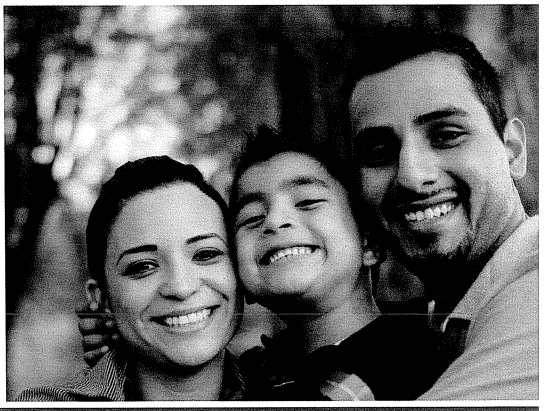
Medical Legal Partnership | Boston

RAISING THE BAR FOR HEALTH

Nutrition Support Programs in the Health Care Setting:

A Prescription for Hunger Prevention



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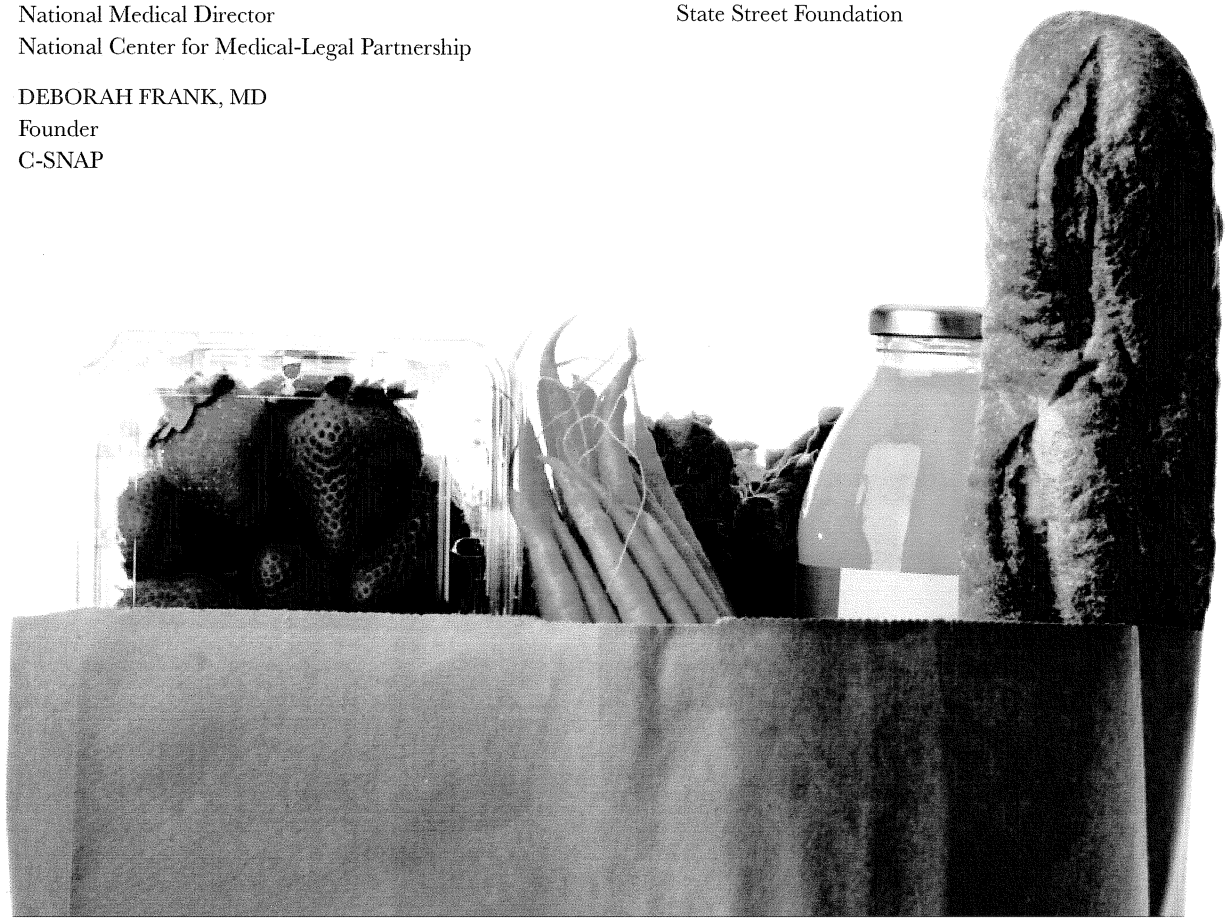


