REPORT TO THE JOINT STANDING COMMITTEES OF THE GENERAL ASSEMBLY
On Aging, Housing, Human Services and Public Health

Special Act 24-5
Plan to Improve Outcomes for the Connecticut Housing Engagement and Support Services (CHESS) Program

January 2025

Andrea Barton Reeves, JD, Department of Social Services

State of Connecticut

Department of Social Services
55 Farmington Avenue
Hartford, CT 06105-3730

I. EXECUTIVE SUMMARY:

Special Act 24-5 requires the Department of Social Services (DSS), in consultation with the Departments of Housing (DOH) and Mental Health and Addiction Services (DMHAS), to review, evaluate, and develop a strategic plan regarding the Connecticut Housing Engagement and Support Services (CHESS) program.

The strategic plan was to address ways to improve outcomes for participants in the CHESS program and to reduce housing instability statewide. The plan was to include, but not be limited to: (1) amendments to the state plan or waiver programs to achieve the goals of the plan; (2) streamlining multiagency administrative procedures to ensure timely benefits to persons who have experienced or are at risk of homelessness; and (3) exploring and applying for federal approval for additional Medicaid waiver programs or amendments to the state plan to target social determinants of health with support for housing, nutritional and health management supports, and others.

DSS would like to take this opportunity to thank our sister agencies DOH and DMHAS for participating in this study and these discussions.

The model, configuration and requirements imposed by the Centers for Medicare & Medicaid Services (CMS) made this program very difficult to operate and difficult for supportive housing providers to implement. Additionally, there were a finite number of housing subsidies for this program. The finite number of housing subsidies, coupled with a Medicaid state plan that allows any eligible member to receive pre-tenancy and tenancy services, created a misalignment from the inception of the program. Due to these circumstances, the state agencies agree that the program should be sunset and all Medicaid members with a housing subsidy transitioned to the existing DMHAS supportive housing program.

II. BACKGROUND:

CHESS is an initiative that combines Medicaid health coverage with housing services, ranging from initial assessment to pre-tenancy and tenancy-sustaining support services, for state residents experiencing homelessness or at risk of homelessness and chronic health issues. This is done by pooling the efforts of state agencies and non-profit partners to bring coordinated health care and housing services to individuals with mental health, substance use, and other serious health conditions.

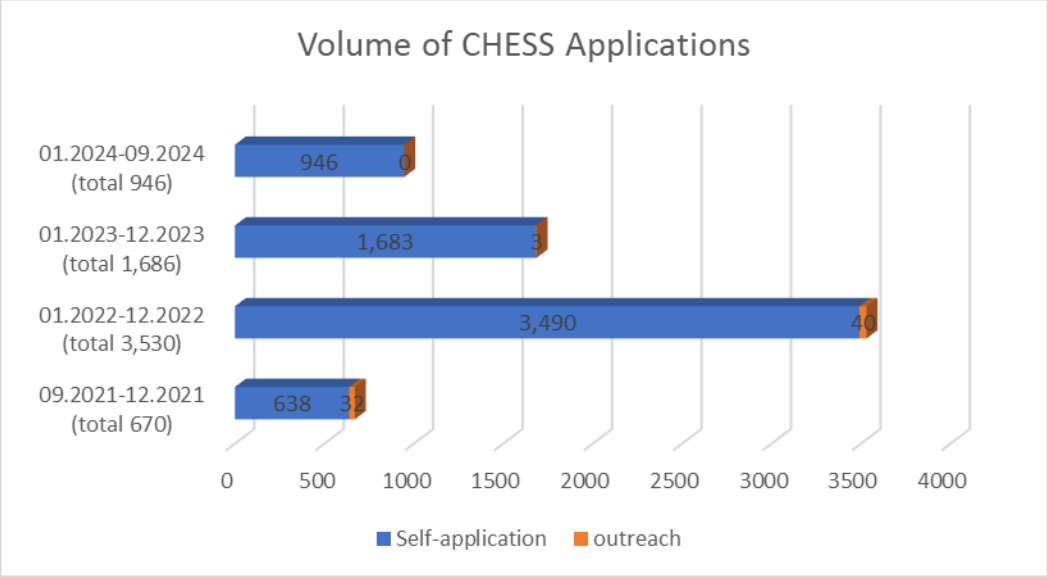
Housing subsidies, which have separate eligibility requirements, are prioritized for applicants who meet the Medicaid program requirements, are experiencing homelessness and on the By-Name List (BNL), which is a centralized, real-time database that tracks every person in the community experiencing homelessness. The BNL contains demographic information, health, mental health and substance use conditions, disabilities, risk factors (e.g., intimate partner violence, human trafficking), homelessness history, and housing needs. The BNL, which is derived from the homeless management information system (HMIS), is used to track the ever-changing size and composition of the homeless population.

CHESS provides supportive housing benefits under Medicaid, coordinated with Medicaid services and non-Medicaid housing subsidies. Medicaid-covered housing engagement and support services include pre-tenancy supports (help with locating and securing housing), tenancy-sustaining supports (help with maintaining successful tenancy), non-medical transportation, and referrals to health care services to address unmet medical conditions.

III. CURRENT OPERATIONS:

The CHESS program was originally designed to serve 300 individuals by year 3. Since the program launch in September 2021, however, 6,832 people have applied for CHESS benefits: 670 in 2021, 3,530 in 2022, 1,686 in 2023, and 946 by September 30, 2024.

Out of 6,832 applicants, 6,757 were self-applicants and 75 were from outreach via Carelon, the behavioral health administrative services organization (ASO).



With Connecticut's statewide eviction moratorium expiring on June 30, 2021, and the federal moratorium expiring on July 31, 2021, there was additional interest in the program, especially due to the belief that there were housing subsidies available for program participants and that this would be a way to circumvent other housing waiting lists.

