CITY OF WORCESTER, MASSACHUSETTS
Department of Health & Human Services
Division of Public Health

Matilde Castiel, MD
Health & Human Services
Commissioner

Karyn E. Clark
Public Health
Director

DATE: **July 17, 2017**
RE: **WORCESTER BOARD OF HEALTH MEETING MINUTES**
START TIME: **6:30 PM**
LOCATION: **WORCESTER DIVISION OF PUBLIC HEALTH**
25 MEADE STREET, CONFERENCE ROOM 109
WORCESTER, MA 01610

Welcome & Introductions:
Meeting was called to order at 6:35pm.
Members present: David Fort, Chair, Edith Claros, PhD, Vice Chair, Jerry Gurwitz, MD, Abigail Averbach and Joanne Calista WDPH Staff: Matilde Castiel, MD, Commissioner of Health and Human Services, Michael Hirsh, MD, Medical Director, Karyn Clark, Director of Public Health, Colleen Bolen, Deputy Director of Public Health, Alexis Travis, Chief of Community Health, Megan DeNubila, Public Health Prevention Specialist and Michele Williams, Principal Clerk

Approval of the June 5, 2017 Minutes:
Motion to approve the WBOH meeting minutes of June 5, 2017 made by Jerry Gurwitz, MD, Second – Edith Claros, PhD, Vice Chair. Approved

Review and act on discussion relative to homelessness, criteria to get into a shelter, unstable housing and panhandling:
Katherine Calano, Homeless Projects Manager, HHS: Informational packets were distributed. The City's HHS was re-established in September 2015 placing the Office of Homeless Assistance under it. Addressed the HUD definition of homeless. The 4 categories are: literally homeless, imminent risk of homelessness, homeless under other federal statues and fleeing/attempting to flee domestic violence. There's a special definition for chronic homelessness, which is a homeless individual with a disability who lives in a place not meant for human habitation, emergency shelter or safe haven and have been continuously homeless for at least 12 months or 4 separate occasions in the last 3 years that combine a total of 12 months. In 2016, there were 1,062 homeless persons in the City of Worcester (664 persons in family households, 398 persons in households without children). The housing status of the family or individual at the time of intake will determine what kind of services they will receive. Those who are literally homeless, there are a range of services available as well from street outreach, emergency shelter, transitional housing, rapid re-housing and permanent supportive housing. We want to look at better strategies for homeless prevention and to be able to

identify those families and individuals before that happens. For families to access emergency shelter the front door is really the DTA, through the Department of Housing Community Development. Massachusetts is the only "Right to Shelter" State in the country and New York City is the only "Right to Shelter" City. What that means is that if a family is found eligible, they will be provided shelter that day. The eligibility for emergency assistance family shelter is either 1 or 2 adult head of household with children under 18 yrs. old. More families are being turned away from DTA because they don't have the documentation needed to proof that they are homeless. That family will then come into my office because we are a "Right to Shelter State"; part of the regulations on a state level for families to access shelter is that if it looks like they may be eligible, they have to be provided some placement. Then they are given 30 days to pull together some documentation. We need DTA to provide us with more data as to why more families are being turned away so we can understand whether it's the criteria or documentation. For individual shelters we have 25 Queen St, which is run by SMOC and 69 Grove St for our veterans. Our Permanent Supportive Housing also known as "Housing First" is targeted to people who suffer from complex medical, mental health and addiction disabilities and the chronically homeless. Our role is overseeing the coordination of the different homeless initiatives. Last spring we had a Housing and Human Services Summit with the goal of identifying what service providers touch on for families and individuals to coordinate and collaborate the type of services we can provide early on. One of the questions we ask people to respond to is "In what way does your agency serve someone who may be homeless or become homeless"? They aren't just providing shelter or housing but it could be any range of services that are needed for that individual. About 2 years ago we started the Street Outreach with the Quality of Life Task Force. We identified hundreds of individuals who were living on the streets and connecting them with services in the community. The Quality of Life Task Force works on establishing relationships with unsheltered individuals and community providers to help facilitate serves access. They also work to provide needed items such as food, blankets, clothes, toiletries, photo ID's or birth certificates and assist with required documentation for access to public benefits. This past winter we were able to coordinate the Worcester Overnight Warming Center, also known as "Hotel Grace", which is an emergency overflow shelter at St. John's Church. It housed over 35 people per night. We also started collaboration with UMass Memorial Health Care to look at integration on medical respite, healthcare for the homeless and discharge planning. The medical respite program would solve some issues for people who are too sick for a shelter but not quite sick enough for acute care in a hospital. They would need that respite period to get back on their feet and a little more stabilized before they go back into a shelter situation. We have the fortune of going to Boston Healthcare for the Homeless, which has a 124 beds medical respite program. We're really intrigued by some of the innovative service models that are going around the country for the panhandling population. Albuquerque, NM pulled together a program that provides jobs on a day to day basis for panhandlers who are looking for work. Also Portland, ME has taken that same pilot. Most importantly, what the state is trying to implement here in Worcester is a "homeless surge". It's basically a surge that brings all the services to one place for a day for your most high in need population. The Boston Housing Authority has set aside units and vouchers for this specific event and walked people around to get them connected. Out of 60 individuals, 53 walked out with either keys or a voucher.