A National Epidemic

Presenting Symptoms

A CASE STUDY

Mrs. J is a single mom with three children, the oldest of whom has acute asthma. Often during the winter, her daughter's asthma gets so bad that Mrs. J has to miss work, and she sometimes worries about losing her job. Mrs. J uses all of her monthly income for rent, utilities and childcare. What little is left over goes to food. Mrs. J recently met with an advocate who recommended she apply for various public benefit programs. Each program, however, is located in a different office and each office is only open during her work hours. The offices are spread throughout town and Mrs. J relies solely on public transportation, which often is unreliable in her neighborhood.

The Diagnosis

REMOTE ACCESS IS NO ACCESS

Families across the country are facing the same impossible choice as Mrs. J. Increasingly, the economic climate in the United States is pushing low-income families (including those employed outside the home) to access government benefits to supplement their income – and yet these benefits are not structured in a way that supports meaningful access by individuals with limited income and full-time jobs, or time constraints related to medical care of chronic disease.

Many resources are available to families struggling to afford food, fuel and housing. Often, however, families are unaware such resources exist, or how to access them. Moreover, these resources tend to be geographically spread throughout different parts of hard-to-navigate cities, towns and rural areas – calling into question the practicality of these services for families who have neither the money to sustain the use of a car nor the time to use public transportation. This physical inaccessibility, coupled with the frequency with which families are required to apply for and renew these supports, render it nearly impossible to take advantage of these resources and still fulfill work and family responsibilities. Thus, many low-income families are left to make impossible choices: visit the pediatrician or the community advocate? The food stamp worker or the housing advocate? The Medicaid enrollment office or the fuel assistance agency? The grocery store or the parent-teacher conference?

The Treatment

CO-LOCATION IN THE HEALTH CARE SETTING

In order to help families meet their basic needs, organizations across the nation are experimenting with co-location – stationing the agencies that frequently serve low-income families in one place in order to facilitate a "one-stop shopping" approach to community resources. Many of these programs serve specific populations for whom co-location is particularly necessary – pregnant women, families with children, and individuals living with HIV/AIDS.[1] In Florida, for example, schools in every county participate in the Full Service Schools Program, which provides onsite nutritional, economic and job placement services, thereby integrating community resources into the school setting.[2]

Research around co-location spotlights the particular advantages of integrating social services within the health care setting,[3] an approach which allows for more comprehensive treatment of patients. Co-locating community resources in a health care setting enhances the impact of health care for vulnerable populations.[4] Individuals like Mrs. J are more likely to use their limited time and income to address a child's health needs than other issues, such as accessing affordable housing or maintaining employment.[5] Co-location in the health care setting removes barriers that too often create irresolvable dilemmas for caregivers trying to choose among basic needs: instead, one trip to the family's local health center provides access to many necessary services without additional transportation time or expense. Moreover, this approach permits clients like Mrs. J to access unfamiliar and sometimes intimidating government agencies in a setting with which they are already familiar. Finally, in addition to the benefit of easier physical access, the co-located agencies themselves are able to gain familiarity with the range of services available to their clients from healthcare institutions, as well as insight into the needs and challenges of the specific populations they serve.

[1] For example, social service providers in Nashville, TN have joined to provide integrated housing, transportation and other assistance to people living with HIV and AIDS in the clinical setting. See http://www.nashvillecares.org/about for more information. Also in Virginia the Manassas District Office of Child Support Enforcement created a multi-agency social service center where families can receive educational and job training, income support access, and other services. See http://www.acf.hhs.gov/programs/cse/pubs/2003/best_practices/va_collaboration_colocation.html for more information. [2] Florida Department of Health, www.doh.state.fl.us/Family/School/services/sh_services.html. [3] "Co-Location of Health and Social Services for Low-Income Families," Center for Social Services Research at University of California Berkeley School of Social Welfare, http://cssr.berkeley.edu/research_units/hrg/projects.html, 2008. [4] Such strategies carry the promise of improving the quality of life for families and ultimately reducing health care costs which can be linked to inadequate food, housing or heat. Bringing Children in from the Cold: Solutions for Boston's Hidden Homless. The Children's Sentinel Nutrition Assessment Program & Medical-Legal Partnership for Children: October 2008. [5] Employment Barriers Among Welfare Recipients and Applicants with Chronically Ill Children. American Journal of Public Health. 2002; 92 (9): 1453-1457. LA Smith, D Romero, PR Wood, NS Wampler, W Chavkin & PH Wise.

