Dignity Health 2MATCH Final Report

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Assessing the effectiveness of the 2MATCH Project on social determinants of health and healthcare utilization

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Introduction

This report summarizes screening and navigation data from the To Match and Align Through Community Hubs (2MATCH) project. The data presented are descriptive analyses of beneficiaries' health-related social needs (HRSNs) which were collected during screenings using the Accountable Health Communities HRSN Screening Tool (shown in Appendix 1) and referrals made during navigation. Identification of HRSNs are central to goals of the 2MATCH program and this report; based in part on these HRSNs, participants are also categorized into three "risk" groups based on their emergency department (ED) use and HRSN screenings:

- *Usual Care*: Participants who report no ED visits in the past 12 months and report no HRSNs
- *Low Risk*: Participants who report 0 or 1 ED visit in the past 12 months and report 1 or more HRSNs
- *High Risk*: Participants who report 2 or more ED visits in the past 12 months and report 1 or more HRSNs

Evaluation Implementation

Dignity Health obtained funding (5/1/2017 to 4/30/2022) through a cooperative agreement with the Centers for Medicare & Medicaid Services (CMS) to develop and implement the 2MATCH program to screen Medicare and Medicaid beneficiaries seeking health services for unmet HRSNs and to connect them with appropriate services in the community through an IT solution combined with patient navigation. As part of the Dignity/ASU Strategic Initiatives research program, Dignity Health and the ASU Southwest Interdisciplinary Research Center (SIRC), Office of Evaluation and Partner Contracts began their evaluation of the 2MATCH project in September 2018. Thus, the data presented in this report are from beneficiary screenings and navigation since the onset of the 2MATCH/SIRC collaboration in September 2018 through the end of the program in April 2022

The Covid-19 pandemic continued through the end of the program, contributing to ongoing changes in how and when care was delivered within St. Joseph's Hospital and Medical Center and the partner clinics implementing 2MATCH. Many patients deferred in-person appointments, and individuals who frequently utilized the ED as a safety net due to their lack of access to primary care also avoided seeking care rather than risk becoming exposed to the virus. [1] Healthcare systems have responded to the pandemic, in part, by pausing elective procedures on several occasions and increasing access to telehealth appointments. Since early March 2020, prior to Arizona's stay-at-home order going into effect, the majority of the 2MATCH staff (Advocates and Advocate Supervisor) began teleworking, and the majority of beneficiary screening and navigation activities were conducted telephonically. This resulted in a decrease in the number of surveys that were completed and significantly reduced the number of high-risk beneficiaries. However, procedural changes were implemented to increase screenings to reach more beneficiaries by telephone.

[1] https://www.ncbi.nlm.nih.gov/pmc/artides/PMC7499838/

Geographic Target Area

The 2MATCH geographic target area (GTA) originally included 13 zip codes:

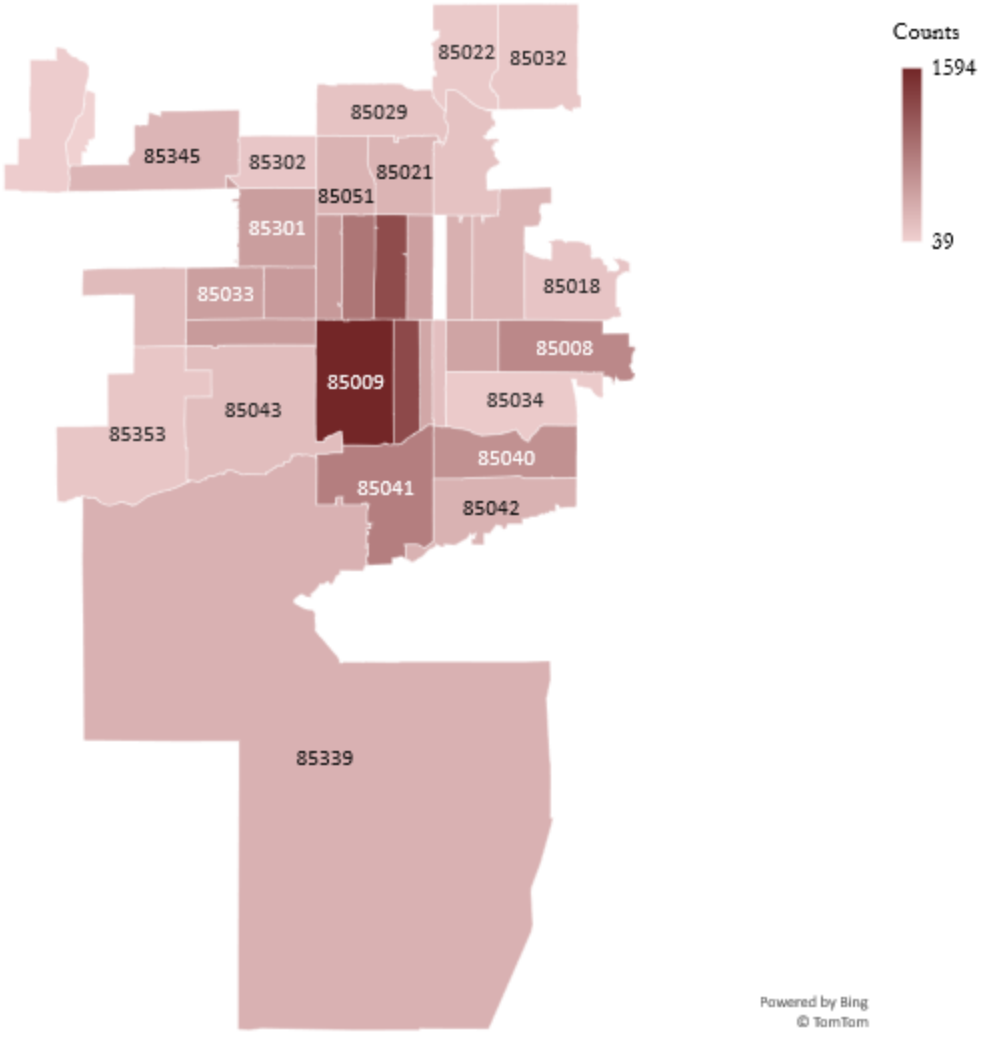
85003, 85004, 85006, 85007, 85008, 85009, 85015, 85017, 85019, 85031, 85033, 85035 & 85040

The GTA was expanded beginning on January 8, 2020 to include 22 additional high-need zip codes in Maricopa County:

85013, 85014, 85016, 85018, 85020, 85021, 85022, 85029, 85032, 85034, 85037, 85041, 85042, 85043, 85051, 85301, 85302, 85335, 85339, 85345, 85353, & 85363

All data presented in this report are based on the GTA as it was implemented during that respective time period (i.e., only including the original 13 zip codes initially and including the expanded 35 zip codes GTA starting in 2020). Data were also collected from beneficiaries screened from non-target zip codes. Screening counts for each of the targeted zip codes are depicted in Figure 1. Appendix 2 outlines the frequency of screenings from beneficiaries screened by the 2MATCH program outside of the GTA.

