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Reading Hospital
TOWER HEALTH
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Case study

Impacting SDOH through cross-sector collaboration

By mobilizing its community to address food insecurity, Reading Hospital reduced healthcare utilization rates by 30%

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This is a follow-up to a case study published in 2020, available here.

In 2017, Reading Hospital in West Reading, Pennsylvania, was awarded a five-year, $4.5-million grant from the Centers for Medicare & Medicaid Services (CMS) to implement the Accountable Health Communities (AHC) model. The model tests whether systematically identifying and addressing health-related social needs can reduce healthcare costs and utilization.

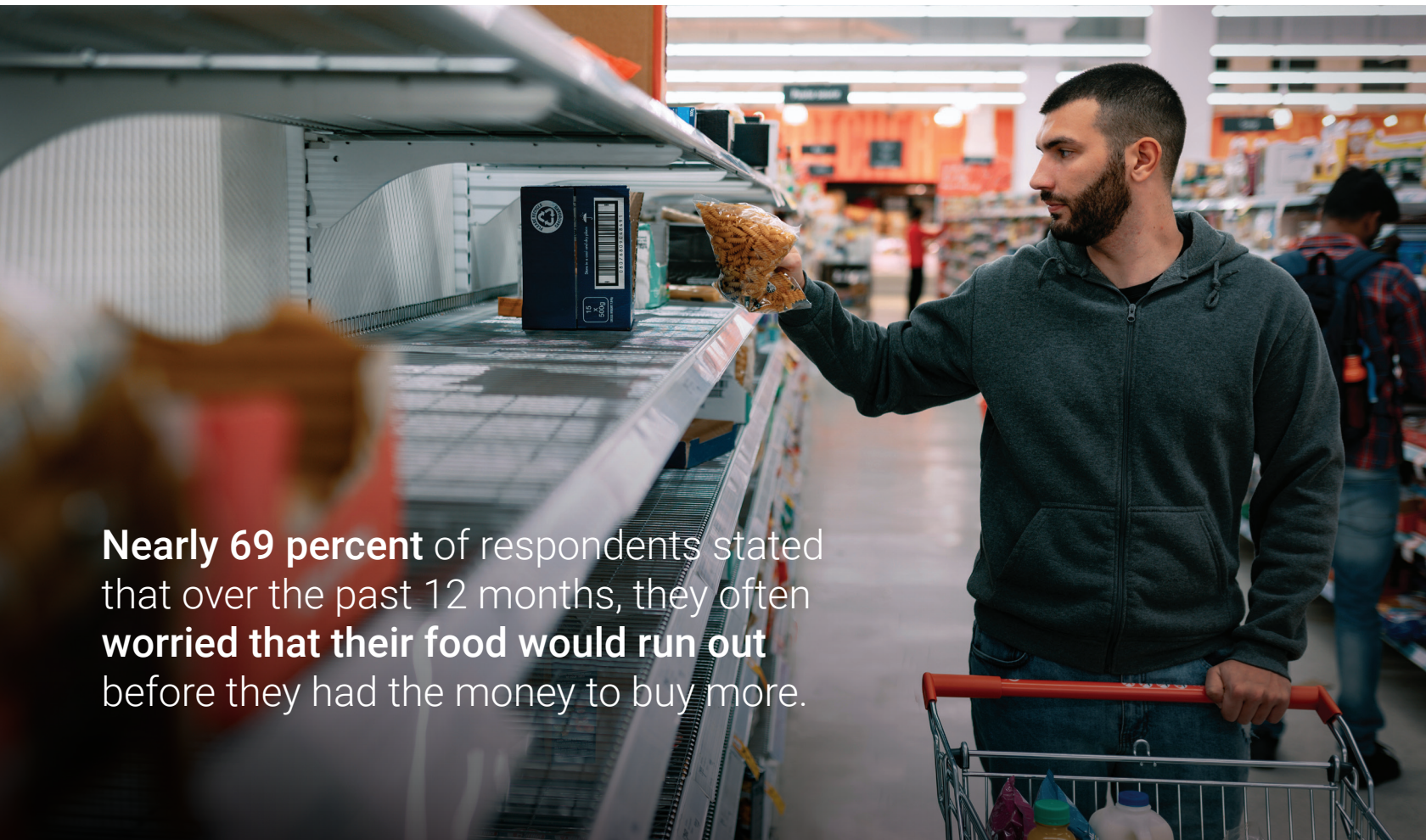
As part of the AHC model, Reading Hospital conducted a gap analysis of Berks County (PA), the area served by the hospital. That analysis showed a food-insecure population that included low-income people, households with children, immigrants, minorities, people with disabilities, and those living in food desert areas.