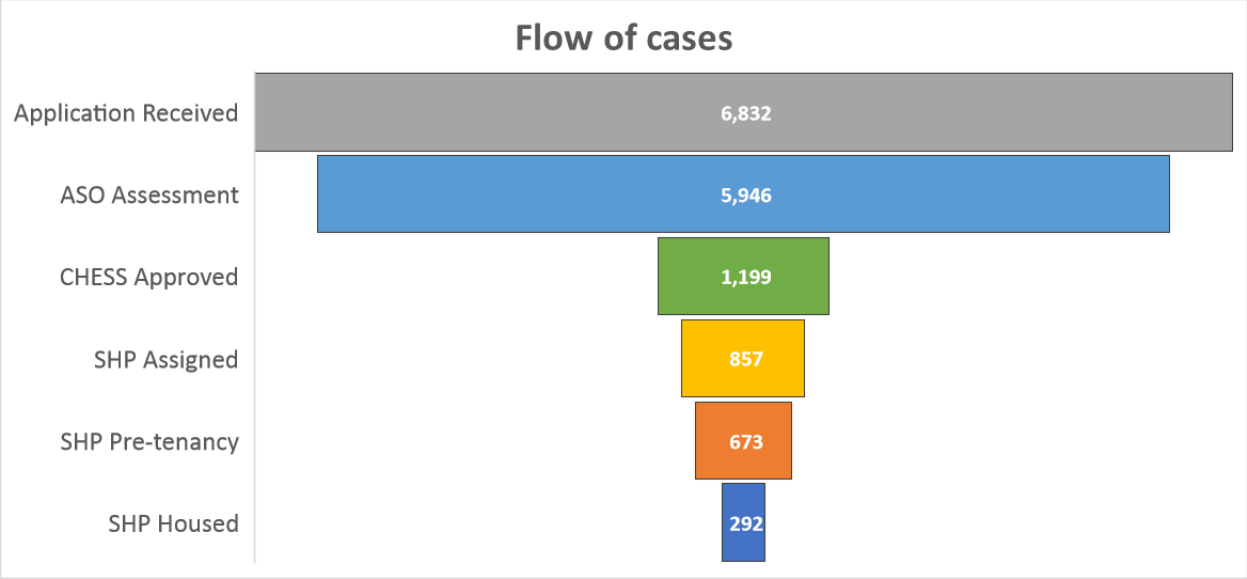
In order to qualify for CHESS, a person has to be an active Medicaid recipient, have a behavioral health diagnosis, a complex health condition meeting a Charleston Comorbidity Index (CCI) score of 4 or more, be at risk of homelessness without CHESS, and have at least two critical needs. When a CHESS application is received, DSS screens and assigns the individual to Carelon, the state's behavioral health ASO, to verify the initial CHESS eligibility. When a person is verified to meet all CHESS eligibility requirements, DSS then approves the applicant's eligibility.

The eligibility determination process is fairly long because Carelon must verify all eligibility criteria. There have been applicants who have never had a primary care provider and have no medical records to determine their CCI score. There are also applicants whose information did not appear in the BNL. In addition, many applicants fail to maintain contact with their Carelon care manager to complete their eligibility verification, often due to transience, secondary to extreme housing instability or homelessness, inability to pay phone bills, or repeated hospitalizations.

Once CHESS eligibility has been approved, the applicant is assigned to a supportive housing provider (SHP) who works with the applicant to conduct a supportive housing assessment and develop a Person-Centered Recovery Plan (PCRP). The PCRP must be approved by Carelon before the SHP can provide pre-

tenancy services. Once a person is housed, the SHP assessor revises the PCRP for tenancy-sustaining services.

Since the program launch, the state's case management system documented 6,832 people who applied for CHESS. Of that amount, 5,946 were assigned to Carelon for eligibility determination and, of that amount, 1,199 were ultimately approved for CHESS. Of those approved, 857 were assigned an SHP, with 673 receiving pre-tenancy services and 292 being housed under CHESS. Of those 292, 262 participants received a housing subsidy and 30 people were housed through an unidentified alternate housing option and/or without a subsidy. Of those 292 housed, 226 were on the BNL (77.4%) and 66 people verified they were at risk-of-homelessness through the self-certification process (22.6%).



CHESS cases as of September 30, 2024:

	DSS/ Carelon			SHP				
	Applications closed or pending for closure during eligibility determination	In eligibility determination process	CHESS approved - pending SHP assignment	In care planning stage	Receiving pre-tenancy services	Receiving tenancy-sustaining services	Housed under CHESS and discontinued services	Total applications received from Sept.2021 to Sept 30, 2024
# of active cases	5,414	313	333	166	314	250	42	6,832

	Total # of people housed	Receiving tenancy-sustaining services	Receiving pre-tenancy services	Pending closure	Closed
Housed with housing subsidy	**262**	164	30	33	35
Housed with unidentified subsidy	**30**	21	0	2	7
Total housed	**292**	185	30	35	42

Among the 292 housed, 215 cases are still active. 42 are closed and 35 are pending for closure review after being housed. Reasons for CHESS closure include the death of the participant, decision to discontinue participation, loss of eligibility, a move out of state, incarceration, or providers not being able to reach the member for their annual re-assessment. Many of the individuals who lost CHESS eligibility appear to have lost Medicaid coverage when they began receiving Medicare benefits and transitioned from HUSKY D to HUSKY C, due to the different income and asset requirements.

Reasons for CHESS closure after housed	Closed cases after housed with housing subsidy	Closed cases after housed with unidentified or no subsidy
Total number of cases closed after housed	35	7
Death	15	1
Not meet Medicaid / other CHESS eligibility	11	2
No longer wish to participate	6	1
Receiving case management from another program	1	
Moved out of state	1	
Unable to contact	1	2
Incarceration		1

Over the course of the program, 262 housing subsidies were utilized and 40 were forfeited. Of those 40, 19 were returned due to the participant's death or institutionalization in a skilled nursing facility or hospital, 9 were forfeited due to the participant's breach of lease or non-payment of lease, 5 were returned voluntarily because they chose other housing options such as Section 8 housing or elderly/disabled housing, and 5 were lost due to an increase in income.

Reasons for forfeited vouchers as of 7/31/2024	40
Death	15
Institutionalization	4
Breach of lease (violation)	6
Non-payment of lease	3
Chose other housing option	5
Not eligible for voucher (over income)	5
Moved out of state	1
Other (unknown)	1

Active providers

CHESS started with 8 out of 50 eligible supportive housing providers. The providers were not familiar with fee-for-service billing under Medicaid and there was difficulty securing provider buy-in and participation. The providers reported that the fee-based and value-based payments were not fiscally viable for their non-profit agencies. The providers also faced chronic workforce shortages and staffing instability. Providers were asking for grants that could support start-up costs. Because of these hurdles, only two providers – both in the Eastern region of the state – are accepting new cases at this time.