Figure 1 Map Depicting Screening Counts by GTA Zip Code

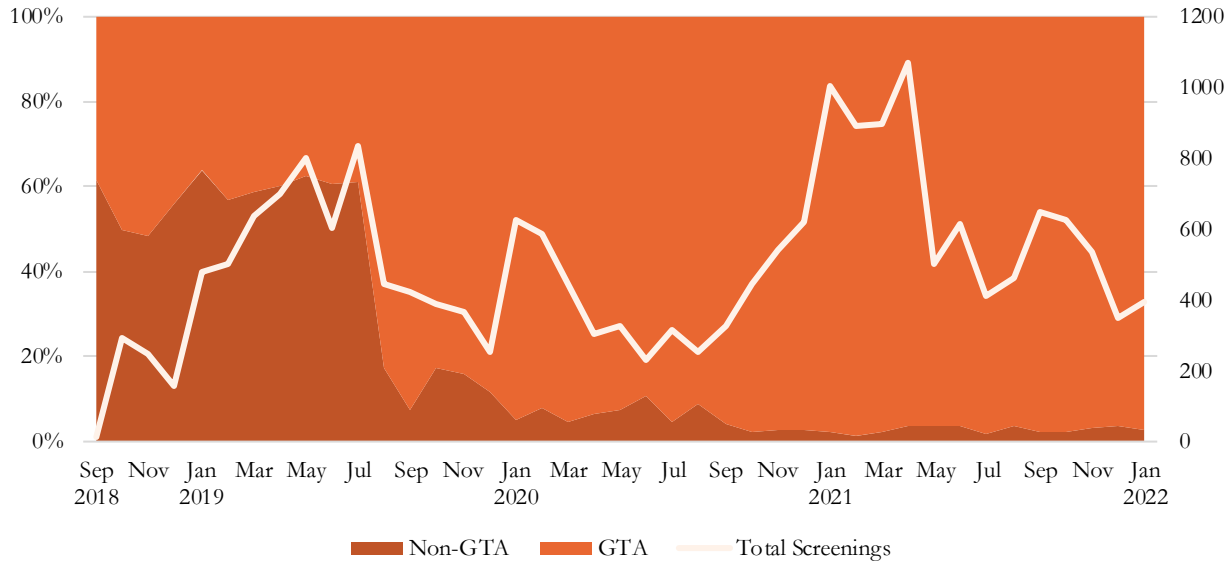


Beneficiary Screenings

Screening Count Trends and Location

The total number of screenings varied over the course of program implementation, with notable decreases during the first half of 2020 during the onset of the COVID pandemic, following by marked increases through April 2021. This variation over time is shown in Figure 2, as is the proportion of beneficiaries screened who lived within the GTA. The proportion of beneficiaries screened who were from the GTA substantially increased in August 2019 when procedural changes were implemented to focus on clients from the GTA. This protocol ensured that the vast majority of beneficiaries screened were from the GTA after that time.

Figure 2 Total Screenings and Proportion from GTA



The majority of screenings conducted by the 2MATCH program (85.6%) occurred within or in conjunction (i.e., telephonically following an appointment or visit) with a Dignity Health St. Joseph's health center or hospital, most of which were conducted in the St. Joseph's Hospital & Medical Center (SJHMC) Emergency Department. Table 1 shows the number of screenings that took place at each participating medical center.

Table 1 Screenings Counts by Medical Center

Medical Center	# Screened	% of Screenings
Dignity Health SJHMC Emergency Department	6207	39.23%
Dignity Health SJHMC Inpatient	3395	21.46%
†Valleywise 7th Avenue Family Health Center / Valleywise Community Health Center – South Central	1604	10.14%
Dignity Health SJHMC Family Medicine Clinic	1268	8.01%
Dignity Health SJHMC Internal Medicine	1128	7.13%
Dignity Health St. Joseph's Westgate Medical Center	675	4.27%
Dignity Health SJHMC Pediatrics	419	2.65%
Native American Connections Behavioral Health Services	364	2.30%
Dignity Health SJHMC Women's Health Center	258	1.63%
Valleywise Pediatric Primary Care	233	1.47%
Dignity Health SJHMC Transitional Care	199	1.26%
Parsons Family Health Center at Circle the City	69	0.44%
Valle del Sol, Inc 1st Avenue Site	4	0.03%

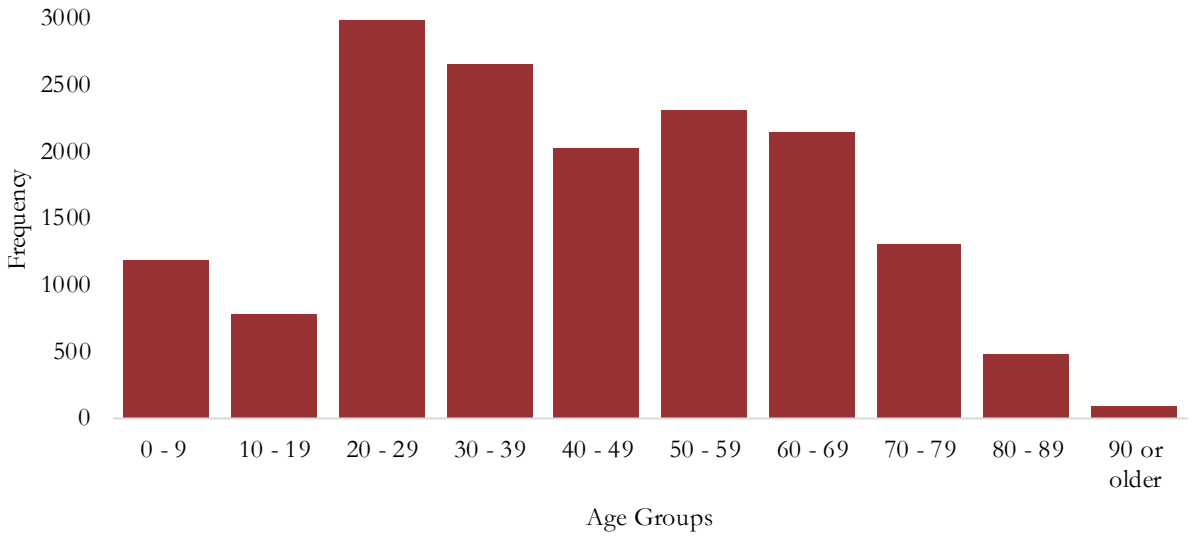
Note. †Valleywise 7th Avenue Family Health Center closed in September 2020 and the majority of staff and services transitioned to Valleywise Community Health Center – South Central.

Demographic Characteristics from Screenings

Age

Figure 3 shows the age distribution for all individuals screened from the GTA. More than half (52.4%) of participants were over the age of 40 years old, and 18.5% were 65 years old or older. The average age of participants was 42.6 years old (*SD* = 21.6).

Figure 3 Age Distribution of Individuals Screened from GTA



Gender

The majority of beneficiaries who reported their gender on the 2MATCH screening identified as female (63.5%) and 36.5% identified as male; however, 588 beneficiaries (3.9%) did not provide their gender.

Race and Ethnicity

Race

Over half of the individuals screened from the GTA identified their race as *White* (52.2%), 25.9% identified their race as *Other*, and 18% identified as *Black or African American*. Participants were able to select more than one applicable race, and Table 2 illustrates the totals for each selection.

Table 2 Race of Individuals Screened from GTA

Race	# Screenings	% of Total†
White	7,234	52.2%
Other	3,577	25.9%
Black or African American	2,443	18.0%
Asian	985	7.2%
American Indian or Alaska Native	587	4.3%
Native Hawaiian or other Pacific Islander	48	0.4%
Did not provide	1944	12.8%

†Values sum to more than 100% because beneficiaries could select more than one race. Percentages reported are of the beneficiaries who provided a response. Additionally, 951 beneficiaries (7%) were multiracial.

Ethnicity: Hispanic, Latino, or Spanish Origin

Nearly half (45.1%) of the beneficiaries screened for the 2MATCH program from the GTA identified as Hispanic, Latino(a) or of Spanish origin. Participants were able to select more than one applicable ethnic group, and Table 4 illustrates the totals for each selection.

Table 3 Ethnicity (Hispanic, Latino, or Spanish Origin) of Individuals Screened from GTA

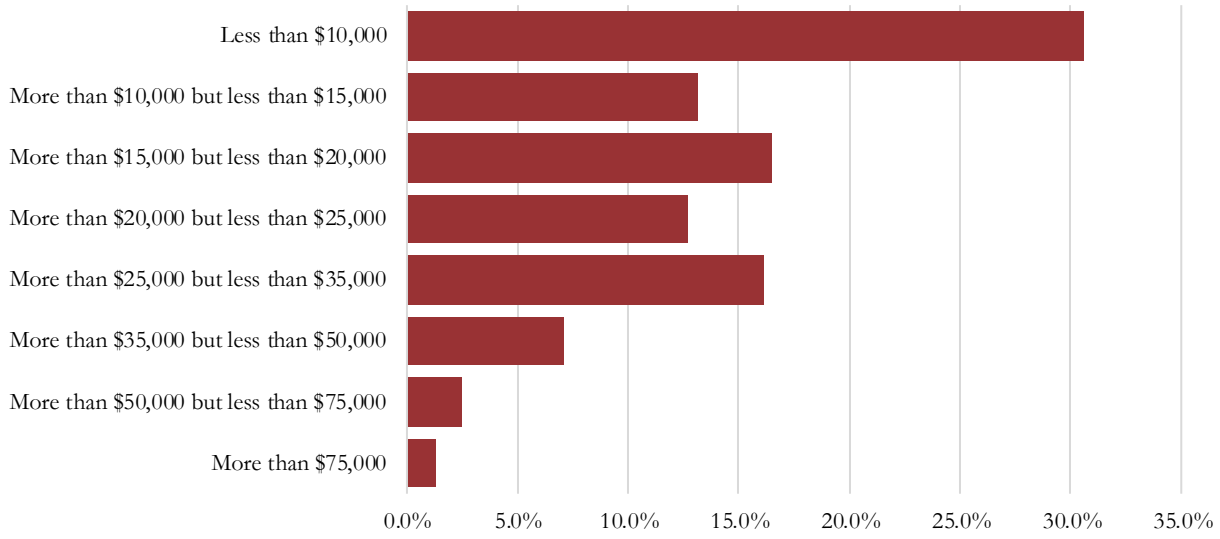
Ethnicity	# Screenings	%†
Yes, Another Hispanic, Latino, or Spanish origin	3,454	23.7%
Yes, Mexican, Mexican American, Chicano	3,306	22.6%
Yes, Puerto Rican	60	0.4%
Yes, Cuban	39	0.3%
No, not of Hispanic, Latino, or Spanish Origin	6,515	54.9%
Did not provide	1,034	6.8%

†Values sum to more than 100% because beneficiaries could select more than one ethnicity. Percentages reported are of the beneficiaries who provided a response.