In the city of Reading, approximately 36 percent of households with people 65 years and over receive SNAP (Supplemental Nutrition Assistance Program) benefits, formerly known as "food stamps." In Berks County, about 10 percent of residents (nearly 43,000 people) are considered food-insecure.

Focus-group research led by a consortium of local organizations (described later in this case study) further quantified the problem of food access in the local community:

- Nearly 69 percent of respondents stated that over the past 12 months, they often worried that their food would run out before they had the money to buy more.
- Over 56 percent of respondents stated that often in the last 12 months, the food purchased did not last, and they did not have enough money to buy more.

The consortium came up with a specific aim: to enhance food access for vulnerable populations in Berks County by April 2022.



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Bringing community partners together to achieve a shared goal

Under the AHC model, the hospital was tasked with aligning clinical and community partners to optimize community capacity to address health-related social needs.

The hospital brought together a consortium of clinical and community-based organizations serving the Berks County area. Members of the consortium included:

- A federally qualified health center (FQHC)
- A managed care organization (MCO)
- The Pennsylvania department of human services — Office of Medical Assistance Programs
- Clinical staff physicians
- Food banks and food pantries
- Non-profit community-based organizations (CBOs)

Many organizations already invested in similar work were willing to come to the table immediately.

"We were already looking for ways to move the needle on food access, food insecurity, and connecting and educating residents on the resources available," said Kristin Gehris, Community Impact Director at United Way of Berks County, an early member of the consortium.

Other organizations were also eager to join. "From the day Desha (Dickson) approached me, I was absolutely on board," said LuAnn Oatman, President at Berks Encore (Ms. Dickson is the Vice President of Diversity, Equity, Inclusion and Community Wellness at Tower Health). "As a community-based organization, we are thankful Reading Hospital recognizes the value we bring. For example, we deliver Meals On Wheels. This gives us access into the homes of seniors all over the county who know and trust us."

The consortium, named the Community Connection Project (CCP), then met to discuss what could be done to improve health and well-being through addressing SDoH in the Reading area. "We focused on the gaps in community capacity to address SDoH needs that we thought we could close in the next couple of years," said Tanieka Mason, Reading Hospital's Director of Health Equity.

