Evaluation of the H.O.P.E Team

Determining Efficiency

Karla Ruiz, MPH
7/12/2013
Housing and Urban Development Definitions to Understand

<table>
<thead>
<tr>
<th>Homeless</th>
<th>“A person sleeping in a place not meant for human inhabitation (e.g. living on the streets for example) OR living in a homeless emergency shelter)”</th>
</tr>
</thead>
<tbody>
<tr>
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<td>“sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter)”</td>
</tr>
</tbody>
</table>
| Chronically Homeless | An unaccompanied homeless person (a single homeless person who is alone and is not part of a homeless family and not accompanied by children with either:  
|                   | A **Disabling condition:**  
|                   | - Diagnosable substance abuse disorder  
|                   | - A serious mental illness  
|                   | - A developmental disability  
|                   | - A chronic physical illness or disability, including the co-occurrence of two or more of these conditions.  
|                   | Has been **continuously** homeless for a year or more.  
|                   | OR  
|                   | Have had **four episodes** of homelessness in the last three years. |

**WELCOME TO THE 16%**

Homelessness does not only affect those who are lazy and drunk, as often portrayed in the media, but individuals and families that are hardworking and/or need medical assistance. Victims of domestic abuse, veterans, people struggling with mental health and substance abuse issues, the poor and working poor, and those without access to homes all have increased chances of experiencing homelessness. At any given time, 271,000 veterans are homeless and 40% of homeless men have legitimate claims of having served in the armed forces. Overall, there are 20-25% of the single adult homeless population that have a “severe and persistent mental health disease” and 5-7% of them may need institutionalization. Although many families and individuals may have employment years of financial losses and low wages make housing not affordable. In 2005, a survey of 24 cities found that 15% of those homeless living in urban areas, were employed and unable to afford housing.⁴ These are the homeless members of societies and if housing or medical assistance does not occur, these individuals have increased chances of becoming chronically homeless.
In 2012, on any given night, almost 100,000 adults are experiencing chronic homelessness, about 16% of all people experiencing homelessness. Over three-quarters of this 16% are men around the age of 50. Whereas homeless individuals have a mortality rate that is 3 to 4 times more than the general population, the 16% have a mortality rate that is 4 to 9 times higher than the general population.\(^6\) Contributing to the high mortality rates are substance abuse and mental health disorders. In a Boston study, researchers were able to show that drug overdoses (opioids were 81%) accounted for one-third of deaths among homeless adults under the age of 45.\(^7\) Although the office of Housing and Urban Development makes a distinction between the two co-morbidities, the DSM-IV has over 9 codes for substance abuse, high numbers that correlate with the higher rates of mental health disorders among the 16%.\(^6\)

**Creating Opportunity for Positive Change**

In 1993, Dr. Rick Baxley founded a clinic, The Health Care Center for the Homeless, whose goal was to give quality care to the homeless and chronically homeless. This clinic continued to expand adding a dental clinic, pharmacy, and multiple outreach programs. Of the many programs that were created, the Homeless Outreach Partnership Effort Team (HOPE Team) embodies the original mission in its entirety. The HOPE Team connects those who live in places not intended for habitation (i.e. woods) to the services provided by the newly named Orange Blossom Family Health Center. Members of the HOPE Team include a supervisor, nurse case manager, veterans outreach specialist, and other outreach specialists.

Everyday teams of two HOPE Team specialists go into the woods and other campsites hoping to provide a connection to quality care and housing establishment services. When a new person is encountered a Homeless Management Intake Services (HMIS) Form is filled out and referrals for anything from getting identification paperwork to meeting with the designated health provider.
In 2012, the HOPE Team reached out to 490 new adults: 350 men, 133 women, and 7 whose gender were never specified. Ages of new patients ranged from 18 to over 62 with 86% of new patients ranging between ages 31-61. In 2012, 7332 services were provided with the majority being site/street outreach at 59% followed by transportation services at 18%. With the limited amount of resources available and the growing number of needs, it is important that all the resources are being used as efficiently as possible.