Income

Individuals were also asked on the HRSN screening tool to report an estimate of their annual household income from all current financial sources. Figure 4 provides the household income for individuals from the GTA. Nearly three-quarters (73%) of the beneficiaries screened reported an income of $25,000 or less (near the 2021 Federal Poverty Level for a household of 4, $26,500), and only 1.3% reported an income of $75,000 or more. The most highly represented income group was less than $10,000. However, over a third (37%) did not provide a response to this question.

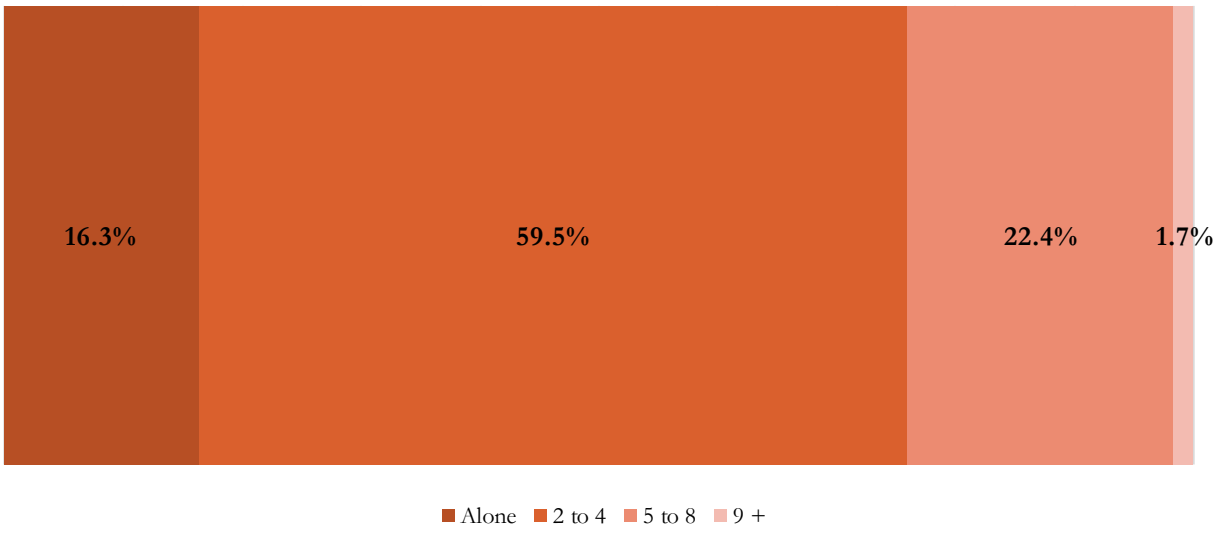
Figure 4 Income of Individuals Screened from GTA



Household Size

As a part of the screening, participants were asked "*How many people do you currently live with?*" to collect information about household size. Participants were asked to count the number of adults (including themselves), children and other dependents living in the household. The most common responses were living with two (21.4%) or three (19.7%) other people (household size of three and four, respectively). The median household size was three individuals; over half (59.5%) lived in a household of two to four people, and 22.4% lived in a household of five to eight people. Only 1.7% of individuals lived in households of 9 or more other people.

Figure 5 Household Size of Individuals Screened from GTA



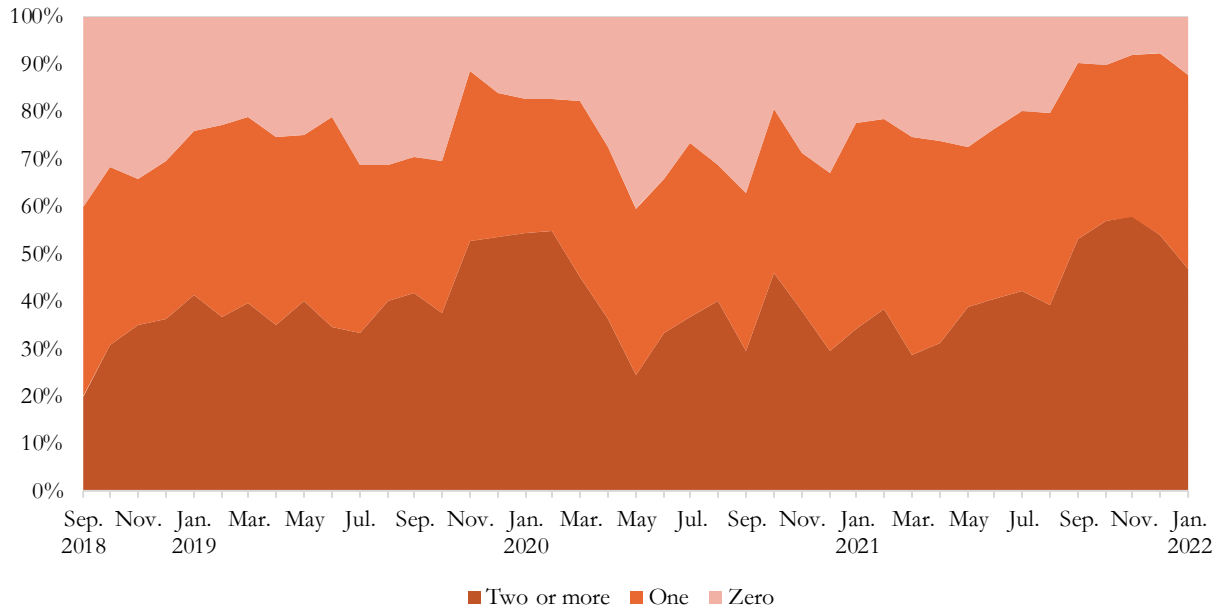
Health Related Social Needs from Screenings

Individuals who were screened were asked about their use of the ED and specific HRSNs, which were used to determine their risk levels.

ED Visits

Individuals were asked to indicate their past-year ED visits: "*How many times have you received care in an emergency room (ER) over the last 12 months?*" At the time of their screenings, the majority (77.6%) of beneficiaries reported having received care in an ED at least once in the past 12 months. Of the individuals who indicated having been to the ED *at least once* in the past year, more than half (52.6%) visited two or more times and 47.4% visited once. Figure 6 depicts the frequency of past-year ED visits since the beginning of the 2MATCH program.

