Adding Shelter and Food to Medical Care

DAVID LEWELLEN

The patient completed the screening form. Was she short of food? Yes. Were her utilities in danger of being shut off? Yes. Was she worried that she would lose her house? Yes. She had filled it out while waiting for the doctor, and Pamela Smith received it before the patient left the clinic in London, Kentucky, a town of 7,000 in one of the poorest, sickest states in the country.

Smith, a community health worker for KentuckyOne Health, a ministry of Englewood, Colorado-based Catholic Health Initiatives, introduced herself. She explained that it was her job to help with patients' nonmedical needs, and she and the patient talked about the screening form.

The patient said that her boyfriend had been out of work for seven months, and they were on the verge of being evicted and losing their car. A job would solve a lot of their problems.

Did the boyfriend have a resume? No. Could Smith help with that? Yes, she could — and did. The man came in the next week, and Smith helped him put together a resume and cover letter and she printed out some copies. Three days later, he got a job in a local factory. A week after that, he was promoted to management.

"I got a thank-you card from them," Smith said, "and then they came in and hugged me and said I had changed their life."

Multiply that story, and the social impact becomes obvious. Maybe in a decade, community health workers will be commonplace, but for now, 13 of them are working in CHI clinics in a pilot program in Kentucky, Iowa and Colorado. Their job is to connect patients with resources for transportation, food, child care, housing and the myriad other needs that can affect health and well-being. Funding to implement the initiative, called Total Health Roadmap, comes from a $2.5 million Robert Wood Johnson Foundation grant, matched by $2.5 million from CHI's Mission and Ministry Fund.

Total Health Roadmap integrates community health workers into primary care. It is a logical outgrowth of CHI's focus on the total health of the community, looking at social and economic factors along with medical ones. As well as establishing community health workers to assist patients at the individual level, the system plans to develop more community collaborations at the institutional level.

ROOTED IN DIGNITY, SOCIAL JUSTICE

"We realized we were doing a lot of good work, but we hadn't tied it all together," said Elizabeth Evans, program director for Total Health Roadmap. Along with many other organizations, CHI is considering ways that a whole system might improve its patients' well-being.

"We're going back to the roots of our foundresses' focus on social justice and basic human


MILK
BUS
PASS

dignity," said Shannon Duval, president and chief development officer of the CHI Foundation. "We want to help people understand that basic human needs are every bit as important as blood pressure."

All along, medical staff have "understood patients have other needs that they haven't had the bandwidth to address," she said, but if community health workers can provide some of that bandwidth, patient satisfaction scores may increase, and patients and families will get what they really need to be healthy.

Smith and her co-worker Jessica Hoskins had both worked in administrative jobs for KentuckyOne in the past, but, Hoskins said, "I wanted to help families. Instead of checking people in and taking copayments, I wanted to do something bigger. I fell in love with the job description." Most of the workers hired by the grant started in fall 2017, and the positions are grant-funded for 30 months.

The job does not require a college degree; successful community health workers have abundant people skills and know how to navigate the system.

"You get a feel for what patients are dealing with, and whether they're shy or outspoken, you roll with it," Smith said. "You have to read their body language, how they hold themselves, how they speak."

Community health workers offer patients "a hand up, not a handout" and will help them act for themselves. The job description is relatively new; community health workers are not health care providers or social workers. Instead, "they are laypeople who had an interest in helping people," said David Swieskowski, MD, the president of Mercy Accountable Care Organization, part of Mercy Health Network in Iowa. Mercy Health Network is jointly operated by Trinity Health of Livonia, Michigan, and Catholic Health Initiatives of Englewood, Colorado.

Mercy Health Network, which is working to move its business model away from fee-for-service and toward outcomes, seemed like a natural place to test a more holistic approach to care.

"We've always believed that the social factors of health are bigger than the medical factors," Swieskowski said.

The vision is to integrate the community health worker role into outpatient clinics' care teams. Mercy Health Network has placed one community health worker in the urban setting of Des Moines and one in Centerville, a town of 5,000 in southeastern Iowa. At both locations, filling out the screening form for needs has been "built into our rooming procedure," Swieskowski said — after a patient is in the examining room, but before he or she sees the doctor, the nurse presents the form to be filled out and then passes it to the community health worker.

Community health workers offer patients "a hand up, not a handout" and will help them act for themselves.

A phrase that comes up often is "closing the loop" — helping a patient who is eligible for services to actually get those services. But it is up to each community health worker, and each patient, to know when a card with a phone number is sufficient, or when the worker needs to make the call on the patient's behalf. Some patients feel overwhelmed and defeated by the bureaucracy in their path. "We'll meet them at the place and let them do the talking," Smith said, "so that next time they'll know what to expect."

Many patients need multiple contacts, Swieskowski said, particularly "people who have difficulty navigating the system anyhow," for reasons that include education, finance, literacy and language barriers.