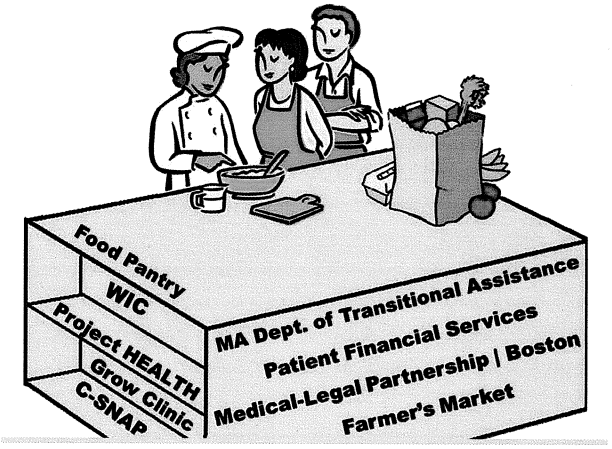
Boston Medical Center: A Hunger Prevention Laboratory

Boston Medical Center ("BMC"), the largest safety net hospital in New England, is uniquely situated to act as a service hub for low-income families. BMC's mission is to provide consistently excellent and accessible health services to all in need of care regardless of status and ability to pay. Approximately 70% of BMC patients are members of underserved populations, including low-income families, immigrants, elders, and people with disabilities.[6]

Perhaps in no single context is BMC's commitment to holistic medical care more evident than that of hunger prevention.

Perhaps in no single context is BMC's commitment to holistic medical care more evident than that of hunger prevention. BMC's Grow Clinic reflects the hospital's long-standing recognition of hunger as a serious health risk, particularly to children. A Pediatrics program, the Grow Clinic provides comprehensive specialty medical, nutritional and social services to children from the Boston area diagnosed with Failure to Thrive – a medical term used to describe a child who is not growing in weight and height according to health standards for their age. Using the national and international procedures to identify and triage malnutrition, the Grow Clinic identifies and treats BMC pediatric patients whose nutritional status parallels that of children in developing nations, where food scarcity is an acknowledged widespread health hazard.[7] Working alongside the Grow Clinic is the Children's Sentinel Nutrition Assessment Program (C-SNAP), a national non-partisan research organization which collects data from health care settings and studies the impact of public policies on the health and well-being of children.

In addition to this specialized clinical care and research, BMC has embraced a diverse set of innovative co-located services and partnerships that promote access to nutritious food, ranging from a hospital-based therapeutic Food Pantry and Demonstration Kitchen, to an on-site WIC office and (as will be discussed at greater length later in this report) a state SNAP* "outstation." Additionally, BMC hosts a seasonal farmers market and partners with Project HEALTH, an undergraduate student service agency that connects pediatric patient-families with community resources. The hospital is committed to facilitating multiple strategies to help families put food on their tables.[8]



THE DANGERS OF FOOD INSECURITY: MALNUTRITION & HEALTH

Absent specialized intervention, malnutrition, including growth delay and iron deficiency:[9]

- Leads to developmental delays and cognitive, motor and/or behavioral disorders
- Compromises immune system's ability to protect against illness
- Increases likelihood of hospitalization
- Decreases likelihood of optimal social development and academic performance

SPOTLIGHT ON MEDICAL-LEGAL PARTNERSHIP | BOSTON

Promoting Food Security through Preventive Law

The Medical-Legal Partnership | Boston (MLP | Boston) allies medical providers with lawyers to ensure that families' basic needs – for housing, food, education, health care and family stability – are met. By combining the strengths of law and medicine, MLP | Boston aims to improve the health and well-being of vulnerable families by addressing the social determinants of health. Chief among such social determinants is household food security. MLP | Boston trains frontline health care workers on the connections between poverty, law and health, and on how they can best screen for barriers to basic needs access. Among other advocacy activities, MLP | Boston operates a weekly Energy Clinic during which legal staff and volunteers meet with patients to assist them in overcoming legal barriers to accessing food and fuel supports for which they are eligible. Legal staff also work closely with the various programs at BMC dedicated to hunger prevention in an attempt to streamline services and maximize their impact for patient-families.

