**

  Of these 50:

  Utilization data collected on: 20

  In the process of collecting utilization data on: 9

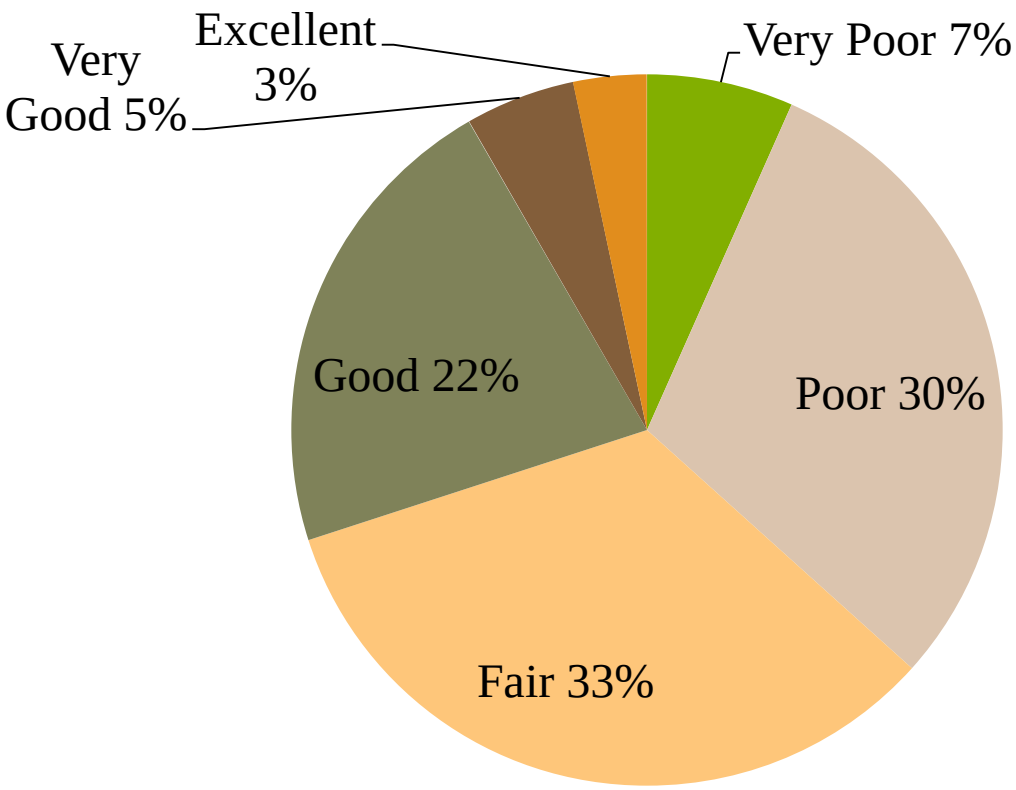
  Did not complete a full 9 months during initial 12 months in program: 21

  Reasons:

Unable to locate	*13*
Moved out of area	*5*
Unable to reach	*2*
Moved in with family	*1*