David Fort, Chair: Thank you for the presentation. It was very informative. As far as the opioid epidemic, how has it affected the housing situation for individuals and families in the City of Worcester?

Katherine Calano, Homeless Projects Manager, HHS: We are seeing a higher number of unsheltered individuals who are experiencing substance use disorder. Whenever the Quality of Life Team goes out to these encampments, where there is hiding of syringes, we are partnering with AIDS Project of Worcester to collect those syringes and making sure that the individuals that we encounter know about harm reduction technics to prevent the spread of disease and Narcan access.

Matilde Castiel, MD, Commissioner of Health and Human Services: It is very difficult to house people in recovery. More importantly, if they are in a residential treatment it's difficult to find them beds because if you're in a treatment facility for more than 90 days you're not eligible for HUD housing. That's one of the issues that happen with the opioid crisis.

Joanne Calista: Is 25 Queen Street the primary shelter? What are the criteria to gain entrance?

Katherine Calano, Homeless Projects Manager, HHS: The Triage Center, at 25 Queen Street, was built in 2013, it became a model of rapid re-housing and diversion. Diversion is a form of homeless prevention. In order for folks to be re-housed through the shelter, they need to have lived in Worcester for 16 to 18 months and provide proof that they have lived in Worcester. In the first night of coming in, they won't be turned away. They don't turn anyone away who are actively using drugs or alcohol. After the intake and assessment have been made, they may be redirected where they should go. It is like the "front door" for the homeless population.

Edith Claros, PhD, Vice Chair: What documentation do you need to proof that you are homeless?

Katherine Calano, Homeless Projects Manager, HHS: A written letter from a third party organization, doctor, eviction notice, housing court records or evidence of incarceration.

Abigail Averbach: Do you have a sense of individuals who are panhandling? Is that a homeless population?

Katherine Calano, Homeless Projects Manager, HHS: For about 2 years now the City had a contract to do outreach specifically to panhandlers. Many of them weren't accessing social security benefits nor had income of their own. Some were housed, some not. Quality of Life goes out and introduces themselves and offer different resources, water or snack packs.

Jerry Gurwitz, MD: Do you have any advice on what we can do related to this issue?

Katherine Calano, Homeless Projects Manager, HHS: We need to look at medical respite, discharge planning, effective discharge practices, mental health, addiction and affordable housing needs. Also when someone goes into the hospital or goes to a doctor's visit are they being asked about their housing situation?

Matilde Castiel, MD, Commissioner of Health and Human Services: There are people that don't access the Triage Center. Those are people that don't want to be away from their husbands, pets or having to leave things behind. There were people that were kicked out of a shelter in the past that don't have a place to stay. We have to shelter everyone. We worked with the faith-based group that picks up the rest of the people that are not accessing the shelter especially in 20 degree or below weather.

Joanne Calista: Do we have data on homeless deaths both before the closing of the PIP Shelter in 2013 and after?

Katherine Calano, Homeless Projects Manager, HHS: I don't have that data. The closest thing we have to that is each year the National Homeless Council will hold a memorial for people that have died in the street or in the shelter. Anyone connected to any homeless outreach and advocacy program would have a list of those names.

Matilde Castiel, MD, Commissioner of Health and Human Services: Morbidity is very high because of complications of illnesses, pneumonia and diabetes. We've also had people with amputations because of the cold.

Joanne Calista: You had mentioned the continuum of care that goes throughout the region. Is funding for the medical respite considered under that and where are we with the process?