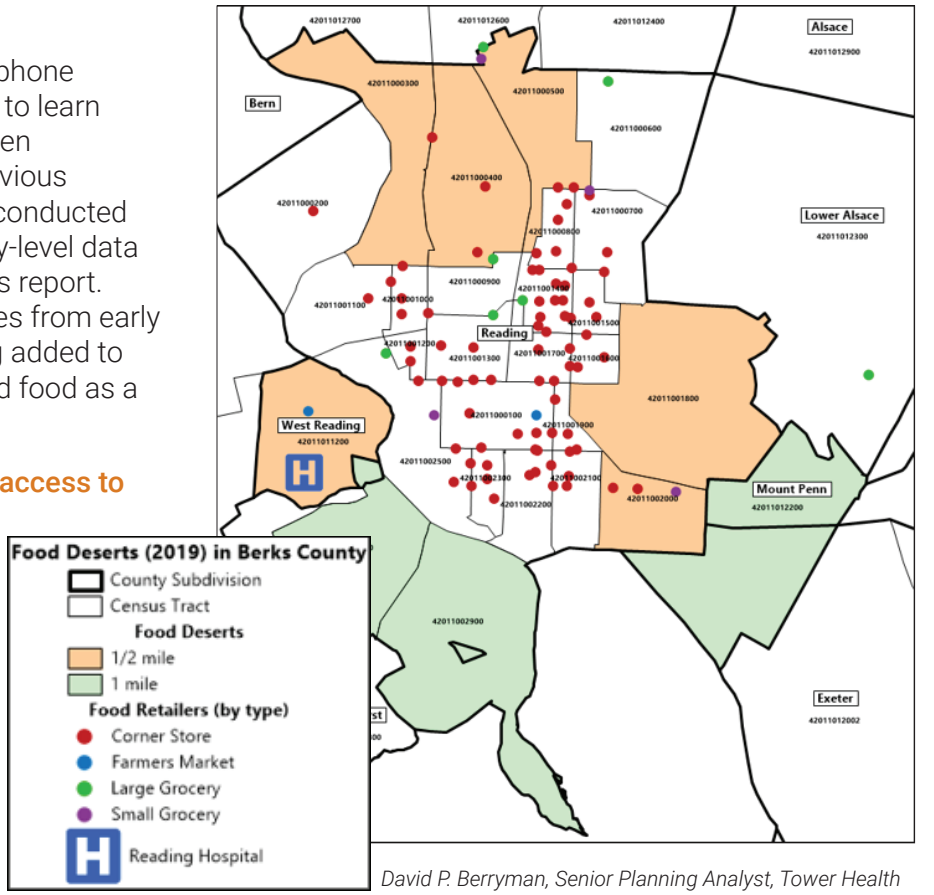
Step 1:

Researching food insecurity and community resources

Food insecurity can lead to poor health outcomes, such as chronic disease and obesity in children and adults. "The concept of social determinants of health (SDoH) is very important to overall wellness," said Jen Bauman, Outreach Manager at Berks Community Health Center, a nonprofit healthcare provider in the region that shares many patients with Reading Hospital. "We have a lot of people that don't take their medication because they need money for food, housing, or childcare."

The CCP launched focus groups and telephone surveys with members of the community to learn more about the challenges they faced when navigating health and social services. Previous Community Health Needs Assessments conducted by the hospital and secondary community-level data sets were incorporated into a gap analysis report. Patient screenings and patient case stories from early screening, referral, and navigation piloting added to the picture. All this data clearly highlighted food as a top need and led to several conclusions:

- **Food deserts in the county hindered access to nutritious food.** Neighborhoods like the Oakbrook Homes, a public housing community managed by Reading Housing Authority less than two blocks from the hospital, lacked full-service supermarkets. Residents relied on corner stores or convenience stores to buy food, which meant less variety, fewer fresh foods, and more expensive items. Many residents were receiving SNAP benefits but there were few stores accepting SNAP in the area.
- **The logistics of accessing food were complicated.** Dozens of food pantries operated across Berks County as distribution points for the Helping Harvest Fresh Food Bank. However, they were under-resourced and needed help providing more flexible hours and easier access to food. "We learned that people didn't know when or where to go for food since food pantry distribution times were not readily available to the public," said Ms. Mason. "It was word of mouth. You had to know the right people to get food."
- **Food options were redundant or not culturally relevant.** "If I go to the food pantry and they don't have the foods I normally cook with, I'm going to be inclined to not take it," said Rick Olmos, COO of Centro Hispano, a non-profit serving the large Hispanic population in Berks County. "And even if I take it, I don't know what to do with it, and it ends up going bad and I throw it out."