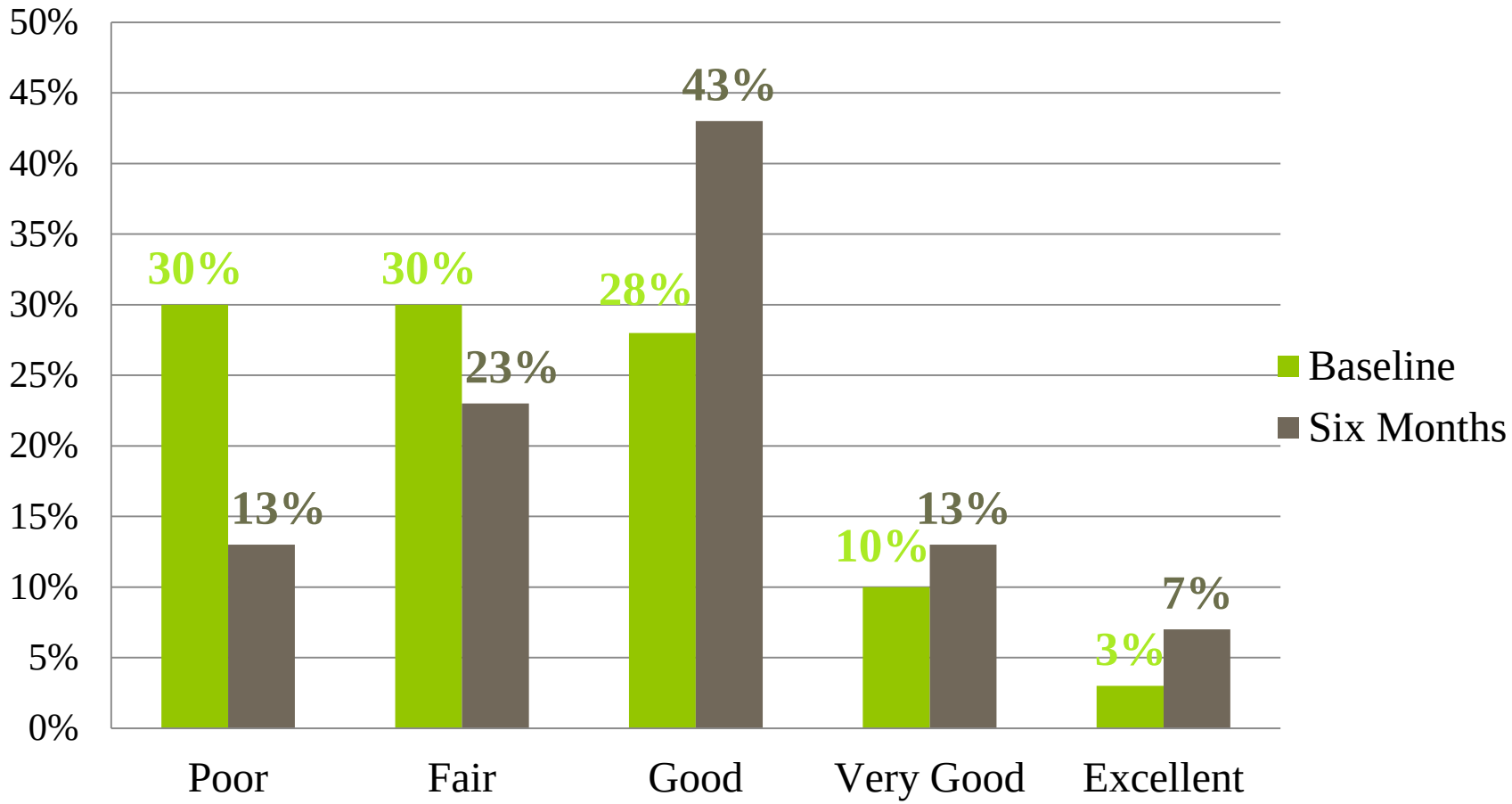
- **# of clients not enrolled a full year (too early to collect): 31**

Self-Reported Health Status at Time of Enrollment N=60



Health Status at Baseline and at Six Months

Baseline N=71; Six months N=30



Hospital ED Visits

(findings based on 20 participants)

Pre Enrollment:

20/20 = **100%** of participants entered the ED before enrolling in the HEU Grant.

Post Enrollment:

17/20 = **85%** of participants entered the ED after enrolling in the HEU Grant.

Brian

Enrolled: June 2012

Visits: pre-enrolled 87, post-enrolled 42

Brian's story

- 68 year old born in Providence
- Never married; no children
- No family relationships
- Loves historical trivia
- Started drinking at 18, 2 pints of alcohol daily
- Homeless for 50 plus years
- ***Hypertension, insomnia, excessive episodic drinking***
- Unable to find stable housing due to ETOH abuse and history
- Behavior while intoxicated disrupts receipt of services
- 52% decrease in ED visits

Little things matter

- 59 encounters in 12 months
- Daily meeting with case manager
- Connected with: Primary Care, FOH, Detox, Safe Havens, La Belle & country estates
- Advocated extended detox stays
- Helped with bus passes, cab vouchers, clean clothes, hygiene supplies, showering at clinic
- Assisted with representative payee
- HEU paid for professional haircut and shave
- Passed away sober with dignity, surrounded by people who cared
- Buried at family's plot at brother's request

Latasha

Enrolled: July 2012

Visits: pre-enrolled 46, post-enrolled 12

Latasha's story

- 49 year old born in NC
- One son; parents deceased; siblings unknown
- Cousin has custody of her son
- Completed 12th grade
- Past experience working as housekeeper and CAN
- ***Substance abuse (alcohol), Hepatitis C, hypertension, depression***
- 74% decrease in ED visits