CHESS Supportive Housing Provider	Region	Status
CRT	North Central	Not accepting new referrals since Nov 2023
MHCT	Western	Not accepting new referrals since June 2023
NLHHC	Southeastern	Open – serving New London County
TVCCA	Eastern	Open – serving New London County
New Reach	South Central	Inactive as of 9/30/2022
Columbus House	South Central	Inactive as of 12/6/2022
Catholic Charities	Southwestern	Inactive as of 4/19/2023
United Services	Northeastern	Inactive as of 9/26/2024

The limited number of participating providers created significant operational issues with the program, especially the Medicaid requirement for state-wideness. As of September 30, 2024, there were a total of 919 active approved cases, excluding those pending for closure. Of those, 404 (44%) are without assigned supportive housing providers.

Supportive Housing Providers	Total active cases (CHESS approved)
Community Renewal Team (CRT)	172
Mental Health Connecticut (MHCT)	176
New London Homeless Hospitality Center (NLHHC)	71
Thames Valley Council for Community Action (TVCCA)	95
United Services	1
No SHP assigned	404
Total	919

DSS compared the health care cost of the 189 CHESS members who were housed between March 25, 2022, and September 30, 2023, for the 12 months before and after housing. Improvements in personal health care management and the person's capacity to access and use the services were directly linked to stable housing. The overall cost of 12 months after housing was higher than the cost prior to housing as the cost of the housing subsidies was included in the analysis. As expected for a supportive housing model, overall medical costs were reduced after CHESS participants were housed.

Cost analysis based on housing sustainability Housed between 3/25/2022 - 9/30/2023 (review of 4 quarters pre & 4 quarters post)			
	Cost 12 months prior to housing	Cost 12 months after housing	Net Cost/ (Saving)
Total housing voucher cost		$1,927,800	$1,927,800
Total costs (including all medical claims)	$7,937,460	$6,865,681	$(1,071,779)
Total costs	$7,937,460	$8,793,481	$856,021
Total housed members	189	189	
Average cost per member per 12 months	$41,997	$46,526	
Average PMPM	$3,500	$3,877	
	Cost up to 12 months prior to housing	Cost up to 12 months post housing	
Cost of services under CHESS	$177,784	$165,411	$(12,373)
Members with CHESS housing subsidy	186	165	
Average per member per year cost	$956	$1,002	
Average PMPM	$80	$84	

The CHESS participants who were housed showed the biggest cost savings in the areas of hospital, extended care facility (nursing home), clinic, and pharmacy. Also, there were significant increases in access to services, including state institutions (outpatient or telephonic psychiatric/behavioral health clinics), home health agencies, Community First Choice (CFC), Mental Health waiver, and the Connecticut Home Care Program for Elders (CHCPE) waiver.

Top 5 Services that Decreased				
Provider type	Cost 12 months prior to housing	Cost 12 months after housing	Net cost / (savings)	%
01 – Hospital	$2,730,029	$2,237,398	$(492,632)	-18%
03 - Extended Care Facility	480,997	121,979	(359,017)	-75%
63 - Drug and Alcohol Center	488,211	295,579	(192,632)	-39%
08 – Clinic	707,068	578,396	(128,672)	-18%
24 – Pharmacy	1,977,460	1,876,935	(100,525)	-5%

Top 5 Services that Increased				
Provider type	Cost 12 months prior to housing	Cost 12 months after housing	Net cost / (savings)	%
90 - State Institution	$38,354	$211,967	$173,613	453%
05 - Home Health Agency	167,321	269,181	101,860	61%

50 - Community First Choice	50,180	141,678	91,498	182%
77 - Mental Health Waiver	686	64,616	63,930	9323%
57 - CT Home Care Program	0	13,972	13,972	

IV. SUCCESSES AND CHALLENGES:

As shown below, the CHESS program has achieved some success in addressing the needs of vulnerable populations.

292 housed. One of the most notable accomplishments of the program is that it housed 292 individuals who were previously experiencing homelessness or significant housing instability. This achievement not only provides these individuals with stability and security, but it also creates a foundation for improving their overall quality of life. The University of Connecticut's Center on Aging is conducting an ongoing evaluation of CHESS participant experiences. UConn researchers complete surveys with all enrolled CHESS participants who sign the UConn IRB HIPAA form. Survey data collected through March 2024 compared outcomes across three groups: 784 individuals still without a housing plan, 180 individuals housed for 6 months, and 127 individuals housed for 12 months. The survey results revealed statistically significant differences in improvement over time. Those who were housed reported greater satisfaction with their living environment in terms of choice, safety, privacy, and proximity to services and community activities. Housing stability also positively impacted their well-being, as symptoms of depression and anxiety decreased, and food insecurity was reduced. Additionally, their self-reported rates of emergency room visits, hospitalizations, and nursing admissions declined. Their financial management skills also improved, as the rates of individuals reporting that their finances were insufficient to make ends meet decreased after they were housed. Overall, the percent of individuals reporting happiness with the way they live their lives doubled (from 30% to 64%) 6 months after moving into housing and remained at that higher level after a full year. (see Appendix). Stable housing is a key factor in breaking the cycle of homelessness and enabling individuals to focus on other aspects of their well-being, such as health, employment, and education.

- *Increased access to services*. In addition to providing housing, the CHESS program has greatly expanded access to services. Many of the individuals housed through CHESS had previously faced barriers to essential services, such as health care, mental health support/treatment, substance use treatment, and social services. Carelon and housing service providers offered integrated support systems and referred CHESS participants to the necessary resources for their unmet needs. The data shows that people housed under CHESS had increased utilization of state-operated or state-funded providers (outpatient or telephonic psychiatric/behavioral health clinic), home health agency, CFC, Mental Health waiver, and CHCPE waiver services, which means they were able to better address their physical and mental health challenges.

- *Decrease in health care cost.* By providing stable housing and access to essential services, the program has reduced the reliance on emergency health care services, such as emergency room visits, which are often a costly consequence of homelessness. People who are housed are more likely to engage in preventive health care, manage chronic conditions, and attend regular doctor's appointments, which reduces the need for expensive emergency interventions. Additionally, the program's emphasis on mental health and substance use treatment has helped to mitigate the long-term costs associated with untreated mental health conditions and substance use. As a result, the CHESS program not only improved the health outcomes of individuals but also reduced the

financial burden on health care systems, demonstrating the broader benefits of housing-first approaches. However, the overall PMPM costs did increase when considering both the health care and housing costs.