Figure 6 Past Year ED Visits



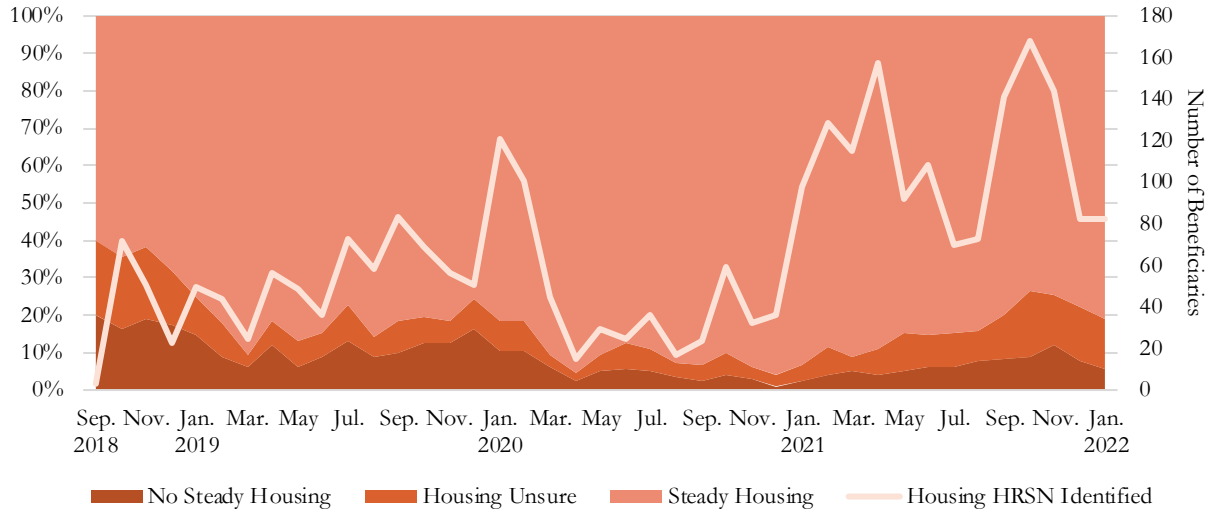
Housing

Individuals were also asked about housing stability: "*What is your living situation?*" Individuals were classified as *Steady Housing*, *Housing Unsure*, or *No Steady Housing* based on their responses:

1. *Steady Housing*: "I have a steady place to live"
2. *Housing Unsure*: "I have a place to live today, but **I am worried** about losing it in the future"
3. *No Steady Housing*: "I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)"

Although the majority of the individuals screened from the GTA were experiencing steady housing (85.4%) at the time of their screenings, a substantial number of beneficiaries reported experiencing either no steady housing (6.9%) or uncertainty about their housing (7.7%). These numbers reflect over 2,200 beneficiaries reporting housing needs. Figure 7 shows the proportions of housing stability and instability over time, as well as the number of beneficiaries who had an HRSN identified based on this screening item.

Figure 7 Housing Stability



In addition to collecting information about housing stability, individuals were asked to identify specific issues related to their current living situation. Endorsement of any of the specific housing issues indicated a HRSN in the housing domain.

The vast majority of participants (90%) indicated they did not have any of the specific housing issues listed in Table 4, and 1,466 specific housing issues were reported to the 2MATCH program. The prevalence of specific housing issues among those reporting a need are provided in Table 5. The most prevalent housing concern was having pests. Individuals were able to select more than one housing issue.

Table 4 Specific Types of Housing Issues

Housing issue	Number of Instances	% of Housing Issues
Pests, such as bugs, ants, or mice	458	31.2%
Water leaks	293	20%
Smoke detectors missing or not working	217	14.8%
Mold	194	13.2%
Oven or stove not working	124	8.5%
Lack of heat	112	7.6%
Lead paint or pipes	68	4.6%
Total Number of Housing Issues	**1,466**	

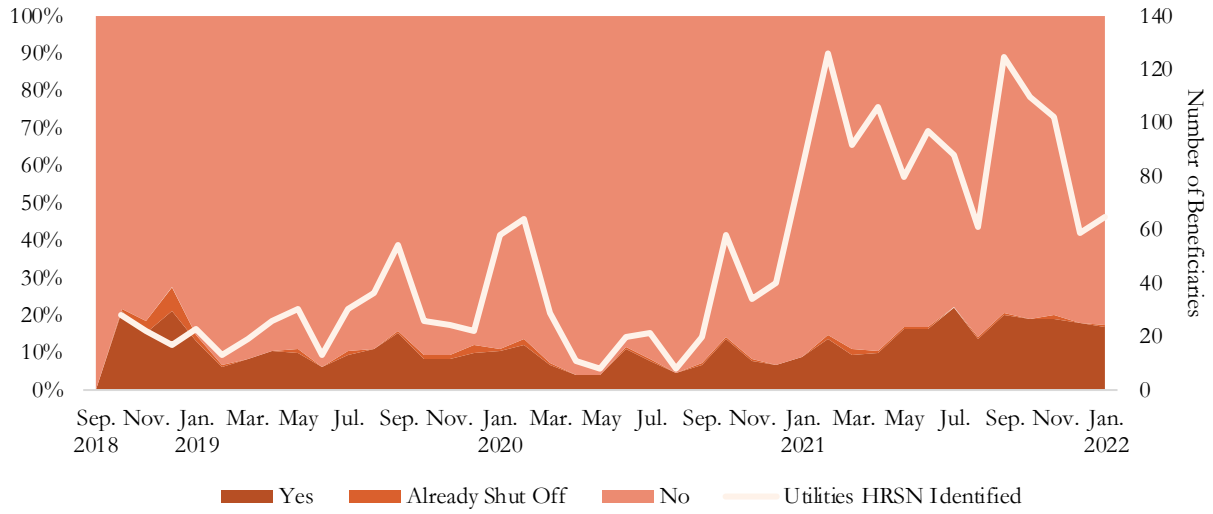
Utilities

Beneficiaries were also asked about their utilities needs using the item, "*In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?*" The majority of participants (87.4%) reported no threats to have their utilities cut off by a utility company. However, 12% of individuals had received a notice that their utilities would be shut off, and 0.6% reported their utilities were already shut off. As shown in Figure 8, although these proportions have remained relatively stable over time, the number of 2MATCH beneficiaries experiencing threats to shutoff utilities started increasing around August 2020 and remained at higher rates through the end of the program.

12.6%

reported receiving a notice their utilities would be shut off or actually having their utilities shut off in the previous year.