METHOD OF EVALUATION

When running a growing operation, it is imperative that the original mission, goals, and objectives are kept and understood by all those involved. In order to be efficient and effective, it is recommended that formative and objective evaluations are completed at regular intervals to better understand where delays in care may be occurring. At its core efficiency is the relationship between a specific product (output) of the healthcare system and the resources (input) used to create a product. For the purposes of this evaluation, the Institute of Medicine definition of efficiency “Avoiding waste, including waste of equipment, supplies, ideas, and energy” was used.² During this evaluation, I performed numerous informal and formal interviews with staff and patient, observed both in the clinic and onsite, and analyzed HMIS data sheets. One performance measure, Increase access to healthcare services for chronically homeless clients, was written by the clinic for the HOPE Team CQI and offered the basis for the evaluation. During the six weeks at the clinic, I came to understand that three areas caused constant barriers to trust and care for HOPE Team staff and clients. These areas were technology, transportation, and providers.

Evaluation Hot Topics

Technology

Explanation of Use of Electronic Health Record
The clinic has all patient data inputted into the Intergy Electronic Health Record (EHR) using Citrix logins. All staff have logins to access the EHR and input data. Two laptops are provided for use by Sharon Couvillon for those doing work in the Mobile clinic or for other HCCH related duties. These two laptops are equipped with Intergy EHR and automatically connect to the internet as provided.

**Explanation of the reporting of new HOPE Team patients and HMIS intake forms**

New patients are “interviewed” by outreach specialists and information is recorded onto the Homeless Management Information Systems intake form. Information on the HMIS intake form hard copy includes but is not limited to:

- Name
- Date of Birth
- Race and Gender
- Homelessness status
- Behavioral Data
- Referrals to be made by the outreach team.
- Social Security Identification Number

**Data Security**

HOPE Team laptops, when available, are kept in either the office at the Orange Blossom Family Health Center or in vehicles assigned to the teams of specialists. Laptops used in the field, although password protected, are kept in full site of anyone who walks by the unaccompanied vehicle.

HMIS intake forms and notes written in the HOPE Team schedules are also left in the vehicle and not carried by specialists when they are visiting the campsites of the HOPE Team patients.

*Violation of The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191*
A fear of laptops being stolen was expressed by one HOPE Team specialist, yet thought must also be given to handwritten documents being viewed or stolen by unauthorized personal. The Privacy Rule protects all individually identifiable health information. Individual identifiable health information includes demographic data and “relates to information that relates to:

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).”

The HMIS intake form includes data that is identifiable; thus increasing the potential for HIPAA violations and penalties.

**Communication**

According to the Agreement Between Homeless Services Network of Central Florida, INC. and Health Care Center for the Homeless-HOPE Team for HUD Supportive Housing Program Grant FL0095B4H071003, attachment A of the grant application, phones may be reimbursed for $1,900. Company phones are used by specialists to communicate with both the patients and providers; however they are not always reliable with texting and voicemails sometimes not arriving until the next day.

Phones are also used to share visual data, a form of telehealth communication. Pictures of skin lesions and abrasions are sent to the main HOPE Team provider via personal cell phone use and do not include identifying information. The question should be asked, “Is it appropriate to be sending any information using personal phones?”

**Transportation**
Explanation of Time management

The majority of time, as reported by the HOPE Team specialists during interviews, is used transporting patients to appointments and back. Although it is a service offered by the HOPE team transportation of patients is not a job responsibility or requirement of the specialists. One specialist reported having to wake up at 4:00 am to pick up a patient and take him to an appointment in a different part of town. In this example, a specialist wakes up to drive a more than a total of two hours to take one patient to an appointment, stays with the patient because they are not met by someone who can walk them through the facility, and drives them back to the campsite. Further assessments and evaluations should explore the potential for compassion fatigue among outreach specialists and the number of patients that could have been visited during these patient encounters.