Little things matter

- 20 encounters in 12 months
- Always reached out to case manager when struggling with sobriety
- Advocated for her at doctor appointments, FOH, and food stamps
- Referred her to Future Works where she is training for future employment skills
- Helped come up with a sobriety plan
- Social Services counselor used LAOCI to create a recovery tool(**?)** box

Jose

Enrolled: July 2012

Visits: pre-enrolled:18; post-enrolled: 0

Jose's story

- 50 years old
- Parents deceased
- One daughter and two grandchildren
- One year of college
- Worked in restaurants when he was younger
- ***History of hypertension, seizures, schizophrenia, insomnia and drug abuse***
- Living at the shelter
- 100% decrease in ED visits

Little things matter

- 79 encounters in 12 months
- Worked on relationship with family
- Met with him daily at Loaves and Fishes to establish trust and dependency
- Connected him with different agencies
- Coordinated to work with case managers from Lighthouse to help him get housed
- HEU helped furnish apartment and make doctor appointments.
- HEU purchased school supplies & Christmas gifts for grandchildren
- Continues to work on importance of family responsibility

Rose

Enrolled: July 2012

Visits: pre-enrolled: 19; post-enrolled: 0

Rose's story

- 68 year old grandmother
- 2nd grade education; illiterate in Spanish and English
- Released from prison after 20 years
- No social security card, Medicaid, or housing
- ***Struggled with PTSD, panic attacks, and hypertension***
- 100% decrease in ED visits

Little things matter

- 14 encounters in 12 months
- Gave her resources: primary care, mental health services in Spanish and dental care
- Helped build relationships with her biological son and daughter
- Assisted with referrals to outside service providers
- Enjoys time with grandchildren and has a room at daughter's house
- HEU helped furnish that room

Bob

Enrolled: September 2012

Visits: pre-enrolled: 30; post-enrolled: 14

Bob's story

- 51 year old man
- Born and raised in Springfield, MA
- High School education
- Played Youth Hockey
- "I practically grew up at the Y"
- Worked as a CNA and custodian
- History of frequent falls with head injuries
- ***Hypertensive, anemic, alcohol dependency, severe depression over passing of parents***
- Moved into transitional housing March 2012
- Evicted after being housed 19 months
- Non-compliant with medical appointments
- 53% decrease in ED visits

Little Things Matter

- Met at least one time a week since Sept 2012
- First year of intervention: total encounters 53, total case management 105 (1:1, case coordination with other agencies, attempts to locate client)
- Provided education about and encourage him to attend AA, YMCA Mocha, Lighthouse, sober community events
- Encouraged him to stay away from triggers
- Assistance with making appointments
- Accompanied him to primary care appointments
- Met him at the ED and advocated for discharge coordination
- Advocated to get him into detox, providing cab voucher & meeting him there each time.
- Advocacy & collaboration with area homeless service providers on his behalf
- Gave bus passes, new sneakers, blanket, pocket dictionary
- Assisted him with building a budget and encouragement to stick to it
- Celebrated 50th birthday with card and small gift
- ***"I like working with you because you don't nag me, you treat me with respect".***

John

Enrolled: September 2012

Visits: pre-enrolled: 8; post-enrolled: 2

John's story

- 53 year old man from Springfield, MA
- 11th grade education
- Worked in restaurant industry for many years
- Became homeless after argument with roommate
- Homeless for 6 months, staying on friends' couches, various shelters, crisis, and streets
- ***COPD, neuropathy, emphysema, history of rectal cancer, GERD, knee problems, gallstones, liver masses, bilateral hip degeneration, hypertension, anxiety, clinical depression, seizure disorder, high cholesterol, urinary incontinence, sleep apnea***
- Walked with cane due to chronic pain
- Medical appointments increased anxiety
- Unable to name providers or specialists
- No cohesive care coordination between providers/specialists
- 75% decrease in ED visits

Little things matter

- Met since Sept 2012; once a week
- First year of intervention: total encounters 79, total case management 123 (1:1, case coordination with other agencies, attempts to locate client.)
- Assisted with housing applications, apartment hunting, & reference letter for housing
- Referred for financial assistance for move-in expenses
- Referral to agencies for free household supplies & Bob's Furniture Charitable Foundation for furniture
- Assistance with making appointments and bus passes
- Wal-Mart gift card
- Coordination with providers to assist with understanding of diagnosis, tests, treatment options
- Provided educational material on medical needs to decrease anxiety
- Assisted with finding new provider
- Assisted with filling prescriptions & understanding medical billing
- Pain decreased significantly; discontinued use of cane
- Was able to decrease mg?? of some medications and discontinue others throughout the year.