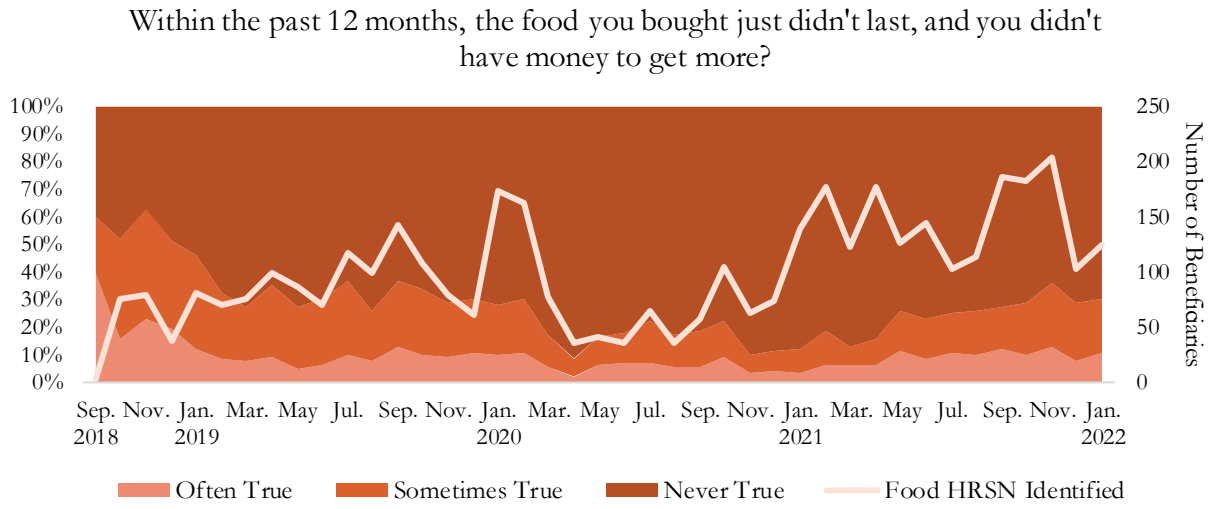
Figure 8 Utility Needs

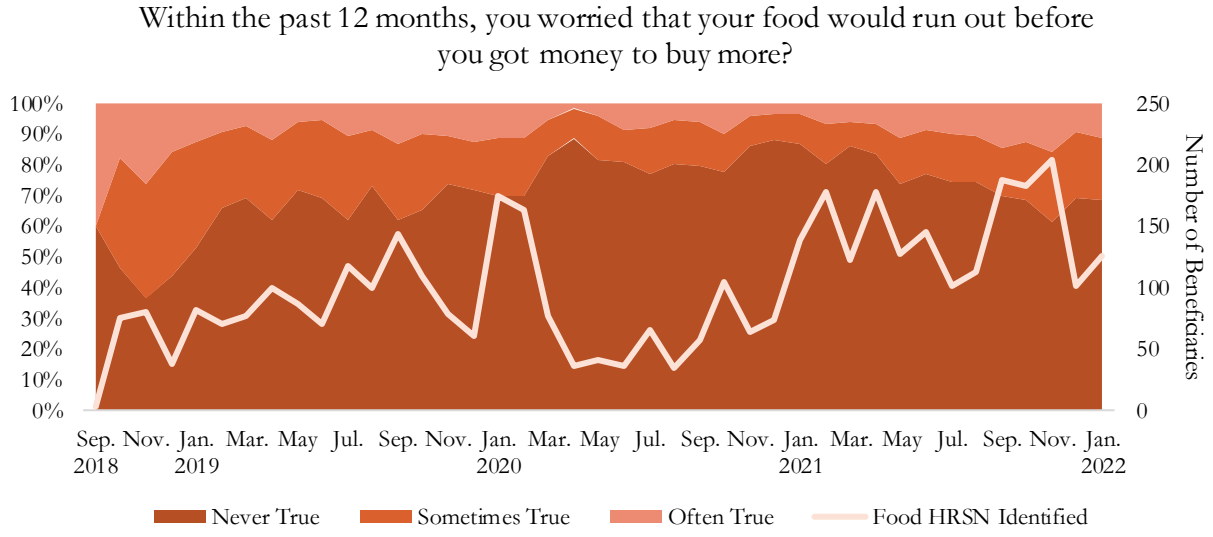


Food

Beneficiaries were asked to respond to two statements regarding food security, which asked individuals about actually running out of food as well as worrying about food running out. When asked if the food they had purchased did not last in the previous year, 23.8% shared this was "*sometimes true*" or "*often true.*" Additionally, when asked about worrying about food running out in the past year, 24.9% of beneficiaries screened indicated this was "*sometimes true*" or "*often true.*" As can be seen in Figure 9, the proportion of participants screened indicating that they never run out of food or worry about running out of food has increased over time before decreasing again the most recent quarter. This is also in the context higher screenings over time, so despite even during months with lower proportions of needs, there remained a high number of beneficiaries reporting food needs.

Figure 9 Food Security





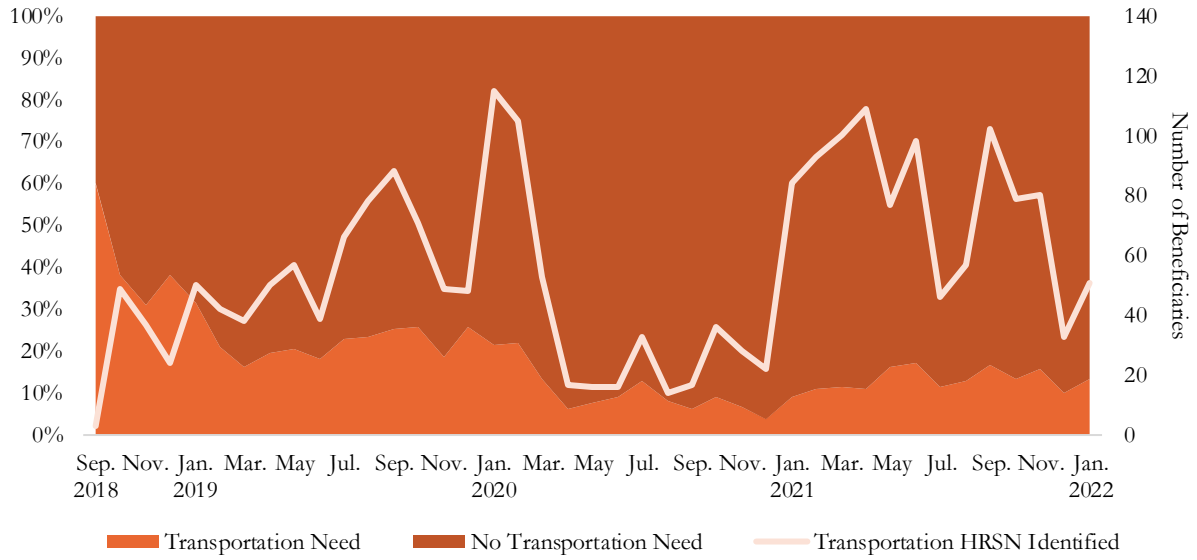
Transportation

14.7%

missed an appointment, meeting or work due to lacking reliable transportation

Beneficiaries were asked about their access to reliable transportation using the following question: "*In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?*" Of the beneficiaries screened, 14.7% indicated the lack of reliable transportation as a barrier to getting to things they needed for daily living. As shown in Figure 10, transportation HRSNs were markedly lower for most of 2020 (during which time when efforts to mitigate the spread of COVID-19 were in place) when compared to 2019; however, since January 2021 identification of transportation HRSNs have again increased.

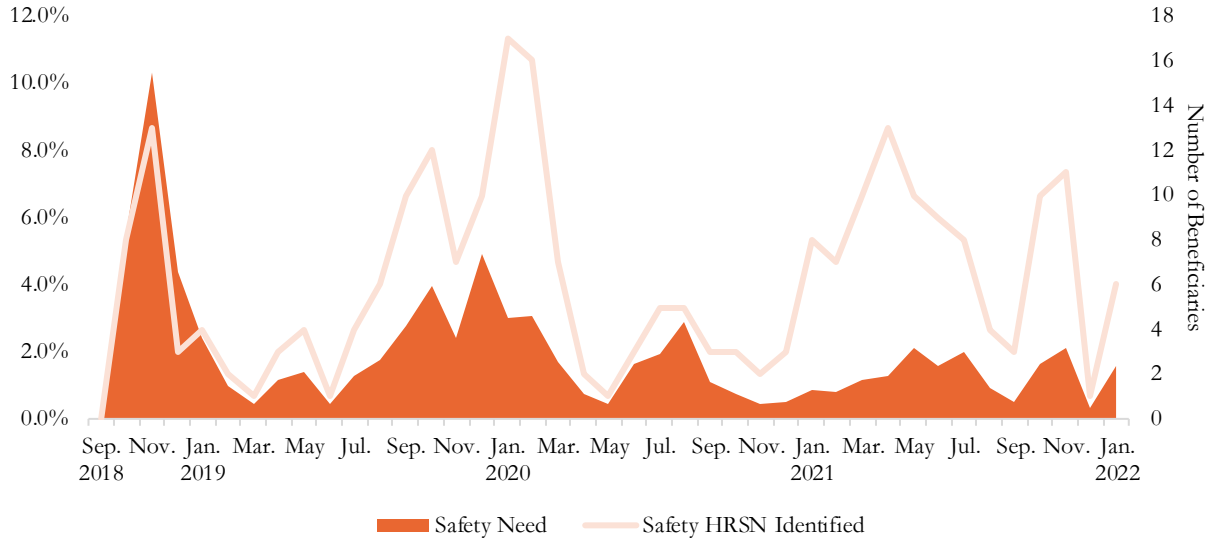
Figure 10 Transportation



Safety

Beneficiaries were also asked about their safety and exposure to violence. The majority of individuals indicated that they never experienced any of the four safety issues: being insulted or talked down to; being screamed or cursed at; being threatened with harm; or being physically hurt. Each of these items were scored from 1 (*Never*) to 5 (*Frequently*), and individuals with a total (sum) score of 11 or more were identified as having a HRSN in the safety domain. Safety needs have remained low over time in comparison to other needs; 1.6% of beneficiaries screened reported a HSRN in the safety domain. Although *proportions* remain low, there have been several increases in the *number* of 2MATCH beneficiaries indicating safety needs during the program; attention should be paid to the rates of safety needs to best connect beneficiaries to the appropriate community resources and services.