***Effective October 1, 2008, the name of the Food Stamps Program was changed to the Supplemental Nutrition Assistance Program, or "SNAP."**

[6] Boston Medical Center. 2008 Fact Sheet. http://www.bmc.org/about/facts08.pdf [7] World Health Organization, Nutrition and Health Development- Action Framework, 2009 http://www.who.int/nutrition/action_framework_NHD/en/index.html [8] BMC's Department of Pediatrics also is host to the Nutrition and Fitness for Life (NFL) program, an innovative clinical and community-centered obesity prevention and treatment program that understands the complex connections between hunger and overweight [9] Boston Medical Center- Grow Clinic. Boston, MA. http://www.bmc.org/pediatrics/services/Specialty/Development/GrowClinic/children.html

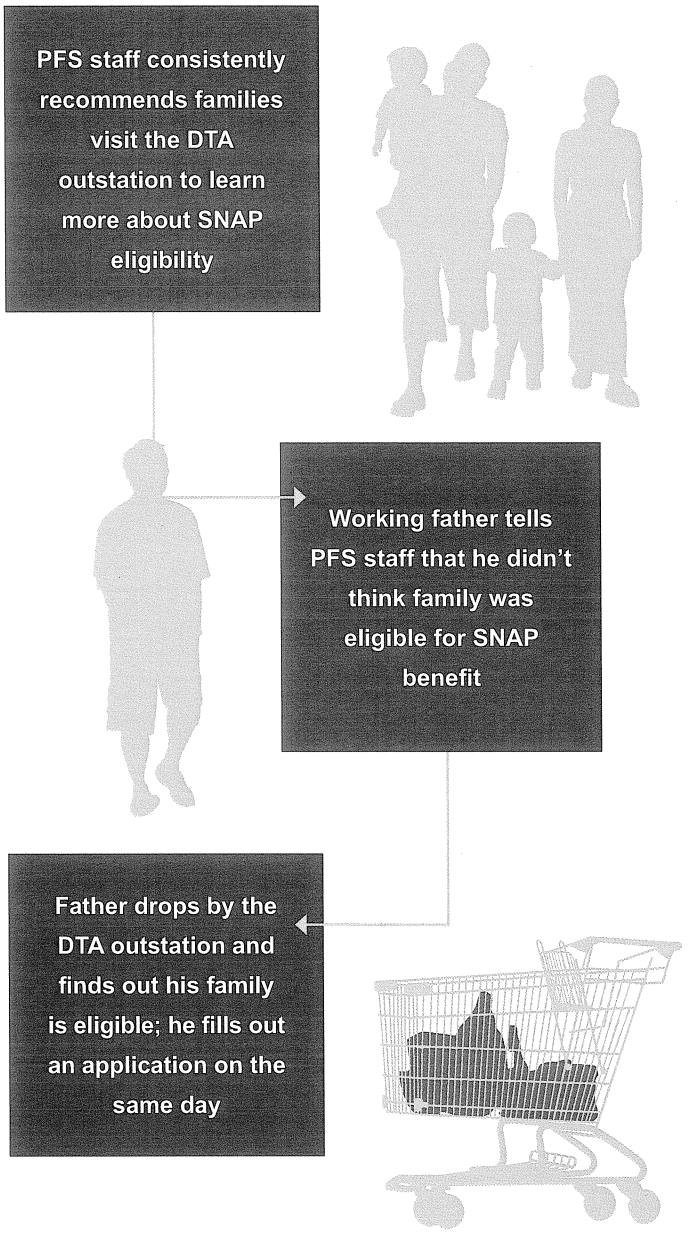
Spotlight on Government Partnerships: The First SNAP[10] "Outstation" at BMC

Historically, Massachusetts's SNAP participation rate among eligible persons has been extraordinarily low. In 2003, according to the U.S. Department of Agriculture's (USDA) Food and Nutrition Service, the state's participation rate was 41% - ranking Massachusetts 49th out of 51 nationwide. Over the next several years, the administering state agency, the Department of Transitional Assistance (DTA), undertook extensive outreach efforts that promoted program recognition and online program access in low-income communities. By 2006, SNAP participation rates in Massachusetts had significantly increased, jumping twenty percent in only three years. Despite this impressive short-term increase, however, Massachusetts remained in the bottom quarter of SNAP participation among all states, particularly with respect to the "working poor" as defined by USDA.