David P. Berryman, Senior Planning Analyst, Tower Health

Step 2:

Helping to improve food access

To tackle gaps in the community and address food access, the CCP submitted a proposal to Leadership Berks, leadership development program of United Way Berks County. A team of individuals from Leadership Berks took the lead on several tactics needed to improve food access. They met with several food pantries in the area to uncover ways to increase food access and remove barriers. The team also facilitated focus groups with food pantry consumers to better understand how food access impacts their needs and to identify potential improvements that would alleviate their burden.

Critical needs such as food pantry operation resources and storage space were identified and shared with the CCP. Food pantry operators needed help with operating a successful pantry distribution, recruiting and retaining volunteers, obtaining more storage space, and improving communication so that residents knew when and where food was available. Food pantry consumers needed to know when and where to go for food and wanted to feel respected and valued.

"There is now more reliable, consistent, easier access to food," said Mr. Olmos. "And that is making a huge difference."

The impact of COVID

Just as the work of the consortium was gaining momentum, COVID-19 hit. "The week before the schools closed in March of 2020, we distributed 140,000 pounds of food, which was our normal distribution," said Jay Worrall, President of Helping Harvest food bank. "The very next week, we distributed 340,000 pounds of food. I think the same impetus that drove the rest of us to clear our local store shelves of chicken and toilet paper, drove low-income clients to food pantries."

Mr. Worrall believes the media attention did two things. "First, it removed some of the stigma associated with getting food from a food pantry. And secondly, the media did a good job of letting people know where food was available.

"Our volume of calls rose substantially right away. And information about how to access charitable food became more public," said Mr. Worrall. Volume has remained high in the years since the pandemic began, as many area families continue to struggle economically. "We are seeing our volume approach its peak — and that's a good thing. Growing knowledge of the food network is really paying dividends for the families that we serve."

The positive results of the closed-loop referral network

The CCP also created a cross-sector care network to share referrals and work together to address unmet social needs in the community. Using WellSky Social Care Coordination as the technology platform, members of the consortium were able to send and receive referrals electronically, assess the needs of referred individuals, and then track the status and completion of the referral, closing the referral loop.

This closed-loop referral system created a level of accountability and visibility that could not have been achieved if referrals were made by traditional emails or phone calls. "I like using WellSky because it helps us communicate better with other organizations," said Esmeralda Castaneda, Health Navigator at Berks Community Health Center. "When I send a referral to Helping Harvest, they can reply in the system and record what is going on with the patient and if the referral was fulfilled, so that we can update our records."

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Step 3:

Achieving high service delivery rates

"I'm very happy with the WellSky system," said Melissa Beltran Del Rio, SNAP and Outreach Coordinator at Helping Harvest food bank. "Our numbers are increasing tremendously. We used to get a few referrals a week, now we often get 10 per day. So it's a huge benefit to have a system that lets me quickly screen the patients and see exactly what they need and what other resources we can offer."

Referrals came mainly from Reading Hospital; however, other CBOs in the network created referrals as well. For example, New Journey Community Outreach Center sends referrals for Spanish-speaking clients to Centro Hispano for assistance. The CCP also trained a team of four Community Health Workers and 15 college interns per year to identify patients with unmet social needs and provide direct referrals to over 25 CBOs in the WellSky Social Care Coordination referral network.

Between September 2018 and April 2022, the CCP team screened 51,327 patients, 36.8 percent of whom were determined to be high-risk. The team then looked at a smaller sample of patients to determine the effectiveness of referrals made in the WellSky platform. Of 1,618 patients screened between June 2018 and February 2020 who were determined to be food-insecure:

59% of food referrals made in the system during the study were successfully completed. Most of the other referrals were in review or in progress. Less than 15% were canceled or unfulfilled.

64% of the sample patients received outreach from a community health worker (CHW). These 1,032 patients formed a cohort for further analysis.

74% of these cohort patients had their food needs resolved within the one-year navigation period.

