Albert G. and Sara I. Reuben Engagement Center - Board of Directors Meeting - Attendance Log			
Date:	Time:		Location:
Board Member	**Organization Represented**	**Eligible to Vote**	**Physically in Attendance - Y/N**
Major Melissa Hamblin	Maion County Sheriff's Office	VOTING	NO - Replaced w/ Co. Dez.
Charnette Garner ✓	Marion County Prosecutor's Office	VOTING	✓
Judge Jose Salinas	Marion County Superior Court	VOTING	NO
Manny Mendez	Mayor's Office - Military Veterans	VOTING	~~NO~~ Resigned
Jan Davidson ✓	Mayor's Office - Faith Based Community	VOTING	✓
Bill Moreau ✓	CCC President - Reuben Estate	VOTING	✓
Lynnea-Redmon Williams ✓	CCC President - Professional Service Provider	VOTING	✓
Andrea DeMink	Mayor's Office-Professional Service Provider	VOTING	Emailed
Margie Payne	Mayor's Office - Mental Health Professional	VOTING	NO
Johnnie Underwood ✓	CCC President - Substance Abuse/Additction Professional	VOTING	✓
Nick Ball ✓	Mayor's Office - Indianapolis EMS	VOTING	✓
Dr. Aaron Kalinowski ✓	CCC President - Medical Health Professional	VOTING	✓
Ken Cattancci ✓	Reuben Engagement Center Board - Person experiencing or has recently experinced homlessness	VOTING	✓
Deputy Chief Bryan Roach ✓	IMPD - Ex-Officio	NON-VOTING	✓
Alan Witchey ✓	CHIP - Ex-Officio	NON-VOTING	✓
Julie Fidler ✓	DPS - Recording Secretary	NON-VOTING	✓
Carl A. Rochelle III ✓	Reuben Engagement Center Director	Tie-Breaker VOTING ONLY	✓

Certified to be true and accurate: Julie Fidler

Julie A. Fidler, Recording Secretary

Albert G. and Sara I. Reuben Engagement Center - Board of Directors Meeting - Attendee Log

Date: | Time: | Location:

Printed Name	Organization Represented	Position/Title	E-mail address
Alan Witchey	CHIP	E.D.	awitchey@chipindy.org
Johnnie Underwood	UBCE	E.D.	johnieindian@aol.com
Aaron Kalinowski MD	Eskenazi	Phys. / Med	akalinow@iu.edu
Bill Moreau	Reuben Estate		bill.moreau@btlaw.com
Jan Davidson	Wheeler Mission	Addiction Program Manager	jandavidson@wmm.org
Lynnea Redmon-Wilson	Dove Recovery House	Addiction Case Manager	lredmon@doverecoveryhouse.com
Charnette Garner	Marion Co Pros Office	Chief Counsel	charnette.garner@indy.gov
Ken Catenacci			kjcmac12@gmail.com
Bryan K Roach	IMPD	DC Administration	bryan.roach@indy.gov
Nick Ball	EMS	Mayoral Appointee	nick@ballfinancial.net
Rev. Tony Alexander	Purpose of Life	Asst. Pastor	aalexander@purposeoflifeministries.com
Amanda Harrawood	IUPUI	Research Manager	aharrawo@iupui.edu

Reuben Engagement Center Evaluation Matrix (DRAFT 1-7-16)