In December 2007, in response to growing concerns about low SNAP participation rates throughout the state and in order to maintain momentum around its community outreach efforts, the DTA implemented an innovative outreach program that would site SNAP workers at "outstations" in health care settings across the state. BMC was selected as one of the pilot sites, and MLP | Boston helped to coordinate the agency's efforts at BMC. In January 2008, the first on-site SNAP outreach worker arrived in BMC's Pediatrics wing. The worker spent one day a week at BMC's Breastfeeding Center screening patients for SNAP eligibility and completing applications on behalf of eligible patients. In addition, the worker received training on the many complementary nutrition and energy-related resources available at the hospital (see panel 3).

To increase the visibility of the DTA outstation and to ensure maximum access for BMC's patient-families, the SNAP outstation was relocated in October 2008 to BMC's Patient Financial Services (PFS) office. PFS assists uninsured or underinsured patients in obtaining medical coverage. Many of the 1,200 - 2,000 patients they see each month are eligible for MassHealth (Medicaid) and are therefore also eligible for SNAP benefits. This overlap in eligibility means that patients can move directly from a meeting with a PFS staff member to the DTA outstation without any preparation or appointment. Of particular utility is the fact that the paperwork needed to complete a MassHealth application is similar to that needed for a SNAP application. By co-locating the DTA outstation in the PFS office, BMC ensures the maximum level of access for its low-income families.[11]

CO-LOCATION IN OPERATION: CONNECTING PATIENTS TO THE RIGHT RESOURCES



[10] Effective October 1, 2008, the name of the Food Stamps Program was changed to the Supplemental Nutrition Assistance Program, or "SNAP."

[11] The publication of this report comes one year into the BMC-DTA partnership. Year one has provided insight into the practices that best support the creation of such a partnership; we anticipate that year two will focus largely on specific SNAP issues and evaluation of the outstation's effectiveness.

Best Practices: Spotlight on Government Partnerships

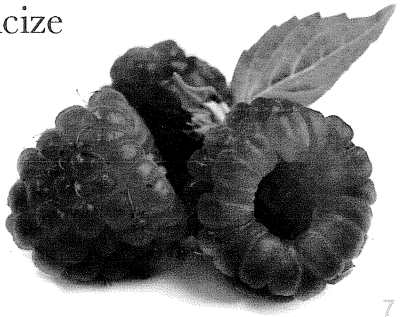
Integrating hunger prevention services into the health care setting promotes the health and well-being of low-income families and fosters an environment in which holistic care can be actively practiced. A co-location partnership with your local SNAP agency is especially beneficial to patient health and can be cultivated in your community as well. In order to support such efforts, we have identified ten key best practices that helped to promote a successful partnership between BMC and the Massachusetts Department of Transitional Assistance.

HEATING AND **EATING:** Another Co-Location Opportunity?

Federal research shows that low-income families often compensate for rising home energy costs by decreasing the amount of money they spend on food.[13] As a result, many low-income families are forced to choose between two basic life needs – deciding whether to "heat or eat." To help alleviate this burden, families may access the Low Income Home Energy Assistance Program (LIHEAP). LIHEAP is a federal grant program administered by the Department of Health and Human Services that provides utility payment assistance to low-income households through state and local agencies.[14] Consider integrating a LIHEAP agency into your health care setting to further meet your organization's hunger prevention goals.

[12] Effective October 1, 2008, the name of the Food Stamps Program was changed to the Supplemental Nutrition Assistance Program, or "SNAP."
[13] Bhattacharya, Jayanta, Thomas Deleeiture, Steven Haider, and Janet Currie. Heat or Eat? Cold Weather Shocks and Nutrition in Poor American Families. Joint Center for Roverty Research and the Institute
[14] The Campaign for Home Energy Assistance, http://www.liheap.org/

- Get to know the people who administer SNAP in your state/community, and help them get to know you, your patients, and your health care setting
- Select administrative personnel on each side of the partnership who can coordinate the co-location initiative
- Locate a private workspace with adequate technology support
- Take steps to create an informed clinical community (such as delivering trainings), so that clinicians will screen patient-families for hunger-related needs and refer them to co-located services
- Identify key stakeholders within the health care institution to work with the "outstationed" government workers on ascertaining patient needs and challenges
- Involve your health care institution's Patient Financial Services department in any co-location initiative from the outset of the project
- Help any "outstationed" government workers feel that they are part of the health care team by introducing them to key medical personnel and involving them in community events
- Establish an evaluation and/or data-tracking process to determine the effectiveness of your partnership
- Evaluate your institution's existing services in order to determine potential for further integration and maximization of resources
- Create a broad and ongoing awareness campaign to publicize the available resource to clinicians and patients



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