BUILDING NETWORK OF CONTACTS

Smith and Hoskins have been on the job since November 2017, and part of their responsibility is to build a network of sources, to know not only the resources available but also to know the people in the offices. They know the grants for child care, the programs for rides and the qualifications necessary to receive that help.

"We're building rapport with lots of different people," Smith said — in fact, one local pastor has given them the key to his church, trusting them to take supplies of food and clothing "in good faith that we're going to do right by them." Another church that has a stock of medical supplies was able to provide a shower chair to a patient who needed one, since his insurance didn't cover it.

In Centerville, Cheryl Barker is learning the resources available to her patients. She knows, for instance, that there are two food pantries in town, but that another one, several miles out of town, allows more frequent visits. For one patient who arrived in town homeless and on the run from an abusive relationship, Barker provided a map of the town and marked the food pantry and the housing office. Soon afterward, she heard that the person had rented a room and gotten a job.

In the Kentucky locations, "the clinic staff are relying on (the community health workers) and excited about them being there," said Neva Francis, vice president for healthy communities at KentuckyOne Health. Doctors, nurses and administrators can concentrate more fully on their jobs, she said, if one person is designated to help with other needs. Each of the three locations is handling procedures slightly differently, but "they're seeing what best suits the clinic and the community health worker."

Looking ahead, Francis hopes that the clinics can partner with local grocery stores, dollar stores and Walmarts to meet more needs. The pilot program also is collecting data on the work their employees are doing, with an eye both to services that might be provided and to making a business case for keeping the community health workers after the grant runs out.

In filling the positions, Francis was looking for "people who knew the community, who were assertive, compassionate, displayed our core values and were willing to go the extra mile to find something."

LOCAL EXPERIENCE

Hoskins and Smith are both from the area where they work and have faced tough times of their own. "I can say, 'I would have gone to this food pantry during the hard time in my life,'" Smith said. "We're not trying to get anything out of them, and we don't judge. We treat everyone like we'd treat our mom or dad. And we know a lot of the people who come through here."

In Iowa, Jamie Sills had spent five years working at a youth homeless shelter in a low-income area of Des Moines before becoming a community health worker at a Mercy Health Network clinic in the same neighborhood. She has actively sought out new resources "that we wouldn't have learned on our own, or that would have taken a lot longer to find. One of my favorite food pantries is 11 blocks from the nearest bus stop. But we found a church that has volunteers that will pick up food and deliver it to people's doors. That kind of thing is not on the internet."

Food is the biggest need in her neighborhood, followed by transportation. Although Des Moines has a bus system, it has gaps and not every stop is disability-friendly. Sills said that the city has more resources than a rural clinic, but the challenge may be matching patients to the right places.

Like Smith and Hoskins in Kentucky, Sills tries to customize her approach to the person in front of her. "They're the ones driving the bus," she said. "I listen to their needs, and we'll make a plan together. I don't say, 'This is what you're going to do,' because then you don't get as much effort."

If the patient can't afford medication, for instance, Sills will talk to the doctor to find out if there's a covered alternative — or argue with Medicaid or the insurance company. "Every guideline is different," she said, "and that's frustrating for me."

It might seem like an option, once a need is identified, for the local CHI hospital to swoop in with a new program to fix it, but time and budget are stern realities.

"I listen to their needs, and we'll make a plan together. I don't say, 'This is what you're going to do,' because then you don't get as much effort."

— JAMIE SILLS

"We can't do it all," Duval said, "but we can be a key convener in these regions" to bring organizations together to identify solutions. That can also mean advocating at the governmental level to solve problems, such as more funding for public transportation.

MAKING THEIR CASE

On a systemwide level, Duval said, the community health workers and their supervisors will be making the case to executives and boards that helping patients solve nonmedical problems is "not only

part of our mission and the right thing to do, but also something that is economically beneficial for our markets."

"If we don't find a solution, we need to figure out what to do on our own," Swieskowski said. For example, at Mercy Health Network's Centerville clinic, Barker keeps a supply of water and granola bars that she buys out of her own pocket. She hopes the system will soon pay for similar basic supplies as an instant supplement to food banks.

Swieskowski said that if the hospital can collect data documenting a problem, it can apply for a grant: "If addressing social needs reduces the overall cost of care, we can get funding for that."

Identifying data sets of patients with food insecurity might eventually be like identifying data sets of patients with high blood pressure, and looking for solutions and follow-ups. "Addressing social needs is something we've never looked at," Swieskowski said, but now they have an opportunity.

Over the grant's 30-month time period, backers hope to show that community health workers lead to better patient health — and that the positions may even pay for themselves. "Our mantra is Month 31," Duval said.

Hoskins hopes the program can become self-supporting. "We can help families do better, keep them from going to the emergency room or living on the street. I hope I'll be able to keep this job that I love."

DAVID LEWELLEN is a freelance writer in Glendale, Wisconsin, and editor of *Vision*, the newsletter of the National Association of Catholic Chaplains.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September - October 2018