Reuben Engagement Center Evaluation Plan				
Evaluation Goal	Specific Success Metrics	Measurement Tool(s) or Strategy	Frequency Reported or Collected	Anticipated First Collection Date
Track monthly client admissions, services provided, and referrals made	1. Total clients admitted and demographics (gender, age, race/ethnicity, homeless) 2. Route of admission (homeless provider or jail diversion) 3. Diversion Anticipated (jail or hospital) 4. Average length of stay 5. Total clients & time for completing detox 6. Frequency of repeat clients 7. Discharge location type 8. Referrals to treatment and other services (based on care plans)	• Eskenazi database or IEMS database?? • IMPD system?? • HMIS database	Monthly	08-16
Track client symptoms relevant to multiple chronic conditions*	1. Clinically practical brief questionnaire, non-disease specific, covering symptoms from multiple domains such as physical, emotional, cognitive, functional, and including sleep, fatigue, pain.	• 23-item SymTrak tool, or its ultra-brief 7-item version. • 2 global items, general emotional and physical health	Intake, discharge; potentially 50 clients at follow-up in treatment.	08-16
Process improvement**	1. Document how outcomes and impact were achieved. 2. Document the process of a program's implementation. 3. Document how REC develops itself, its structures, its supporting programs including communications and marketing. 4. Document the program, management and infrastructure capacity to deliver on REC promised outcomes. 5. Document and evaluate process to solidify the letters of agreement/ commitment with supportive service providers. 6. Types and quantities of services delivered.	• Documentation. • Focus groups with clients and providers.	Every 6 months	08-16

	7. Beneficiaries of those services. 8. Resources used to deliver the services. 9. Practical problems encountered. 10. Ways that problems were resolved.			
Improve the services and procedures conducted in the Reuben Engagement Center	1. External referral success from law enforcement and homeless providers 2. Success of collecting needed metrics 3. Metric trends 4. Comparative metrics to other diversion programs 5. Why transferred from REC to ED - What uncontrolled medical issue? Seizure/fall? Delirium tremens? 6. Why transferred from REC to jail - What issue? 7. Agreed to detox but then preferred to go through APC? If so, why? 8. Difficulty in accessing primary care or other off-site health care? ***	• Review of law enforcement records ?? • Surveys to community providers • Interviews with key stakeholders • Focus groups with clients and providers • Review data from other diversion programs	Annually	01-17 (six month and then annually)
Measure the estimated cost savings to the community based on clients served	Estimated costs from: 1. Hospital costs including emergency department and inpatient costs 2. Jail costs following public intoxication 3. Court costs following public intoxication 4. Law enforcement costs – arrest, transportation costs. 5. Emergency Medical Services (EMS) – ambulance	Establish estimated cost of services most often accessed by those current brought in from public intoxication	Every six months	01-17
Measure the actual cost per client to provide services	1. Actual per diem per client 2. Actual per stay cost per client (e.g., detox costs of meds, provider/staff time). 3. Comparative costs per client to other diversion programs	Actual budget expenses compared to actual clients accessing services	Annually	01-17 (six month and then annually)

Measure actual cost aversion for 50 Engagement Center clients	1. Retrospective data on all medical and criminal justice expenses over a five year period prior to entering the Engagement Center 2. Actual medical and criminal justice data after exiting the Engagement Center for a three year period	• Collect five year retrospective data on prior hospital, criminal justice and medical services • Collect actual comparable data for 2016-2019	Annually	08-17
Measure three year success of clients completing services at the Engagement Center	1. Hospital costs including emergency department and inpatient costs 2. Jail costs following public intoxication 3. Court costs following public intoxication 4. Law enforcement costs – arrest, transportation costs. 5. Emergency Medical Services (EMS) – ambulance 6. Long-term impact on permanent housing . 7. Impact on linking client with disability income.****	• Review data collection from the 50 clients • Review all client data on predetermined data elements • Collect and review long-term data from HMIS	Three year assessment	08-18

*From Dr. Aaron Kalinowski: The baseline data we get here could be very interesting and help direct resources / services.

** From Johnie Underwood: Information from process evaluations is useful for understanding how program impact and outcome were achieved and for program replication. Looking at outcomes – without analyzing how they were achieved – fails to account for the human capital (e.g., over-worked staff) involved in getting to good outcomes and the true costs of the program. Examples of questions asked for process improvement: Did the program succeed in helping people to stop smoking? Was the program more successful with certain groups of people than with others? What aspects of the program did participants find gave the greatest benefit? What specific interventions were put into place by the program in order to fight the problem being tackled? Did the interventions work or not – and how and why? What were the kinds of problems encountered in delivering the program – were there enough resources from the beginning to do it well? Was it well managed? Were staff trained or educated to the right level of the program design? Is their skill level at facilitating the program processes sufficient from beginning to end? Was there adequate support to the program?