Data from the closed-loop referral platform **empowered community health workers to serve patients more effectively.**

"The WellSky closed-loop referral platform makes it easier for CBOs to help the community by connecting with various partners in a way that is easy and efficient," said Juliet Simplicio, SDOH Program Coordinator at Reading Hospital. "Prior to this platform, sending emails and/or waiting for responses via phone was not effective or realistic."

Empowering CHWs with data allowed these vital members of the care continuum to serve more effectively.

"The Community Health Worker position is so important for patients because we have the ability to provide information where and when it is needed the most," said Nereida Salvador Abreu, Certified Community Health Worker at Reading. "We help reduce health disparities in underserved communities: we create connections between vulnerable populations and healthcare providers; and we navigate patients through social service systems."

Demographic profile

Of the patients in the cohort who received outreach from a CHW:

- Most were female and Hispanic;
- Most had a high school diploma or higher education;
- Just over half lived in households of three or more people;
- About 37 percent of patients had housing and transportation needs, in addition to food needs;
- Around 26 percent of patients were on the Reading Hospital Diabetes Registry.

Findings: Addressing SDoH can improve community wellness

Among the patients on the Diabetes Registry, A1C rates decreased by an average of 2.2 percent. Before the study, data for the patients in the cohort showed historically high emergency department and inpatient hospital utilization and generally lower utilization of primary and outpatient care. This data validated the efforts to identify and engage high-risk and vulnerable patients burdened by SDoH needs. The study data also demonstrated significant reductions in healthcare utilization and costs among cohort patients, especially those with resolved needs in the two years after their navigation case opened with a CHW.

When looking closely at the 747 patients in the cohort with resolved food needs, the data showed that:

- **32% reduced** — Emergency department visits
- **32% reduced** — Hospital admissions
- **30% reduced** — Re-admissions
- **31% reduced** — Hospital costs

Summary

When communities struggle to improve the SDoH of a population, a strong network of clinical and community partners can join together to make improvements and create change. Collaboration on a shared aim, such as food access in this case, has provided much needed support to community-based organizations like food pantries, who may need help from local hospitals and other well-funded stakeholders to overcome logistical issues and fulfill their mission in the community.

"So many organizations came to the table immediately to serve our neighbors in need," said Desha Dickson, Vice President of Diversity, Equity, Inclusion and Community Wellness at Tower Health. "This consortium of organizations deserves the credit for what we have achieved."

Results of the study suggest that addressing SDoHs like food insecurity can lead to many improved measures of health and well-being. These results are a testament to the value of collaborative work between hospitals and CBOs that can justify, sustain, and scale similar programs.

A closed-loop referral platform like WellSky Social Care Coordination equips healthcare providers to more easily refer a patient experiencing SDOH needs such as food insecurity to the help needed. The platform ensures more referrals are fulfilled, enables greater collaboration among community providers, and delivers more detailed outcomes data that leads to better decision making.

Over 60% of our health is impacted by social determinants of health (SDoH) like access to food, jobs, childcare, and housing. **WellSky® Social Care Coordination** (formerly Healthify) empowers health plans, health systems, and state and local governments to identify social needs and coordinate care through an integrated network of more than 20,000 community- and home-based SDoH providers. For more information, visit wellsky.com.

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Reading Hospital is the flagship, Magnet Recognized, acute care hospital of Tower Health. Located in West Reading, Pa., Reading Hospital is a 714-bed hospital that is home to many top-tier specialty care centers, including: Reading HealthPlex, McGlinn Cancer Institute, Miller Regional Heart Center, Reading Hospital Rehabilitation at Wyomissing, an emergency department that includes a Level I Trauma Center and the Beginnings Maternity Center, which houses the region's only Level III Neonatal Intensive Care Unit (NICU). With more than 1,000 physicians, specialists, and advanced practice providers across 49 locations, Reading Hospital has been recognized for its quality outcomes and clinical expertise across services lines. It is listed as one of America's 100 Best Hospitals for four consecutive years and received a 5-Star Rating from CMS two years in a row.