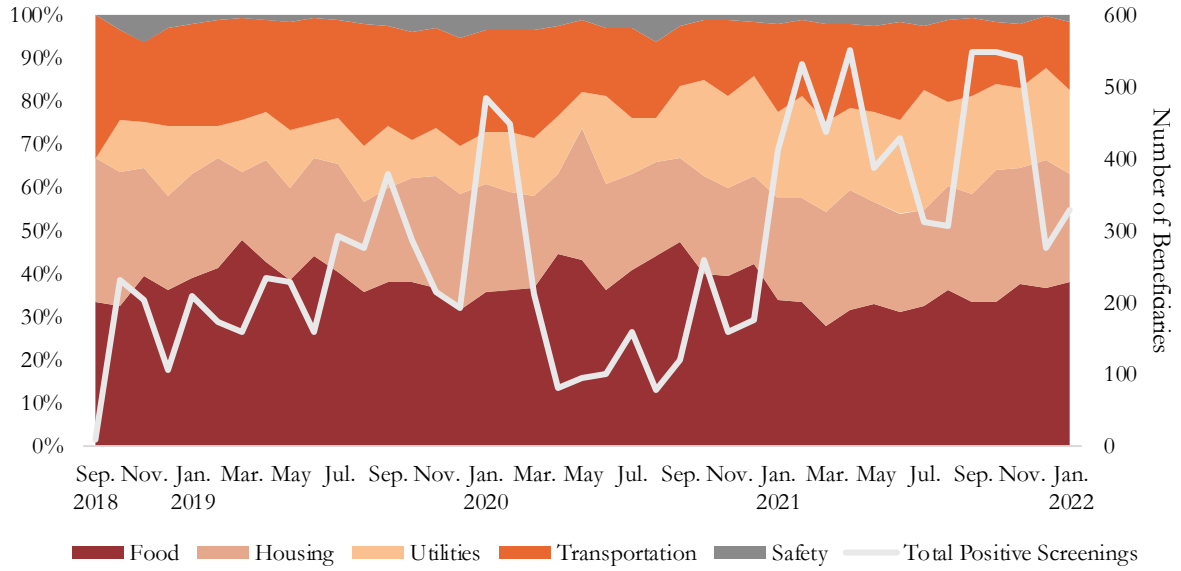
Figure 11 Safety



Positive Screenings

Positive screenings account for individuals who indicated any HRSNs screened "positive" for that domain. Food insecurity was the most prevalent HSRN, representing 36.2% of positive screenings, followed by 24.5% of positive screenings for housing instability, and 20% of transportation issues, and 17.1% for utility issues. Safety was the least prevalent positive screening at 2.2% of positive screenings. Figure 11 shows the rates of positive screenings for each domain as a proportion of all positive screenings since the beginning of the 2MATCH program, as well the total number of positive screenings across all domains for each month.

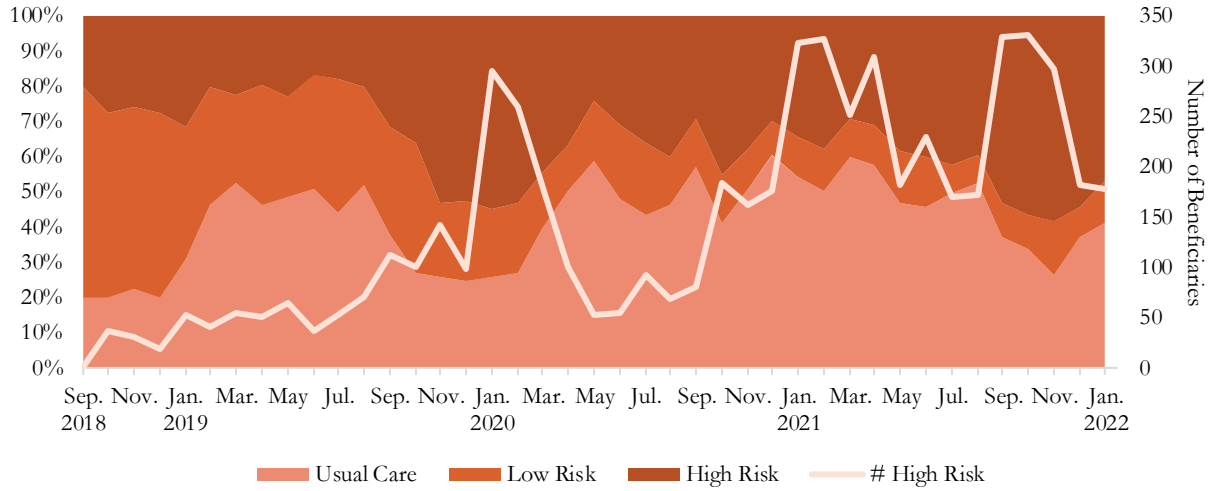
Figure 12 Positive Screenings



Qualification for 2MATCH Program

The vast majority (97.5%) of beneficiaries screened were community-dwelling (i.e., not living in institutional settings) and were, therefore, classified into *usual care*, *low risk*, or *high risk* categories. Of the eligible beneficiaries, a total of 5,751 individuals (37%) were categorized as *high risk*, 2,757 (17.7%) as *low risk*, and 7,025 (45.2%) as *usual care*. As demonstrated in Figure 12, the number of *high risk* beneficiaries screened in the 2MATCH program was variable over the course of the program, including an increase in the last two quarters of the program.

Figure 13 Qualification Category of Individuals Screened



Risk and HRSNs by Participant Demographic Characteristics

Differences in risk levels and HRSNs by participant demographic characteristics were also assessed using chi-square tests of independence (i.e., the associations of risk level and HRSNs with gender, race, ethnicity, and income). The results from each set of these analyses as well as descriptive differences between groups are summarized below.

Differences in Risk Levels by Participant Demographic Characteristics

Risk levels were measured using three categories: *usual care* (45.2%), *low risk* (17.7%) and *high risk* (37%). As outlined in the introduction, participants who did not utilize the ED in the past 12 months and reported no HRSNs were categorized as *usual care*. Participants who indicated 0 or 1 ED visit in the past 12 months, and 1 or more HRSNs were considered *low risk*. The *high risk* group consisted of participants who visited the ED 2 or more times in the past 12 months, and reported 1 or more HRSNs. Table 5 shows these risk levels by demographic characteristics, as well as the associated chi-square test of independence.

Risk Level: Significant Differences between Characteristics

- Gender
- Race
- Ethnicity
- Income

Women were more likely to be classified as *usual care* and men were more likely to be classified as *high risk* or *low risk*. There were also significant differences in risk levels by race. Among the *high risk* category, Native Hawaiian or other Pacific Islander, Black or African American, American Indian or Alaska Native, and "other race" participants were more highly represented when compared to the overall sample. Additionally, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and Black or African American participants were more highly represented in the *low risk* than the overall sample. Finally, participants indicated as Asian, White, and "other race" participants were more highly represented among the *usual care* category.

Additionally, when compared to Hispanic, Latino, or Spanish origin participants, non-Hispanic, Latino, or Spanish origin participants more highly represented among the *low risk* category and less represented among the *usual care* category.

Participants with a household income of less than $25,000 were most highly represented among both the *high risk* and *low risk* categories. Participants with household incomes over $25,000 were more highly represented among the *usual care* category.

Table 5 Risk Levels by Participant Demographic Characteristics

	n (%)		
	High Risk	Low Risk	Usual Care
Gender, $\chi^2(2) = 8.38, p = .015$			
Female	3,528 (36.8%)	1,633 (17%)	4,417 (46.1%)
Male	2,005 (37.4%)	995 (18.6%)	2,355 (44%)
Race, $\chi^2(10) = 260.41, p < 0.001$			
White	2,774 (37%)	1,168 (15.6%)	3,546 (47.4%)
Other race	1,375 (37.8%)	593 (16.3%)	1,667 (45.9%)
Black or African American	1,067 (41.8%)	512 (20.1%)	972 (38.1%)
Asian	293 (29.5%)	92 (9.3%)	608 (61.2%)
American Indian or Alaska Native	248 (40.9%)	173 (28.5%)	186 (30.6%)
Native Hawaiian or other Pacific Islander	22 (44.9%)	10 (20.4%)	17 (34.7%)
Ethnicity, $\chi^2(2) = 13.2, p = .0014$			
Hispanic, Latino, or Spanish Origin	2,581 (37%)	1,305 (18.7%)	3,098 (44.4%)
Non-Hispanic, Latino, or Spanish Origin	3,091 (37.6%)	1,352 (16.5%)	3,772 (45.9%)
Income, $\chi^2(4) = 195.3, p < .001$			
Less than $25,000	3,184 (40.3%)	1,691 (21.4%)	3,016 (38.2%)
More than $25,000 but less than $50,000	765 (30.5%)	405 (16.1%)	1,340 (53.4%)
More than $50,000	133 (32%)	68 (16.3%)	215 (51.7%)