Additionally, the CHESS program has encountered several sizable challenges that have impacted its ability to fully meet the needs of those it serves.

- *Housing voucher demand significantly outpaced supply*. One of the primary challenges is the disparity between housing voucher demand and supply. For every one voucher available, there were 26 applicants, which created a bottleneck in providing housing for individuals in need. This disparity shows the overwhelming demand for housing assistance, which far outpaces the availability of resources.

- *Lack of affordable housing stock*. In addition to the demand for housing vouchers, the lack of affordable and deeply affordable housing stock presents another major obstacle. Despite the program's efforts to provide stable housing, the overall shortage of affordable and deeply affordable housing options in the state limits the program's capacity to house individuals. Many landlords are reluctant to participate in the program due to low rental rates, strict regulations, or a lack of units suitable for individuals with complex needs. Among the 292 CHESS participants who were housed, only 30 (10.2%) were housed without using Rental Assistance Program (RAP) vouchers.

- *Restrictive CMS requirements*. CMS requirements introduced several operational challenges for the CHESS program. For example, the program requires a DSS nurse to review all assessments, which adds a layer of complexity and delays to the process. Additionally, conflict-free case management is mandated, which means that the same provider cannot provide both participant assessment and case management services. This creates operational difficulties as the coordination between different service providers becomes more fragmented. Furthermore, the program's definition of homelessness, which includes individuals at risk of homelessness, led to a significant increase in the volume of applications, stretching the program's capacity to effectively manage demand. The absence of fee-for-service allowances for outreach and engagement services, which did not meet the definition of "pre-tenancy services," further complicated the program's ability to engage and retain participants. Moreover, challenges with the firewall rule, designed to prevent conflicts of interest, added additional barriers to efficient service delivery.

- *Design and Implementation challenges*. Design challenges include multiple client touches due to the need to confirm initial eligibility by Carelon, followed by a final determination of eligibility by a DSS nurse. Due to the CMS firewall restriction, the individual must meet with three persons in order to qualify for services: a Carelon intensive case manager (ICM), the SHP and a direct service provider. This caused significant delays and frustration for the individual to have re-tell their story and situation multiple times and did not lend to successful rapport building. Persons experiencing homelessness and extreme housing instability often present with complex trauma which makes it difficult to trust. Best practice in addressing the needs of this population entails engaging with one consistent staff member over time to establish rapport and develop a longer-term working relationship. It was also difficult for providers to obtain information necessary for the program due to multiple outreach efforts and the inconsistent living situations of the individual. There were also challenges with the lack of statewide provider participation in the program. Initially, eight providers were involved, but that number decreased to just four active providers due to factors like low

reimbursement rates, significant upfront work that was not billable, and the complexity of the billing and case management systems. These issues not only made it difficult for providers to remain engaged in the program but also created gaps in service provision. As a result, the program struggled to maintain a robust network of providers capable of delivering the level of care and support needed by participants, which impacted the program's ability to meet CMS' statewideness.

- *DSS efforts to alleviate the challenges*. To address some of these challenges, DSS took several steps to improve the program's implementation. The DSS quality management team provided technical assistance to service providers to improve their understanding of programmatic expectations, services, and the case management system. DSS removed prior authorization requirements, which had been creating delays and difficulties in billing, and increased the service hours to reduce providers' challenges. DSS also re-evaluated the criteria for homelessness in the screening process to focus on individuals who needed assistance. Furthermore, in an effort to expand the network of service providers, DSS reached out to DMHAS-approved housing providers to recruit more agencies for the program.

- *Provider challenges*. Despite these efforts, the program continues to face significant challenges. DSS started with eight housing providers but lost four of them, resulting in a lack of statewide coverage. Participating providers also reported an inability to accept new referrals. Currently, two of the four providers are not taking new referrals due to a lack of staff capacity to provide services. The providers also reported low reimbursement rates and a significant amount of up-front work that is not billable.

- *Housing challenges and general lack of affordable housing throughout Connecticut*. The housing challenges are particularly acute due to the limited availability of RAP vouchers from DOH. The RAP vouchers could not be sustained for other CHESS participants when a participant forfeits their RAP. This lack of affordable housing options across Connecticut remains a persistent issue, preventing the program from fully achieving its goal of reducing homelessness and ensuring long-term housing stability for all participants.

V. INTER-AGENCY RECOMMENDATIONS:

While the program achieved significant outcomes, including housing stability and improved access to services, the ongoing challenges – particularly the higher demand for housing vouchers than supply, lack of affordable housing, complexity of regulations, and provider shortages – proved difficult to overcome.

The recommendation from the interagency workgroup is to sunset the 1915(i) State Plan for CHESS and transfer individuals with vouchers and the funding that supported the services to the DMHAS supportive housing program. The group felt that this transfer would be a much more efficient way to serve these individuals as DMHAS' program serves thousands of individuals already and there seemed to be no clear distinction between the individuals being served by DMHAS and those being served through CHESS. Medicaid reimbursement would continue as DMHAS is able to bill for eligible services through Targeted Case Management.

Steps needed to sunset CHESS include:

- Posting for public comment

- Legislative approval to sunset the Medicaid State Plan Amendment (SPA)
- Notice of action to CHESS participants
- Removing the CHESS application and information from DSS' website
- Transferring funding to DMHAS so providers can continue to support housed participants

VI. SUMMARY:

When supportive housing was first introduced almost 30 years ago in Connecticut, it was found that providing housing along with wrap-around services help individuals manage their lives and led to a reduction in Medicaid costs. The results from CHESS have been consistent with these findings. While the CHESS program has achieved notable outcomes, including improved housing stability and a positive impact on the health and well-being of its participants, the overall housing challenges, including lack of affordable housing, and shortage of providers, have been significant obstacles. These challenges created an administrative burden that led to the decision to sunset the CHESS program.

Following the inter-agency's recommendation to sunset the CHESS program, DSS has assessed all CHESS active cases to determine their current status, required actions, and connections to other programs.

CHESS case status and the status breakdown

As of November 20, 2024, there are 1,219 open CHESS cases: 294 cases are in the process of eligibility determination; 1 case is pending CHESS approval; 338 cases are approved but pending provider assignment; 100 cases are in the care planning process; 298 cases are receiving pre-tenancy services; 188 cases are receiving tenancy-sustaining services. Additionally, there 3,087 CHESS participants pending closure.