Katherine Calano, Homeless Projects Manager, HHS: The notice of funding availability came out on Friday for the continuum of care. They have a limited range of services that they are looking to fund on the federal level and it's looking at the "Housing First" piece. I think that medical respite and emergency response is seen on the end of shelter where the feds aren't looking to fund those kinds of programs. We went to Boston for the Healthcare for the Homeless and we talked to them about their funding structure for medical respite. They bill up to 4 times a day for something that resembles a clinic visit. We need to make sure that our local health insurance programs can be adapted to that kind of a model. We have experts in the state that are looking at medical respite.

Edith Claros, PhD, Vice Chair: You had mentioned that during the week of the "Housing Surge", a good number of individuals had left with apartment keys or a voucher. Is there any data stating how long they stay and if they are tracked if they leave?

Katherine Calano, Homeless Projects Manager, HHS: The continuum of care holds the entire system of homeless management information. If anyone has had any type of homeless service provider, they will be in the HMIS system. We have over 300 units for individuals of permanent supportive housing. Right now there are around 60 vacancies. They do track while people are in there, mental illness, treatment, type of services they are getting and the length of time. One thing that should be tracked is the amount of time it takes from referral to actual placement.

Review and act on discussion relative to Tobacco Permit – 927B Main St. Worcester:
Megan DeNubila, Public Health Prevention Specialist: Over the past 24 month period, the store has been cited for selling without a permit, sale to a minor, loose cigarettes and blunt wraps. The renewal permits for tobacco are January 1st of every year. We are pretty lenient with the application process; we usually give stores one to two months after the deadline. The application came in late. We had to do a cease and desist order for selling tobacco because he didn't have a permit.

Karyn Clark, Director of Public Health: We issue tobacco permits out of this office. We take state and local laws very seriously. We want to make sure that products don't end up in hands of minors. At this point because there have been multiple violations and you have had a 7 day suspension, we felt that it was import to bring this in front of the Board and understand what is happening at your

store. This is your opportunity to explain to us how this is going to cease and what you're going to do to change it.

Su Chen: First time selling to a minor. Another violation was due to an expired tobacco permit. Busy and forgot to renew it. The 3rd violation was because of a tobacco product that was banned in Worcester. Ever since the legal age law passed, my business dropped 50%.

Karyn Clark, Director of Public Health: We appreciate you coming in and we also know the struggles of owning a small business. We try to work with the community when it comes to retail and tobacco permits. We see ourselves as partners and try to gain compliance, that's our philosophy. Our job is to enforce state and local regulations and when we see an establishment have multiple violations in a 24 month enforcement period, we get very concerned.

David Fort, Chair: Thank you for coming in sir. We are here to work with the community. Explain to us what's going to be different going forward. What's going to change?

Su Chen: We are very concerned with selling to a minor. I do care about young kids trying to get cigarettes. Going forward we will ID everyone. I want to comply with the regulations.

Karyn Clark, Director of Public Health: Megan, what would be the next step in this process?

Megan DeNubila, Public Health Prevention Specialist: A suspension requires a 7 days' notice. The BOH would need to pick a date at least a week from today to start the implementation of a 30 day suspension.

Edith Claros, PhD, Vice Chair: What type of suspension would this be?

Megan DeNubila, Public Health Prevention Specialist: It would be to stop selling tobacco products and remove them from the shelves for 30 days. We would then go in and make sure that they are not selling tobacco products for that 30 day period.

Karyn Clark, Director of Public Health: The Board's options are; you can issue a 30 day suspension or suspend the suspension.

Megan DeNubila, Public Health Prevention Specialist: All of these violations happened in a 24 month period. One of the violations has dropped off in May 2017. You can either move forward with the 30 day suspension or you can hold off on the suspension unless he has another violation within the next 24 month period. If he were to violate he would automatically have the suspension.

David Fort, Chair: On this Board, we have worked a long time to protect the kids. I want you to get serious about protecting the kids.

Edith Claros, PhD, Vice Chair: One of the things that I see is that there are different types of violations. How are you planning to prevent this from happening again other than asking for an ID? What system do you plan on putting in place? Maybe put up a sign?

Su Chen: I can put up a sign.

Abigail Averbach: We want to see that you understand the rules and are doing the best that you possibly can. Are you confident that you understand all the details that are in the regulations? If not, you can go over the regulations with Megan or the inspector to make sure that you are complying with the regulations.