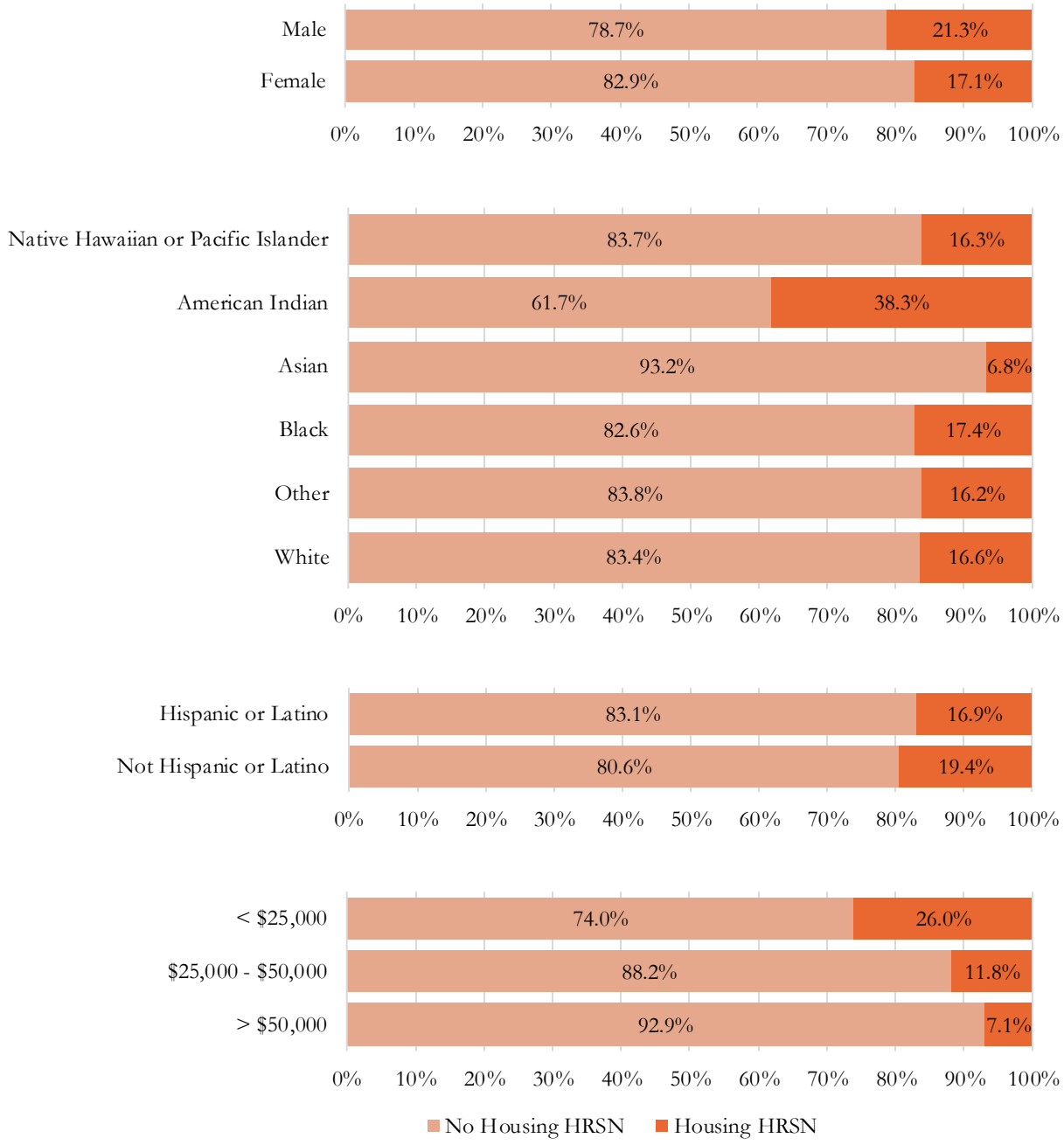
Health Related Social Needs by Participants' Demographic Characteristics

Differences in rates of positive screenings for the top three HRSNs (food, housing, transportation) were also tested between participants' gender, race, ethnicity, and income.

Housing Stability

There were statistically significant relationships of housing stability with: gender, $\chi^2(1) = 39.77, p < .001$; race, $\chi^2(5) = 268.18, p < .001$; ethnicity, $\chi^2(1) = 15.74, p < .001$; and income, $\chi^2(2) = 276.14, p < .001$.

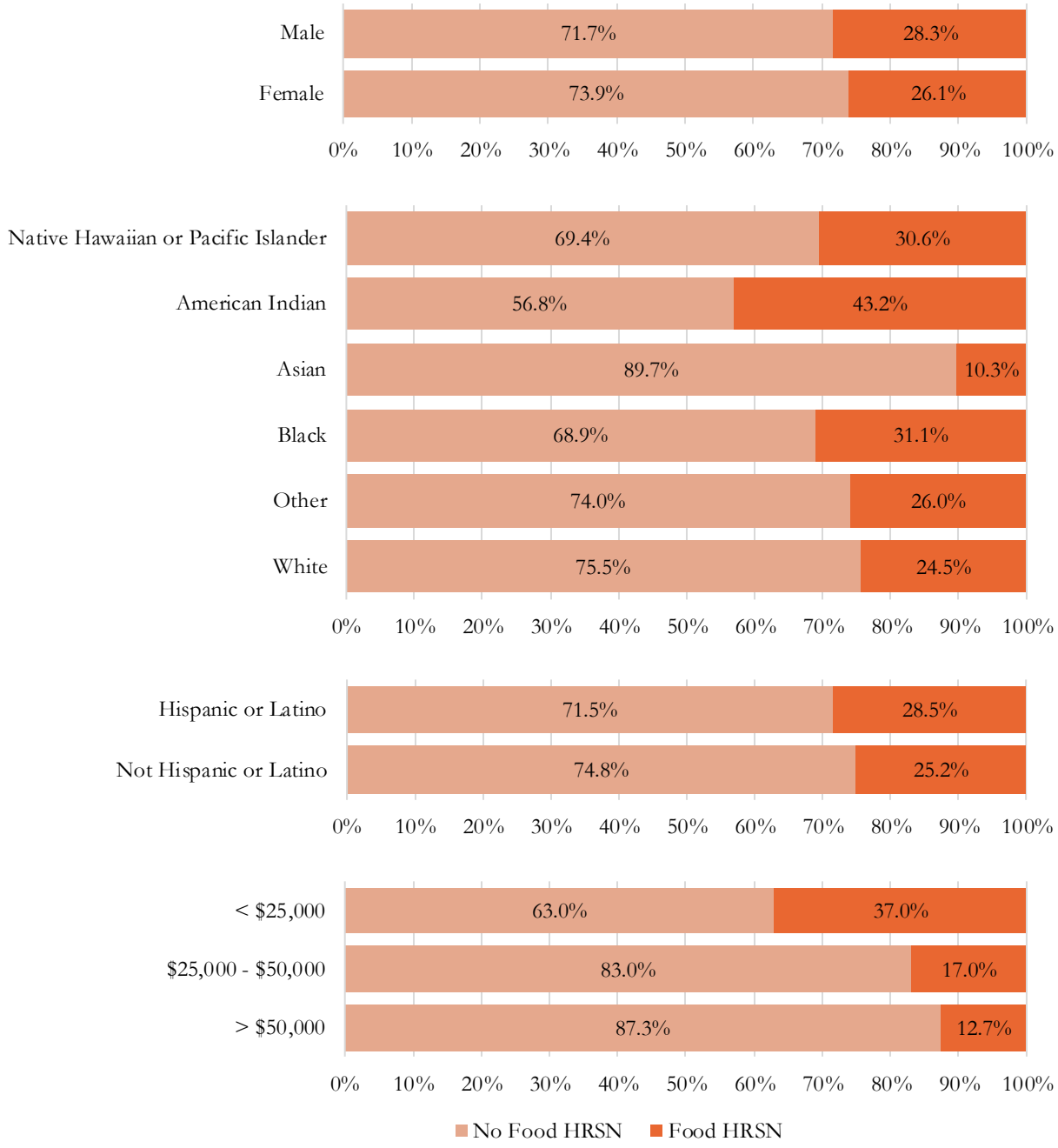
Figure 14 Housing Stability by Demographic Characteristics



Food Security

Additionally, there statistically significant relationships between food insecurity and each of the participant characteristics tested: gender, $\chi^2(1) = 8.72, p = .003$; race, $\chi^2(5) = 263.61, p < .001$; ethnicity, $\chi^2(1) = 20.76, p < .001$; and income, $\chi^2(2) = 419.41, p < .001$.