All active referrals and current applicants will get a Notice of Action (NOA) from DSS, notifying them that the program has been closed. The 188 housed individuals will get noticed that the program has closed with the option to shift to DMHAS.

CHESS case status as of 11/20/2024	Number of individuals	Adverse actions
Total active/open (excluded pending closure and closed)	1,219	
CHESS ICM referral assigned to Carelon pending assessment	294	Issue NOA 8 under Money Follows the Person (MFP) 15 under CFC
Pending SHP assignment (new cases)	338	Issue NOA and offer time-limited case management services
CHESS in care-planning	100	Issue NOA and offer time-limited case management services 3 under MFP 2 under CFC

CHESS receiving pre-tenancy services	298	Issue NOA_and offer time-limited case management services 6 under MFP 9 under CFC
CHESS receiving tenancy-sustaining services (178 with assigned providers, 10 without providers)	188	Issue NOA with option to transfer to DMHAS 1 under MFP 11 under CFC 157 housed with voucher 10 housed but lost voucher 21 housed with unidentified subsidy
Pending for closure	3,087	
Recommended closure	2,546	Issue NOA
Closed	2,648	No action required

CHESS participants connected with other programs

CHESS status	CHESS & CFC	CHESS & MFP	CHESS & ABI I and II waivers	CHESS & CHCPE waiver	CHESS & Mental Health waiver	CHESS & PCA waiver	CHESS & Autism waiver
In eligibility determination process with ASO	15	8		4	1		
In care planning with SHP	1	3					
In pre-tenancy with SHP	9	6		1		2	
In tenancy-sustaining with SHP	11	1		3	8		
Pending closure	54	43	5	5	6	9	1
Total #	90	61	5	13	15	11	1

As shown in the table above, there are a total of 196 CHESS participants already connected with other programs, including MFP, CFC, and waiver programs. These individuals are particularly vulnerable to institutionalization without stable housing and care services. It is critical to coordinate with their case managers and inform them of the program closure in advance.

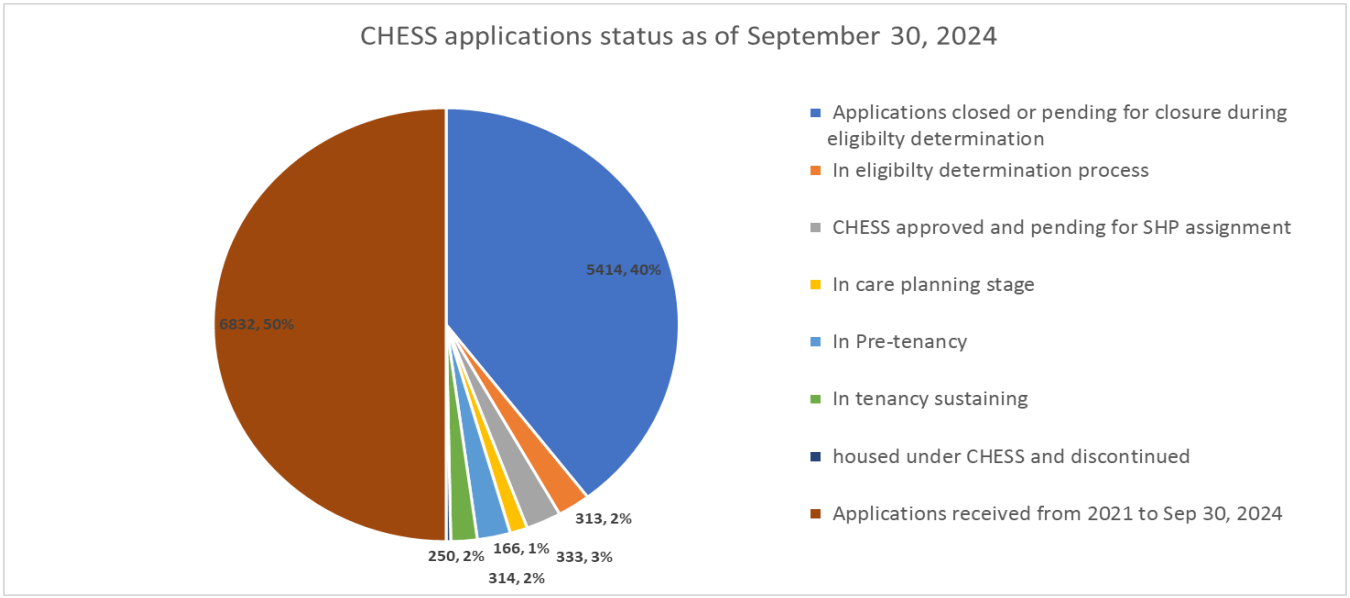
Since MFP participants have access to RAP vouchers and housing services, the 61 CHESS members who are already connected with MFP will be advised to pursue housing services under MFP. For the 45 CHESS participants connected with other waiver programs, case managers will be contacted to ensure these individuals receive appropriate support, especially those needing more intensive assistance.

The 90 CHESS participants who are enrolled in CFC need more attention because CFC does not provide case management services and these individuals are at risk of losing their services without qualified housing or PCA services. Special coordination is necessary to ensure these individuals are connected with the appropriate supports before the CHESS program closure.

Although the CHESS program is sunsetting, it has been a meaningful initiative aimed at addressing the challenges associated with homelessness, including access to health care and the management of chronic health issues. DSS will consider the lessons learned from the CHESS program when planning future initiatives.

VII. APPENDICES:

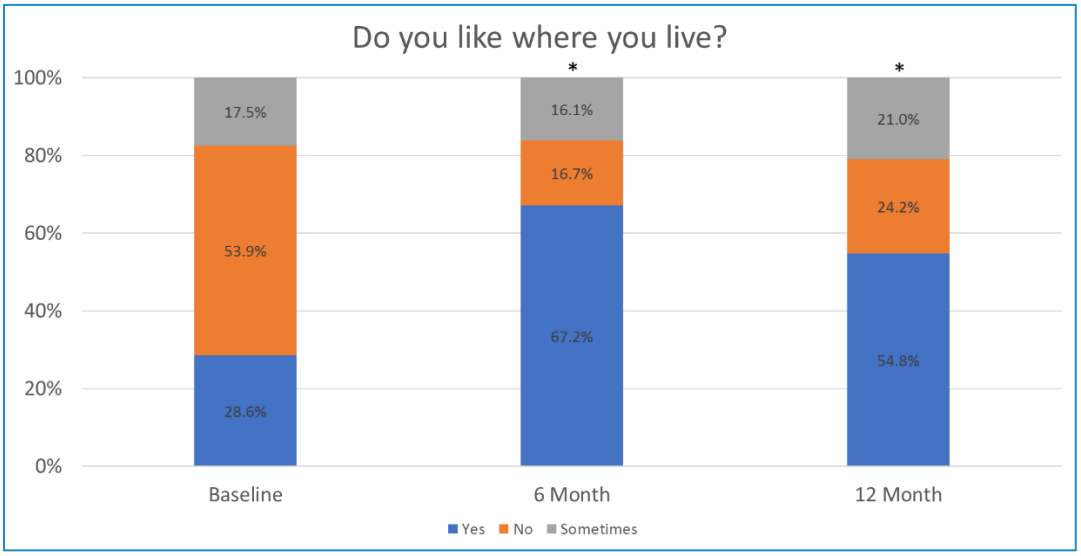
1. CHESS cases status as of September 30, 2024:

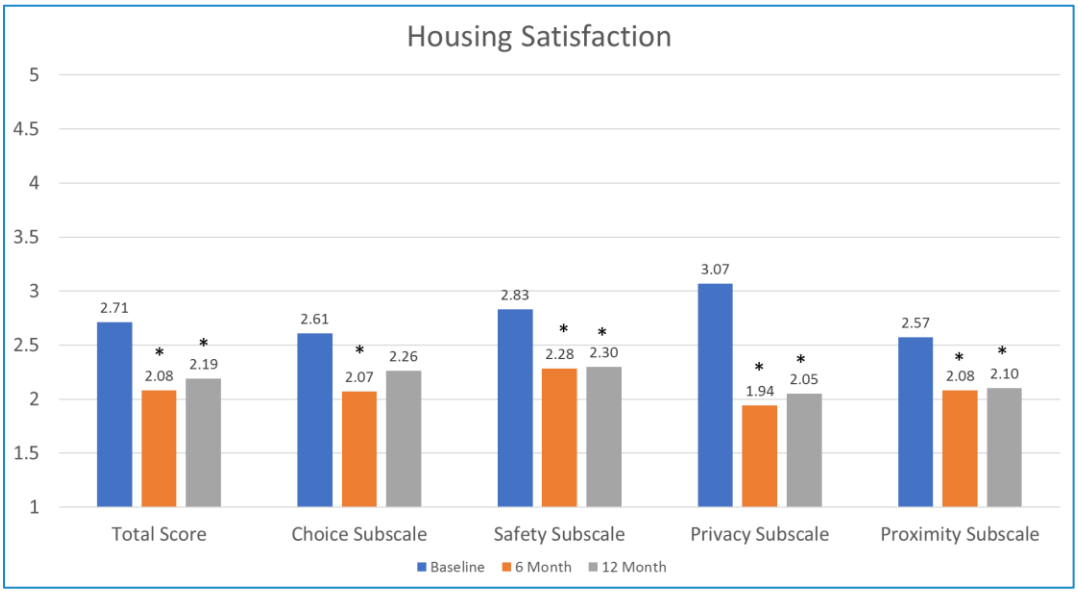


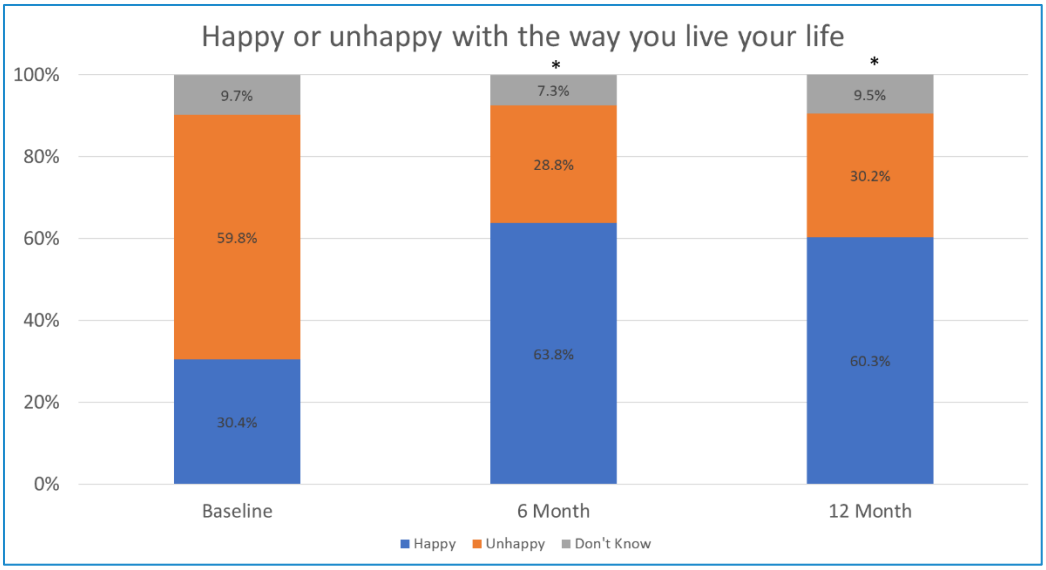
2. UConn Center on Aging's survey on CHESS participants

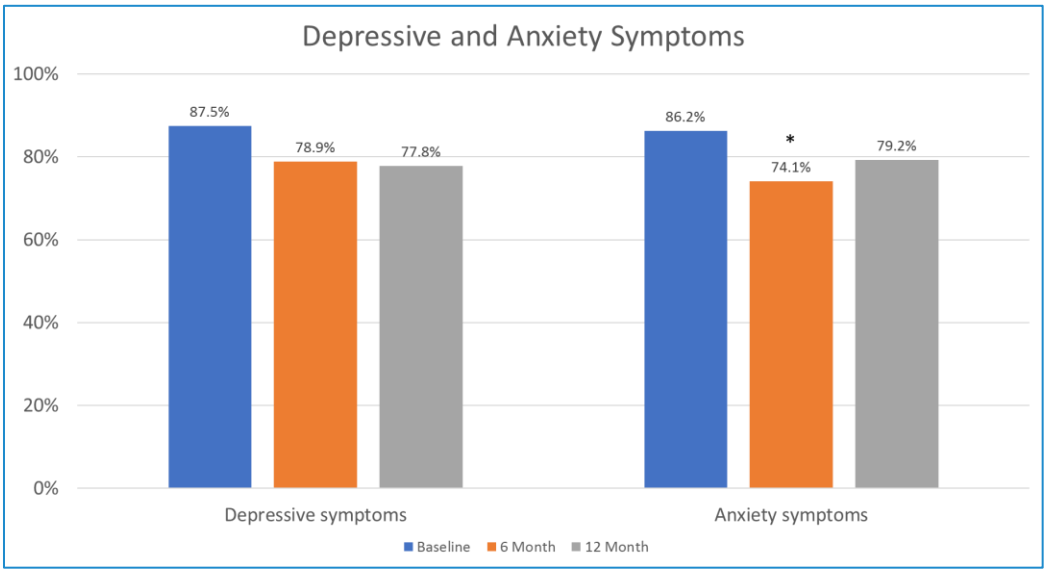
   - Researchers: Julie Robison, PhD, Alexandra Depalma, MS, Kristin Baker, BS, Kate Kellett, PhD, Deb Migneault, MSW, Azucena Minaya, MS, Martha Porter, BA