Joanne Calista: In addition to viewing all the regulations, perhaps go over them with your father because some of the regulations may not be something that he knows.

Karyn Clark, Director of Public Health: If there was a motion to suspend the suspension, we want him to read the regulations again and sign them. If there are questions, then we will be happy to go over it with him in the store and make sure he doesn't have illegal products.

David Fort, Chair: Let's take a motion to vote on this issue. All in favor to suspend the suspension, 5-yes 0-no.

Abigail Averbach: If there are any violations within the next 24 months, there will automatically be a 30 day suspension.

David Fort, Chair: We're here to work with the community. We have certain priorities when it comes to protecting the children. Thank you for coming. We appreciate your attendance and opinion.

Review and act on discussion relative to status of infant mortality in Worcester:
Cathy Violette, NP, Worcester Healthy Baby Collaborative, Vice Chair: Distributed infant mortality report submitted to City Council, prepared by Dr. Castiel. In the early 1990's, the Infant Mortality Task Force was formed and has met in multiple areas throughout the city. It is a group of volunteers from organizations with an interest in reducing infant mortality in Worcester. In the past 2 years, Worcester Infant Mortality Reduction Task Force, changed and realigned itself and became Worcester Healthy Baby Collaborative. Have a website, many activities and partnerships with DPH and March of Dimes. The "Nhyira Ba" project that came out of that helped to address awareness for the Ghanaian community who were having losses. We are pleased to say that it is changing. In 2015 there were 4 deaths in the city that were counted in the mortality rate. We've worked on a project with the CDC partnership and had Trevor Gagnet come to Worcester to work with us. He has been the Project Management Coordinator housed at WDPH. That function has proven to be important, that keeps us online and in a good working order for our quarterly meetings. We have had 4 summits for Infant Mortality Awareness. Last year we had it at City Hall; we set up 10 stations and surveyed the population to find out what initiatives they really wanted. Our focus has moved to the Latino population because their rates are changing. We spent last summer talking to many people at health fairs. We had a quilting project that brought community people together. We are doing a project called "The Baby Box". It is padded and able to serve as a safe-sleep surface, similar to a crib. It was originated in Finland. The Baby Box University has agreed to provide Worcester's delivering hospitals with 500 boxes as long as we can work with them to assure that the moms get the education. We did 10 boxes in a mini pilot project over the last year and were awarded the Remillard Grant to forward that project and give out the 500 boxes. We work with the clerkship students from UMASS, where we try to improve access to care. There is a Worcester initiative that we put forth for healthy baby healthy business. It teaches employers, through a free enrollment, how to keep their workers while pregnant, safe, healthy, attending appointments, and providing supportive environments in the work place.

David Fort, Chair: Thank you for your presentation. Can you please show us the Baby Box?

Michael Hirsh, MD, Medical Director: Inside the box are a soften pad, suction device, onesie, teething ring, pacifier and lots of information for the parent. This is appropriate for the first 4 months.

Abigail Averbach: Particularly deaths among the Hispanic women, what are the predominate causes of death? Is it primarily prematurity? You had mentioned preterm deliveries.

Cathy Violette, NP, Worcester Healthy Baby Collaborative, Vice Chair: Yes by at least 50% or more. Mostly these babies were born at 24 weeks.

Alexis Travis, Chief of Community Health: Worcester Healthy Baby Collaborative is looking into setting up a formal fetal infant mortality review process and that's evidence base way of reviewing infant deaths. We'll do some interviews with parents who have had an infant death as well as work with people like the DA's office and Child Protective Services to get that overall picture of what is happening. By educating the medical community we were able to reduce the number of infant deaths in the Ghanaian community and those have been sustained at a low level. We need to do the same process for the Latin community. This is what we will be discussing at the September 22nd summit.

Michael Hirsh, MD, Medical Director: We just left a meeting of the City Council Public Health Sub-committee and Sara Shields, Medical Director of Healthy Baby Collaborative, gave a presentation. One of the points that she has been pushing for a while is home visitation. Maybe with support from our Academic Health Collaborative, we could train college, medical and nursing students to supplant some of that nursing function. If we could get the home visitation added in, we would have a better chance of understanding what the obstacles to raising kids healthy.

Next Meeting
August 21, 2017

Topics for Next Meeting
Review and act on discussion relative to housing safety and security

Adjourn:
8:20PM