Working Collaboratively to Address Patients’ Social Needs

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New York, NY
Healthcare’s Reality

1 in 5 Americans receives healthcare via Medicaid, including 45M children

Many present with significant unmet basic resource needs — food, heat, electricity, housing, education

Data shows these patients disproportionately struggle with obesity, asthma, high blood pressure, depression, and diabetes
Patients’ lives outside the clinic drive vast majority of health outcomes

Unmet Social Needs: At What Cost?

$35 - $7,000 = cost range of comprehensive metabolic panel

Source: Variation in charges for 10 common blood tests in California hospitals: a cross-sectional analysis

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Unmet social needs impact health outcomes & utilization...

- Patients do not receive help paying gas/electric bills → 30% more likely to be hospitalized¹
- Children with food insecurity → 152% more likely to be in fair or poor health from childhood to adulthood²
- Difficulty paying rent → increased acute care utilization and emergency room visits³

...but there remains a disconnect in practice

4 in 5 physicians surveyed⁴ said:

- Patients’ social needs are as important to address as their medical conditions
- Unmet social needs are directly leading to worse health
- They are not confident in their capacity to address their patients’ social needs

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³ Kushel, Gupta, Gee and Haas. “Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans.” Journal of General Internal Medicine, 2006.
⁴ Study conducted by Harris Interactive on behalf of the Robert Wood Johnson Foundation in Fall 2011 among 1,000 physicians, of which 690 were primary care physicians and 310 were pediatricians.
We envision a healthcare system that addresses all patients’ basic resource needs as a standard part of quality care.

The Health Leads Vision
Our Clinical Partners

Plus, more than 200 provider organizations that have participated in other HL engagements
Our Direct Service Approach

Clinical Communication

Screening

Intake

Follow-up

Resource Referral & Plan

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Woodhull Hospital

- Located in Brooklyn, NY
- Safety net hospital serving a large Medicaid and uninsured population
- 47% of children in Bedford-Stuyvesant live below the Federal Poverty Line*
- 40% immigrant population hailing from over 170 countries
- Service area encompasses many neighborhoods identified as medically underserved and/or having a shortage of providers and also has a facility-specific designation for mental health provider shortage based on higher than average workload**

*Source: 2012 Report cccnewyork.org

**NYC Health and Hospitals Woodhull 2016 Community Health Needs Assessment
Health Leads at Woodhull Hospital

- Desk opened in 2010 in the Pediatric Practice and OB-GYN
- Since 2012, Health Leads desk at Woodhull has been exclusively in the Pediatric Practice – volume has more than tripled; resource connections have quadrupled

- Staffed by:
  - student Advocates
  - BSW Interns from NYU
  - Full Time Program Manager

- HL program works closely with the Social Work Department
  - Mutual Referrals
  - Can work cases concurrently
  - Communication on cases - closing the loop
Case Study: Working in Collaboration with Social Work

Patient E

- Referred to Health Leads by the Social Worker for assistance with SNAP application
- Had been denied in the past when applying on her own because of missing documents
- Was interested in divorcing her partner and was meeting with legal services at the hospital
- Applied for SNAP with Health Leads assistance and was approved for emergency benefits
- Returned to HL after a DV incident and was referred back to the Social Worker, who involved ACS in the case
- Patient E and two children were moved into a shelter
- HL continued to assist with baby supplies, clothing, and application for cash assistance
- Continual check ins and support from both HL Advocate and Social Worker
- Patient E received cash assistance, continued SNAP benefits, and found a job training program on her own
Top Presenting Needs at Woodhull Hospital Pediatric Clinic

1. Food
2. Commodities (baby supplies, clothing)
3. Child-related (child care, after school, summer camp)

Breakdown of Food Needs
- 70% SNAP
- 18% Food Pantries
- 6% WIC
Improving Food Security

2010-2012
- Referred to HRA office
- Language barrier and discrimination faced by many clients
- Clients didn’t follow through on going to the office or had negative experiences when they did and gave up

2012-2014
- Referred to St. John’s Bread and Life
- They quickly become overwhelmed with number of clients referred and clients have trouble keeping appointments
- Continue referring clients successfully for their food pantry and baby supplies

2014-2015
- Quality Improvement Project
- Referred to on site SNAP enroller
- Only on site one day/week
- Issues with documentation and keeping appointments
- Enroller left and there was no replacement lined up
Quality Improvement Project
January-March 2016

Key Hypothesis:
Collaborating with an internal community resource to address SNAP needs will decrease the number of clients who experience application delays and denials, fewer missed SNAP application appointments, which will, in the future, yield more successful resource connections.

Predicted Results:
- Less canceled/missed initial SNAP application appointments with SNAP Coordinator (Wende)
- Less rescheduled SNAP appointments because clients is informed of what documents to bring
- Fewer delayed applications
- Potentially more resource connections (and less disconnections for clients)
Quality Improvement Project
January-March 2016

Results:

- Opened more SNAP needs (FY16- 162 vs FY15- 115).
- Resolved more SNAP needs (FY16- 175 vs FY15- 97).
- However, there was no significant change in the percentage of success
  - FY16 = 27% (48)
  - FY15 = 29% (28)

Learnings:

- Clients have trouble keeping set appointments, even with reminders
- Clients had trouble gathering the necessary documentation
- Clients preferred receiving assistance at Woodhull and were more comfortable in this setting than going to an HRA office
- Need for us to provide more hand holding, training for our staff and direct application assistance
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2016
- Quality Improvement Project
- Trained Health Leads Advocates to submit applications and documents on site
- Joined NYC SNAP Task Force and received training from Food Bank NYC for direct mediation with HRA staff
- Clients still had trouble with documentation and completing interviews, although we had more options to resolve those issues
Quality Improvement Project

May - October 2016

Aim

Achieve improved successful resource connection rate for the Food need by honing efforts on key sub needs that influence to need success rate (SNAP).
Increase food success rate by 10% points by 10/31/2016

Implementation

- Train staff and Advocate workforce
- Participate in SNAP Task Force (partnership with Food Bank NYC, HRA and many CBOs.
- Mediation Model for difficult cases
- Streamline document submission
- Troubleshoot cases via HRA liaisons
Results

SNAP success rate for Woodhull was 50% in October 2016 vs. 27% in March 2016

Disconnection rate dropped from 48% in March 2016 to 33% in October 2016

45 Student Advocates and 5 HL staff participated in various SNAP trainings

Key Learnings

Troubleshooting cases and using the mediation model is labor intensive and time consuming but often resulted in positive outcomes for the clients

Staff training improved information provided to clients and their ability to access benefits in a timely manner
## Improving Food Security

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<tbody>
<tr>
<td>Referred to HRA office</td>
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<td>Quality Improvement Project</td>
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<td>All HL Advocates trained by Single Stop</td>
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<td>Program Managers trained on POS and given accounts to submit documents directly to HRA</td>
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<td>Clients don’t always follow through with their applications, but those who do see better results</td>
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Woodhull doubled our SNAP success rate from 25% to 50% and maintains a current cumulative success rate of 44%.

Increased success in patients accessing their benefits and maintaining benefits.

Improved relationship with clinical providers - built trust between clients, providers and our program.

Involvement in mediation model and task force reduces barriers for all New Yorkers, not just our clients.
More Opportunities = More Possibilities
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