Use of Bus Passes

Most HOPE Team patients are given bus passes to return from appointments and/or hospital stays that they are taken to. Veteran Affairs (VA) patients are not afforded that same benefit due to grant requirements and provisions. If the HCCH offers a service to increase quality care to patients they must find a better way to offer access to that service.

Appointments of New Hope Team Patients

A select number of patient slots are intended for new hope team patients or patients that the HOPE Team believes need to come in. Unfortunately, walk-ins and other patients are often scheduled for those slots. HOPE Team patients live in the woods for a reason, whether it is because they have schizophrenia with paranoid personality disorder, excessive substance
problems (i.e. mental disorders), or chronic homelessness, these patients do not want to be in an enclosed building among strangers for long.

While looking through the HMIS reports and comparing the gathered data, I noticed multiple same day visits (i.e. walk in) that were then canceled. Patients form a line before the clinic opens and non-emergent walk-ins will wait hours to see a provider for their concerns. HOPE Team patients are often brought to appointments by HOPE Team specialists knowing that some wait time will be required. Further assessment is needed to determine why walk-in patients who wait to see providers are indicated as NO SHOWS on the EHR, its impact on relationships between the HCCH and its clients, its impact on the relationship between the HOPE Team and the HCCH, and to determine if quality care is compromised.

Providers

**Designated Hope Team Provider**

Multiple providers see HOPE Team patients; however, there is one specified HOPE Team provider and nurse. When this HOPE Team provider is scheduled off or when they take a leave of absence, who covers? Is there anyone else who will go out with the HOPE Team specialists in her absence?

Four years ago, an Outreach Nurse Case Manager was added to the HOPE Team in order to provide better care for patients and to work with the providers as pertaining to assessments and referrals.

**Mental Health**

Mental Health issues are the biggest problem that homeless and chronically homeless patients face. In November 2012, 12 of the 15 new HOPE Team patients had some sort of mental health
and behavioral struggle. Currently, the clinic is home to one LHMC, a part-time Nurse Practitioner with psychiatric specialty, and a doctoral student in psychology. Patients are able to make an appointment or have a walk-in meeting with the LHMC when time is available or the patient warrants it. Multiple times while shadowing the LHMC, I witnessed providers calling on the behavioral health specialists for patients that had come in for medical appointments. Just as medical providers were able to pop into the LHMC’s office to ask questions, the HOPE team would benefit from having a mental health specialist on site for assessments.

**Case Manager**

Within the job description summary for the Outreach Nurse Case Manager is a requirement to “case manage unsheltered clients including identification of eligible persons, triage to health care needs, and referrals to cooperating agencies as appropriate”. Within the job description summary of every Outreach Specialist, especially the Lead, is a requirement to “provide case management and supportive services by means of assessing the needs for and access to mainstream benefits, housing referrals for low income homeless, living in camps, on the streets and in emergency shelters”. In 2012, the HOPE Team performed 7,332 official services under 25 service categories, with the majority of services being street outreach programs followed by transportation services. Based on interviews and observations, the majority of the time actually spent on the field is used for transportation of patients to programs, appointments and services. Further investigation is required to determine and compare the exact cost-effectiveness in fiscal terms, of specialists spending the majority of their days as transportation versus housing and health care referrals. This evaluation point is a reflection of the deficiencies mentioned in technology and transportation portion of the evaluation.

**Recommendations**
Technology Recommendations:

Lack of a functioning laptop has caused multiple time delays, data input repetition, and additional use of time that could have been spent providing outreach services. Improving the infrastructure will improve security and safety, allowing for an improvement in time management and efficiency. All teams should have a functioning laptop, especially the Nurse Case Manager and Provider while on site. It is important to note that after my presentation, I was made aware that the laptop that has been broken for the past two months was ordered and there has been no follow through due to the grant’s regulations. If the problem is with the expender, then communication needs to occur in order to guarantee that the HOPE Team is performing at the most effective level.