Helga

Enrolled: October 2013

Visits: pre-enrolled: 22; post-enrolled: 12

Helga's story

- 53 year old; born in Germany
- No family support
- Homeless over 4 years
- ***History of depression, bi polar, PTSD, and acute anxiety***
- Lack of trust issues
- Difficult to engage with
- Multiple legal issues
- 45% decrease in ED visits

Little things matter

- 106 encounters in 12 months
- Met with her daily
- Difficult to build a trusting relationship
- Resistant to receive HEU services; social services counselor had lunch with her and was able to build trust
- Provided resources for help with primary care & mental health services
- Provided socks, hygiene supplies, bus passes
- Moved into single-room occupancy
- HEU helped furnish room with sheets, lamps, pictures
- Able to pay rent and be responsible

Hospital Admissions

(Findings based on 20 participants)

Pre Enrollment:

15/20 = **75%** of clients went to the hospital before enrolling in the HEU Grant.

Post Enrollment:

11/20 = **55%** of the clients went to the hospital after enrolling in the HEU Grant.

Brian

Enrolled: June 2012

Pre Enrollment: 6

Post Enrollment: 2

- **67% decrease** in hospital visits from a year before entering the program to a year after

Bob

Enrolled: September 2012

Pre Enrollment: 5

Post Enrollment: 0

- **100% decrease** in hospital visits from a year before entering the program to a year after

Emergency Department Visits *(5 hospitals)*

Client	Pre ED	Post ED	%
Brian	87	42	52
Latasha	46	12	74
Sally	15	9	40
Sofia	4	4	0
Kristin	4	1	75
Jose	18	0	100
Reuben	13	7	46
Jake	5	0	100
Rose	19	0	100
Frank	7	5	29

Client	Pre ED	Post ED	%
Denzel	15	11	27
Barbara	8	14	75(↑)
Peter	14	13	7
Tom	7	15	114(↑)
Bob	30	14	53
Allen	5	3	40
John	8	2	75
Kevin	1	4	300(↑)
Phil	5	2	60
Helga	22	12	45

Acute Care Admissions

Client	Pre Admit	Post Admit	%
Brian	6	2	67
Latasha	1	0	100
Sally	2	1	50
Sofia	0	0	0
Kristin	1	0	100
Jose	2	0	100
Reuben	7	7	0
Jake	0	0	0
Rose	2	0	100
Frank	3	1	67

Client	Pre Admit	Post Admit	%
Denzel	2	2	0
Barbara	5	7	40(↑)
Peter	1	0	100
Tom	3	4	33(↑)
Bob	5	0	100
Allen	0	1	100(↑)
John	1	1	0
Kevin	0	1	100(↑)
Phil	1	0	100
Helga	0	0	0

Data from Providence Behavioral Health

Client	Pre Providence	Post Providence	%
Brian	6	1	83
Latasha	0	0	0
Sally	0	0	0
Sofia	0	0	0
Kristin	0	0	0
Jose	0	0	0
Reuben	0	2	100(↑)
Jake	0	0	0
Rose	0	0	0
Frank	0	0	0

Client	Pre Providence	Post Providence	%
Denzel	3	2	33
Barbara	0	0	0
Peter	0	0	0
Tom	0	0	0
Bob	0	0	0
Allen	0	0	0
John	0	0	0
Kevin	0	0	0
Phil	0	0	0
Helga	0	1	100(↑)

Frequency and Total Cost of ED Visits

Total difference in cost: $92,916

Client	Pre Enrollment	Post Enrollment	%
Brian	87 $49,590	42 $23,940	52 $25,650
Latasha	46 $26,220	12 $6,840	74 $19,380
Sally	15 $8,550	9 $5,130	40 $3,420
Sofia	4 $2,280	4 $2,280	0
Kristin	4 $2280	1 $570	75 $1,710
Jose	18 $10,260	0	100 $10,260
Reuben	13 $7,410	7 $3,990	46 $3.420
Jake	5 $2,850	0	100 $2,850
Rose	19 $10,830	0	100 $10,830
Frank	7 $3,990	5 $2,850	29 $1,140