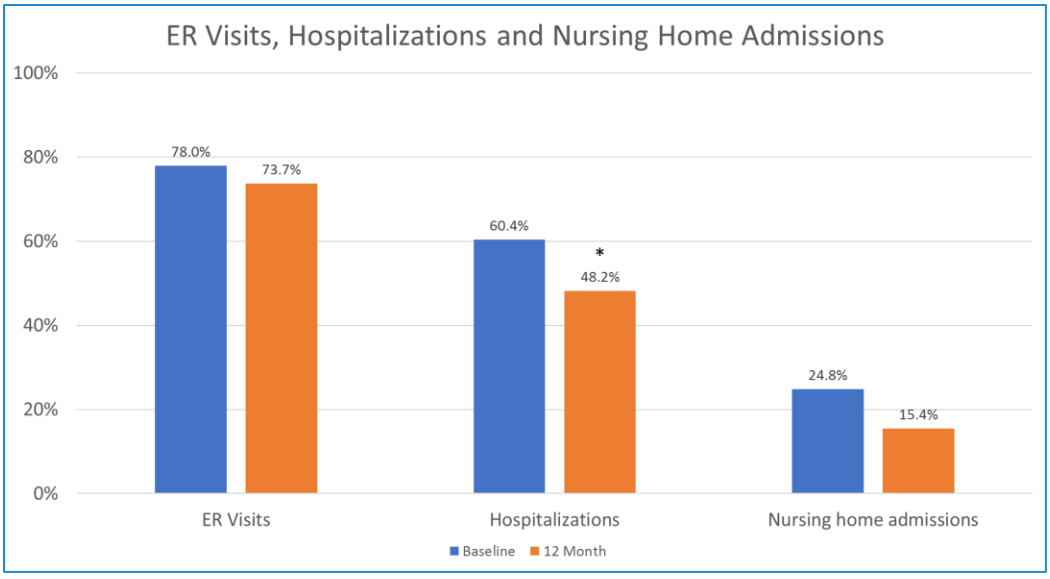
- As of 3/31/2024, 1,107 people enrolled in CHESS and 234 people housed.
- Participant experience interview conducted for three groups: Baseline interview with everyone enrolled who signs IRB HIPAA form before supportive housing plan is in place (N=784), and for people who are housed, 6 months after (N=180) and 12 months after (N=127)
- Charts show comparison between baseline, 6 months, and 12 months. The * symbol indicates a statistically significant difference from baseline level.