Safety Precautions

Another concern that was revealed during the evaluation was safety for the laptops and other documents along with possible HIPPA violations while outside the clinic. A simple and low cost fix would be the installation of lockbox. This lockbox would need to be fixed and immovable and would work best under the front passenger seat. This would decrease the number of free floating documents and give a secure spot for laptops, while the outreach specialists are on site. Additionally, phone conversations overheard by patients concerning other clients may also prove to be a HIPPA violation. The current company phones being used do not always deliver messages or incoming calls. Personal phones have been used to text or send images to providers. In that case, I would recommend phones that not only work properly, but have texting and image taking capabilities. Ultimately, messages and images should be secure. One budget friendly option is a program from www.cortext.com. This program offers free HIPAA
compliant encryption and the downloadable app works with iPhones, Android, and desktop computers.

**Transportation Recommendations:**

There is no complete way to reduce the overuse of the HOPE Team as a mean of transportation to the appointment; however, an expansion in relations with the VA and other community partners may improve. An immediate solution is an increase of bus passes that can be used by the HOPE Team. Currently, not all specialists are provided with bus passes to give to patients after they are taken to their appointment. After multiple conversations with staff members and the specialists, some patients do need to be monitored; however, most can be given a bus pass to get back to their campsite on their own.

**Collaboration and Team Work**

Attitudes and behaviors towards the HOPE Team also need to improve. Compassion fatigue is a possibility when every staff member and provider has limited resources with numerous claims on their time. Yet the risk increases when an outreach specialist feels underappreciated, not only by the program clients, but by the staff as well. One way to improve the perspective of the staff towards the outreach programs is to have new hires go out to the campsites with the HOPE Team. It is difficult to respect and understand what we do not know; by walking in the shoes of the HOPE Team hopefully they will be seen as more than helpful free transportation that cares.

**Provider Recommendations:**

Every provider sees HOPE Team patients, yet the designated HOPE Team Provider has appointment slots meant solely for clients that need to be seen that day. These spots need to
remain open and if they cannot all remain open for the clients that they were intended, it is my recommendation that at least one always stay open on the main providers schedule.

*Mental Health*

Two other recommendations regarding providers: Mental health is a major concern and almost every new patient established in 2012 has either a substance abuse problem or other mental health disorder. It would be highly beneficial for the clinic and the outreach team, if a mental health specialist would come out on site at least twice a month. Furthermore, if none of the recommendations are implemented a part time case manager will eventually need to be hired.

Conclusion:

The HOPE Team is the branch of the clinic that targets the chronically homeless. This team of specialists establish relationships and garner trust that are invaluable to the function of the clinic. Just as every provider and member of the staff strive to provide quality care, in this evaluation, I witnessed the HOPE Team specialists going above their required duties and serving a population that feels neglected by addressing the concerns brought forth by this evaluation, it is my hope that the Healthcare Center for the Homeless continues to be a source and provider of hope.
REFERENCES


## Universal HMIS Intake Form

### Service Point ID #

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<th>First Name:</th>
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### Client Homeless?

- □ Yes
- □ No

### S. Military Veteran?

- □ Yes
- □ No
- □ Don’t Know
- □ Refused

### Does client have a disability of long duration?

- □ Yes
- □ No

### Criteria for chronic homelessness: 1. Unattached individual (i.e. no children or spouse with client); 2. Has a disabling condition; 3. Pattern of homelessness: either continuously homeless for more than one year; or four episodes of homelessness over the past three years

### City & State or Zip Code of Last Permanent Address

“Permanent” means apartment, room, or house where client lived for 90 days or more

### Where did client stay last night?

- □ Place not meant for habitation
- □ Living with family
- □ Foster care/group home
- □ Living with friends
- □ Rented house/apartment
- □ Client doesn’t know
- □ Owned house/apartment
- □ Client refused to answer
- □ Jail, prison, or juvenile facility
- □ Hospital
- □ Psychiatric hospital or facility
- □ Substance abuse treatment center

### How long has client been living there?

- □ 1 week or less
- □ More than 1 week, but less than 1 year
- □ 1 to 3 months
- □ More than 3 months, but less than 1 year
- □ 1 year or longer

### Referral Goals
What State did you first become homeless?

What State were you born?