***Dr. Kalinowski's Pedigo clinic at Horizon House is not fully staffed; there will be times when we won't have a provider available to see a client on-demand. If this leads to increased costs, then potentially could be helpful to justify expense of adding a provider (though Dr. Kalinowski is already working on increasing staffing).

****Some individuals may have a mental health / medical impairment that precludes employment but may qualify for disability income which can then be used to support housing.

Reuben Engagement Center (REC)
Metrics and Evaluation Plan
DRAFT 1-7-16

As a summary, the evaluation plan will cover,

I. Ongoing Dashboard of Admission, Detox Completion and Treatment Referral – monthly outputs report.
II. Process Improvement Assessment – annually.
III. Estimated Fixed Cost Savings – six month and ongoing annual reports.
IV. Actual Cost Per Client Analysis – annually.
V. Actual Cost Aversion based on 50 genuine clients – comparative assessment from year to year.
VI. Success/Recidivism of Clients – third year cumulative assessment.

YEAR 1 (January 2016 – December 2016)

The evaluation team will work with REC board members to construct and operationalize a series of **dashboard Items** that can be automatically generated and presented at monthly board meetings, and ideally available via website. These dashboard data elements will be standardized so that trend patterns can be examined. Examples of dashboard items are shown in the **REC Evaluation Matrix**.

A care plan is #1 of four possible outcomes.
The other three outcomes, which will be reported for REC internal dash board purposes not external dash board metrics, are: #2 Violence in REC then arrested, #3 Medical emergency in REC then transported to hospital, #4 Self-discharged from REC against medical advice.

Additionally, we will collect data on safety issues and adverse events (e.g., death, falls, seizures, other trauma, violence against another client or staff, arrested at REC, transfer to emergency room (reason for transfer). Adverse events will be reported for internal purposes and will be used as training opportunities to determine "what we can do differently" and "how we can reengage clients".

The evaluation team will collect ongoing cost data to determine **average per-person REC costs**. These REC costs will be compared to costs for two types of comparisons:

1. **Individual histories**. In this method, clients serve as their own controls. We will consecutively invite the **first 50 REC clients** to consent to release of medical and criminal histories so that we can gather five-year retrospective data. Retrospective data will include prior hospital costs, criminal justice involvement (jail, court, law enforcement), and emergency medical services. The story is that we might expect the same persons to exhibit similar costs in the future year if we did nothing at all, and that hopefully the REC will interrupt the cost trajectory. (Note: See Year 2 plan for prospective follow-up of these 50 clients).

2. **One-time fixed study of costs**. We will work with community stakeholders to determine **the 2015 average per-person fixed costs** based on the minimum specified REC eligibility (i.e., Public Intoxication). This will include the 2015 average per-person cost for the following categories for persons following public intoxication,

YEAR 3 (January 2018 – December 2018)

In Year 3, the evaluation team will follow-up on the first year of 50 REC clients to examine costs data discussed above:

a. (1) Hospital costs including emergency department and inpatient costs
b. (2) Jail costs following public intoxication.
c. (3) Court costs following public intoxication.
d. (4) Law enforcement costs – arrest, transportation costs.
e. (5) Emergency Medical Services (EMS) – ambulance.

We will also assess the following outcomes:

1. How many weeks remained in the referral treatment program.
2. Whether completed the referral treatment program.
3. Recidivism broadly defined.
    a. Any pathway from REC to an event related to the 5 cost areas:
        i. Hospital
        ii. Jail
        iii. Court (not a recidivism indicator? i.e., it is good if they attend court)
        iv. Law enforcement -- arrested
        v. Emergency medical service
    b. Learn reasons why.
    c. Not failure of REC, marker of severity or condition, indicates need more services.
    d. Compare to benchmark of high recidivism for 50 clients' individual histories.

*Footnote: The evaluation team will partner with IUPUI (Public Health, Biostatistics, Public Affairs, Social Work, etc.) to identify students and volunteers to participate in REC evaluation efforts through internships and research credits.