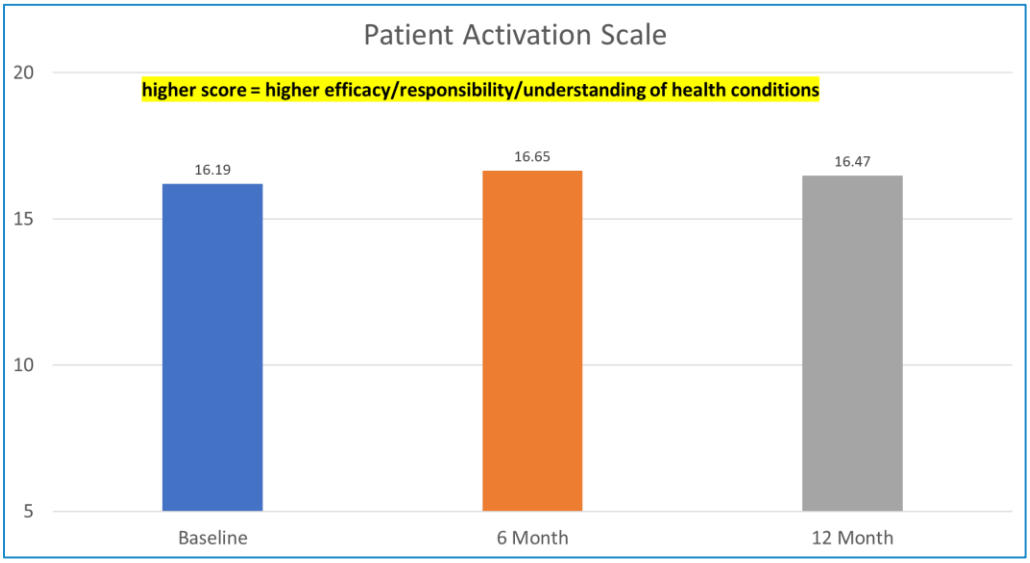


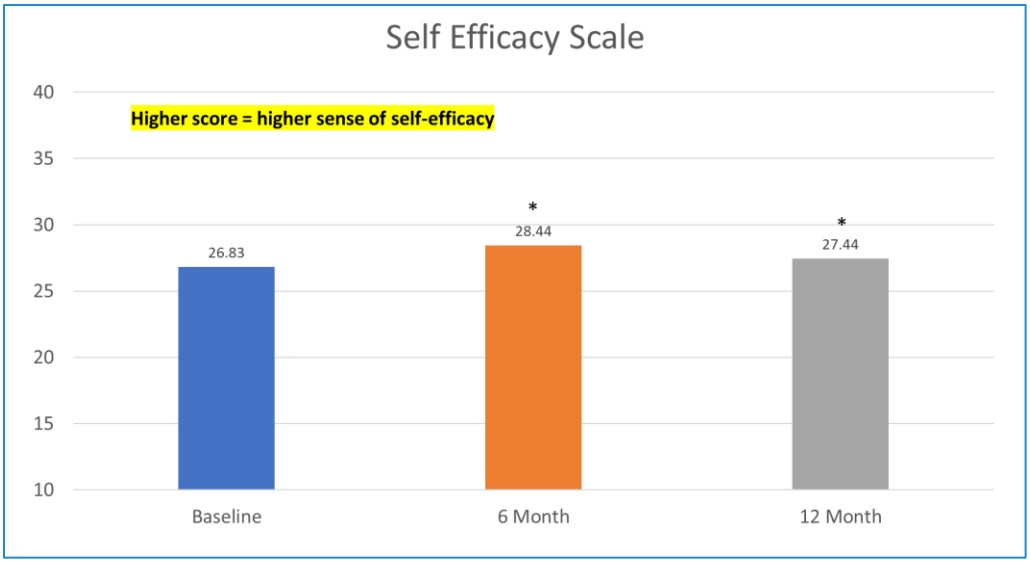


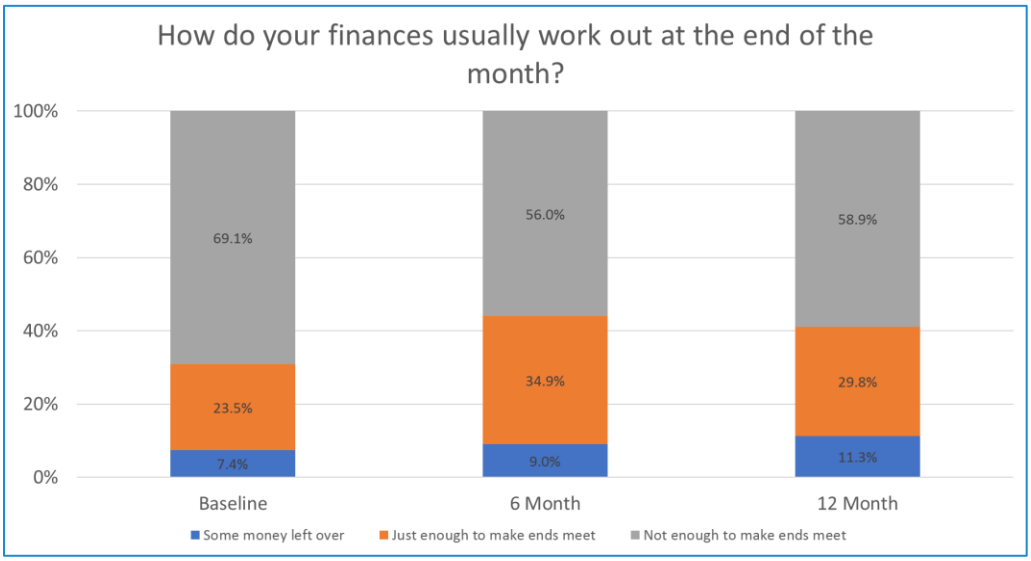

Happy or unhappy with the way you live your life
100%
80%
60%
40%
20%
0%
9.7%
59.8%
30.4%
*
7.3%
28.8%
63.8%
*
9.5%
30.2%
60.3%
Baseline
6 Month
12 Month
Happy
Unhappy
Don't Know

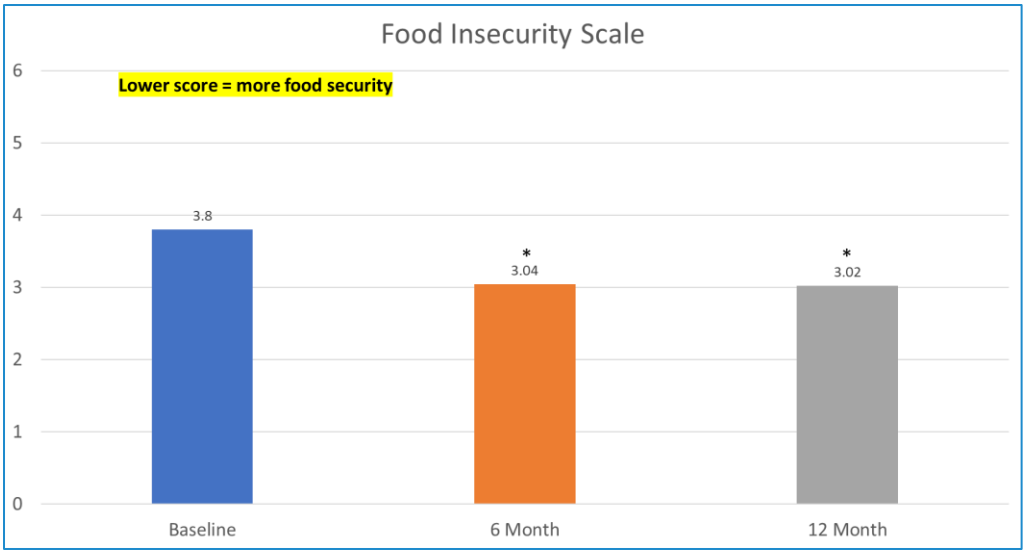

Depressive and Anxiety Symptoms
100%
80%
60%
40%
20%
0%
87.5%
78.9%
77.8%
86.2%
*
74.1%
79.2%
Depressive symptoms
Anxiety symptoms
Baseline
6 Month
12 Month


ER Visits, Hospitalizations and Nursing Home Admissions
100%
80%
60%
40%
20%
0%
78.0%
73.7%
60.4%
*
48.2%
24.8%
15.4%
ER Visits
Hospitalizations
Nursing home admissions
Baseline
12 Month


Patient Activation Scale
20
15
10
5
higher score = higher efficacy/responsibility/understanding of health conditions
16.19
16.65
16.47
Baseline
6 Month
12 Month


Self Efficacy Scale
Higher score = higher sense of self-efficacy
40
35
30
25
20
15
10
26.83
*
28.44
*
27.44
Baseline
6 Month
12 Month


How do your finances usually work out at the end of the month?
100%
80%
60%
40%
20%
0%
69.1%
23.5%
7.4%
56.0%
34.9%
9.0%
58.9%
29.8%
11.3%
Baseline
6 Month
12 Month
Some money left over
Just enough to make ends meet
Not enough to make ends meet


Food Insecurity Scale
Lower score = more food security
6
5
4
3
2
1
0
3.8
*
3.04
*
3.02
Baseline
6 Month
12 Month