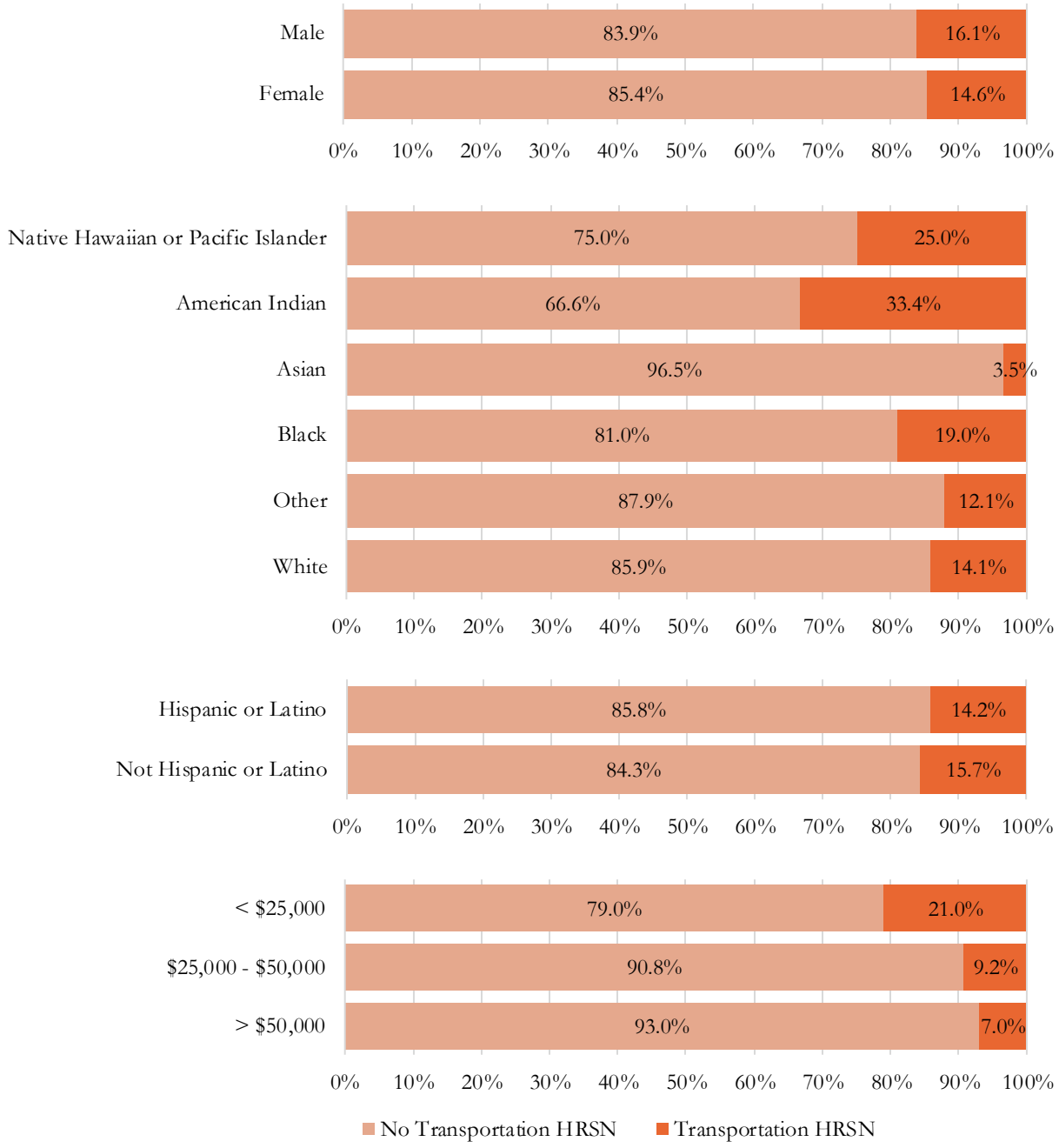
Figure 15 Food Security by Demographic Characteristics



Transportation Reliability

There were also significant relationships between transportation reliability and each of the participant characteristics tested: gender, $\chi^2(1) = 6.07, p = .014$; race, $\chi^2(5) = 327.81, p < .001$; ethnicity, $\chi^2(1) = 6.59, p = .01$; and income, $\chi^2(2) = 210.62, p < .001$.

Figure 16 Transportation Reliability by Demographic Characteristics



Navigation

Referrals from Navigation Services

Each referral made for individuals who participate in navigation is categorized regarding the type of services for which referrals are made and the organizations to which participants are referred. Frequencies regarding this information are provided in the section below.

Receiving Services

The top 20 services to which beneficiaries were referred are represented in Table 6. Referrals to food pantries and emergency food were most frequent, in addition to food needs being further categorized into several other food-related service offerings (i.e., affordable food, SNAP, vouchers, delivery), followed by referrals for utility assistance. Frequent referrals were also made for utility assistance, transportation assistance, financial assistance, and several housing-related services.

Table 6 Referrals to Specific Service Offerings

Service Offering	Count
Food pantries	1,393
Emergency food	1,129
Utility assistance	808
Affordable food	788
SNAP (food stamps)	756
Transportation assistance	615
Affordable housing	536
Financial assistance	518
Emergency financial assistance	387
Rental assistance	294
Housing support services	291
Social service navigation	289
Homelessness prevention	261
Medical transportation	227
Transitional housing	226
Food vouchers	210
Shelters & temporary housing	128
Housing financial assistance	116
Housing inspections	69
Home repairs	57

Receiving Organizations

Referrals are also categorized according to the organization to which individuals are referred. The 20 organizations receiving the most referrals are shown provided in Table 7.

Table 7 Receiving Organizations and Services

Receiving Organization	#
St Mary's Food Bank	759
Chicanos Por La Causa	504
Pilgrim Rest Baptist Church	436
City of Phoenix	329
Cultural Cup Food Bank	484
Keogh Health Connection	403
City of Phoenix Human Services Department	23
Wildfire	213
ICM Food & Clothing Bank	103
City of Glendale	121
West Valley Community Food Pantry	89
Arizona Public Service	77
Hope for Hunger	119
St Mary's Food Bank Alliance	120
Glendale Community Services Department	29
City of Tolleson	40
Society of Saint Vincent de Paul Diocese of Phoenix	57
The Salvation Army Laura Danieli Senior Activity Center	60
Lutheran Social Services of the Southwest	160
City of Phoenix Senior Services Intake Line for 60+	56

Appendices

Appendix 1: AHC HRSN Screening Tool Core Questions

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**[6]
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**[7]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. [8]

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

Appendix 2: Screenings by non-GTA Zip Code

Zip Code	Count	Zip Code (cont'd)	Count (cont'd)
85041*	259	85283	24
85013*	174	85204	23
85301*	146	85210	23
85014*	140	85225	22
85339*	109	85202	20
85021*	99	85305	20
85051*	94	85351	18
85016*	89	85028	17
85042*	84	85382	17
85012	72	85208	16
85018*	69	85306	16
85303	66	85024	15
85029*	63	85048	15
85037*	63	85251	15
85043*	53	85307	15
85020*	43	85086	13
85323	40	85147	13
85326	39	85254	13
85345*	39	85256	13
85302*	37	85335*	13
85032*	34	85379	13
85034*	34	85203	12
85201	33	85207	12
85392	33	86301	12
85022*	32	85138	11
85023	32	85224	11
85027	30	85253	11
85044	30	85364	11
85053	29	85375	11
85338	29	85383	11
85353*	28	85122	10
85282	27	85205	10
85281	26	85295	10
85308	26	85374	10
85304	25	85395	10
85257	24		

Note. Non-GTA zip codes with at least 10 screenings. All data presented in this report are based on the GTA as it was implemented during that respective time period. Zip codes marked with an asterisk (*) were not initially part of the GTA but were the original 13 zip code GTA but were added to the expanded 35 zip code GTA starting in 2020.

Appendix 3: HRSN Resolution Status

HRSN Status	HRSN Status Option	HRSN Status Definition
Resolved	1. Resolved	The beneficiary's need has been met.
	2. Successful	The beneficiary made contact with a community service provider that may be able to address the unmet need within the next six months.
Unresolved	1. Unavailable	A community service is unavailable to address the unmet need for more than six months (for example, the beneficiary made contact with a community service provider that may be able to address the unmet need but was put on a wait list longer than six months and there is no other community service available with a shorter wait list).
	2. Attempt Failed	The navigator attempted to contact the beneficiary on at least three consecutive occasions to resolve the unmet need, but was unable to reach the beneficiary.
	3. Opt Out	The beneficiary opted out of navigation services for the unmet need.