Domestic Violence?  (Females Only)  □ YES or □ NO

Have you ever been in Foster Care?  □ YES or □ NO

Monthly Income:

SSI/SSDI – Income: __________  Food Stamps: __________  Other: __________

Emergency Contact:

Name: __________________________
Relationship to you: __________________________
Street Address: __________________________
City: __________  State: __________  Zip: __________
Phone: (_____) _______ ______
Your personal cell phone number: (_____) _______ ______

Medical History:

Do you have a history of any of the following: (check yes or no)
1. Cancer? If yes, list specifics
   □ YES  □ NO
2. Cirrhosis of the liver?
   □ YES  □ NO
3. End-stage renal disease?
   □ YES  □ NO
4. HIV+/AIDS
   □ YES  □ NO
5. Tri-morbidity: co-occurring psychiatric, substance abuse and chronic medical condition?
   □ YES  □ NO
6. Chronic alcoholism?
   □ YES  □ NO

Do you have alcohol or substance abuse issues?  □ YES or □ NO
If yes, what is your preference or choice?

Are you interested in detoxification?  □ YES or □ NO

Camp Location: __________________________

Release of Information / Signed HMIS Intake Form

Notes:

__________________________________________

__________________________________________

__________________________________________
# HOPE Team Referral

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<th>Service Point ID</th>
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## Date

Date: __/__/__

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<td>Native Hawaiian or Other Pacific Islander</td>
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</table>

## Is Client Homeless?

- □ Yes
- □ No

## U.S. Military Veteran?

- □ Yes
- □ No
- □ Don’t Know
- □ Refused

## Is Client Chronically Homeless?

- □ Yes
- □ No

Criteria for chronic homelessness: 1. Unattached individual (i.e., no children or spouse with client); 2. Has a disabling condition; 3. Pattern of homelessness: either continuously homeless for more than one year or four episodes of homelessness over the past three years

## Referred Client To:

<table>
<thead>
<tr>
<th>Residential Stability</th>
<th>Permanent Housing</th>
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<th>Shelter Plus Care Program</th>
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<th>Salvation Army</th>
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Other:

□
### Increased Skills or Income

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<td><strong>Other:</strong></td>
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### Greater Self-Determination

<table>
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<th>Service</th>
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<td><strong>Other:</strong></td>
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Form completed by:

- **Staff Name**
- **Staff Signature**
- **Date**

*By signing this form, you are acknowledging the referral(s) by the HOPE Team to the above listed community resources.*

Client Name (Printed):

Client Signature:

Date: ___ / ___ / ______

Referral Outcome:
### Patient Demographics according to CQI for 2012

#### Gender

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<th>Percentage</th>
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#### Male Age Ranges

- **18-30**: 156
- **31-50**: 155
- **51-61**: 18
- **62+**: 20
- **No DOB**: 1

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**Example of Data Sheet**

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<th>same day?</th>
<th>Any canceled appts?</th>
<th>Vet</th>
<th>Last Perm State of H</th>
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**Female Age Ranges**

- 18-30: 46
- 31-50: 70
- 51-61: 8.2
- 62+: 6
- No DOB: 0

**Clients Served By Race**

- American Indian Or Alaskan Native: 396
- Asian: 84
- Black or African American: 1
- Native Hawaiian or Other Pacific Islander: 78
- White: 2

**Clients Served By Ethnicity**

- Hispanic/ Latino: 53
- Non-Hispanic/ Non-Latino: 427
- Not Given: 10