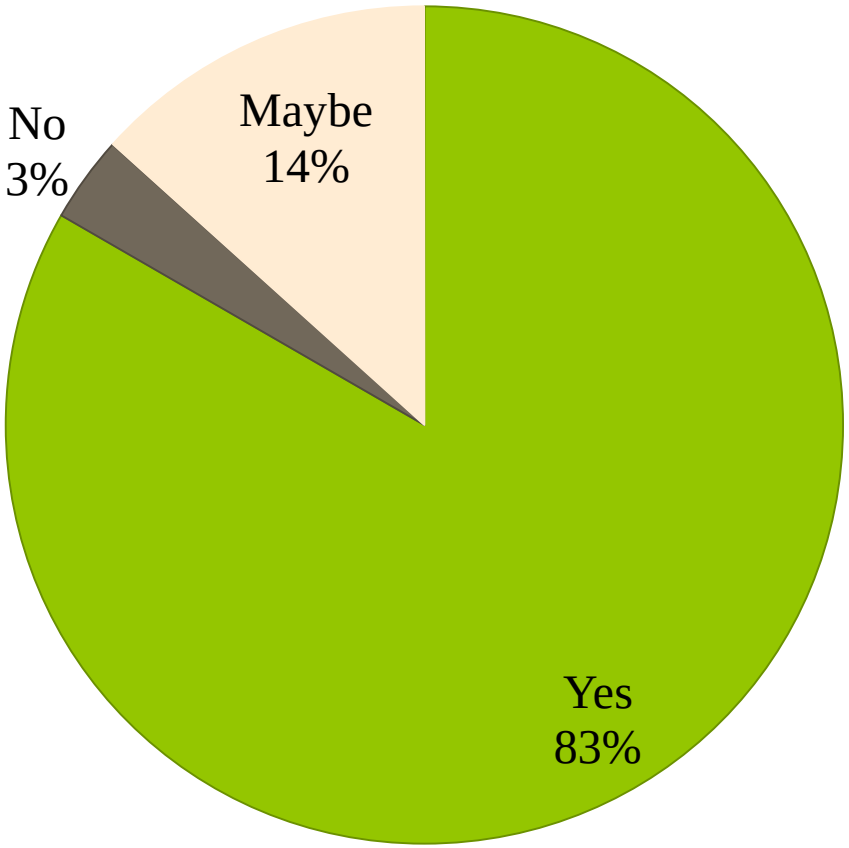
Client	Pre Enrollment	Post Enrollment	%
Denzel	15 $8,550	11 $6,270	27 $2,280
Barbara	8 $4,560	14 $7,980	75(↑) + $3,420
Peter	14 $7,980	13 $7,420	7 $570
Tom	7 $3,990	15 $8,550	114 (↑) +$4,560
Bob	30 $17,100	14 $7,980	53 $9,126
Allen	5 $2,850	3 $1,710	40 $1,140
John	8 $4,560	2 $1,140	75 $3,420
Kevin	1 $570	4 $2,280	300(↑) + $1,710
Phil	5 $2,850	2 $1,140	60 $1,710
Helga	22 $12,540	12 $6,840	45 $5,700

A Cost-Benefit Analysis…

Total Difference/Cost Reduction: $305,553

Client	ED Pre	ED Post	Acute Pre	Acute Post	Prov Pre	Prov Post
Brian	$49,590	$23,940	$76,800	$28,800	$79,700	$21,207
Latasha	$26,220	$6,840	$4,800	0	0	0
Jose	$10,260	0	$12,000	0	0	0
Rose	$10,830	0	$16,800	0	0	0
Bob	$17,100	$7,980	$81,600	0	0	0
John	$4,560	$1,140	$2,400	$2,400	0	0
Helga	$12,540	$6,840	0	0	0	0
Total	$131,100	$46,740	$194,400	$31,200	$79,700	$21,207
Post Difference		**$84,360**		**$163,200**		**$57,993**

Participants' Satisfaction with Program
N= 60



Would you recommend this program to a member of your family or a friend?

Who is Likely to Succeed in the Program?

Participant likely to have success in the program:

- is female
- has a primary care provider
- spent the previous night in a shelter
- is looking for work
- had a high number of ED visits in the previous year

Unique Features of the Program

- Intensive and highly-focused case management
- Primary care connection
- Multi-disciplinary team: *case management*, *primary care*, *mental health care*
- Housing connection
- Grant funding & patient services account
- Multi-hospital (regional) cooperation
- Overall community connection
- Hospital-university collaboration

Thank You!

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