CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for Multi-Level Approach to Addressing Housing Insecurity and Unmet Social Needs

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ABOUT THE PROGRAM

Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill.

ABOUT THE TOOLKIT

This toolkit can be used as a roadmap for healthcare institutions that are seeking guidance on how to integrate addressing housing insecurity and related unmet social needs for the patient populations they serve. We use a multi-level approach, which includes clinical, educational and community-based activities. For more information contact: hello@omolaramd.com

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Toolkit for Multi-Level Approach to Addressing Housing Insecurity and Unmet Social Needs

Housing Insecurity (HI) has been defined as inextricably linked to poor physical and mental health. Moreover, low-income minority families are disproportionately affected, partly due to housing discrimination and racial segregation. HI is prevalent in many communities served by Northwell Health in New York City, the 14th largest clinically-integrated health care system in the US and serves >8 million people, with the majority residing in Queens and Nassau. Queens is the most diverse county in the country, with 46% immigrants and no racial/ethnic majority. Half of the population are limited English proficient and 22% are uninsured. In Nassau, county-level health data completely masks major health disparities of severely underserved communities. Two of our most vulnerable communities in the Northwell Health catchment area are Jamaica, Queens and Hempstead, Nassau. These "vulnerable communities" have higher rates of asthma, type 2 diabetes hospitalizations, and late prenatal care, with a 20% uninsured rate.

Community needs assessments included forums with community residents who repeatedly reported lack of smoke-free, stable and affordable housing, difficulties in managing chronic illnesses and frequent exacerbations of respiratory and cardiovascular illness due to substandard housing. Health providers reported high levels of housing instability, a major obstacle to care coordination, leading to high no-show rates. Housing vouchers were inadequate to cover costs. Local emergency housing programs have waitlists and inadequate numbers of housing units.

Using a collaborative approach to tackle unmet social needs

Through a collaboration between the 3rd largest health system in NY, Northwell Health, and local community-based organizations (CBOs), we propose a multi-level approach (patient, community, health workforce) to address the wicked problem of HI in two communities in Queens and Nassau counties with major health disparities.

At the patient level, we will expand SDH screening across 4 clinical practices that serve our communities, provide resources and follow-up for patients with adverse SDH. Those with HI, and eligible for the Northwell Medicaid Health Home (MHH), a care coordination program for at-risk patients with chronic conditions, will also receive "SHELTER services" (home safety assessment/education, financial counseling, housing repair and legal aid) provided by CBO partners. At the community-level, community campaigns will be accomplished through creation of community "Collaboratives", with local CBOs, health centers, legal aid agencies, housing authorities and community residents. Lastly, in order to strengthen the health workforce, we will employ a skill-based curriculum focused on care of vulnerable populations (VPs), to improve SDH knowledge, referral and resource navigation.

In our communities, **Housing Insecurity** has led to a trifecta of **poor access, low use of preventive care and suboptimal chronic disease management,** resulting in poor health.

"Poor housing is **always associated with high rates of morbidity and mortality**, yet housing generally is not high on the list of societal needs and governmental priorities."

– Robert E. Novick,

World Health Organization

Planning

With the adoption of the Affordable Care Act, Northwell Health like many other health systems around the nation, experienced increase patient volume of individuals and families in their facilities, who had previously had little to no access to healthcare due to lack of insurance. A significant proportion of this population included low and middle-income individuals who were also experiencing unmet social needs, including financial strain, food insecurity and housing insecurity. In order to address these needs, the largest pediatric practice in Northwell Health embarked on an initiative to integrate screening and referral for social determinants of health (SDH), which are societal conditions in which people are born, grow, live, work and age and are responsible for at least 50% of a population's health.[1,2] In less than a year of implementation, it became apparent that of all the SDH that the program was aiming to address, housing insecurity (HI) was the most challenging.

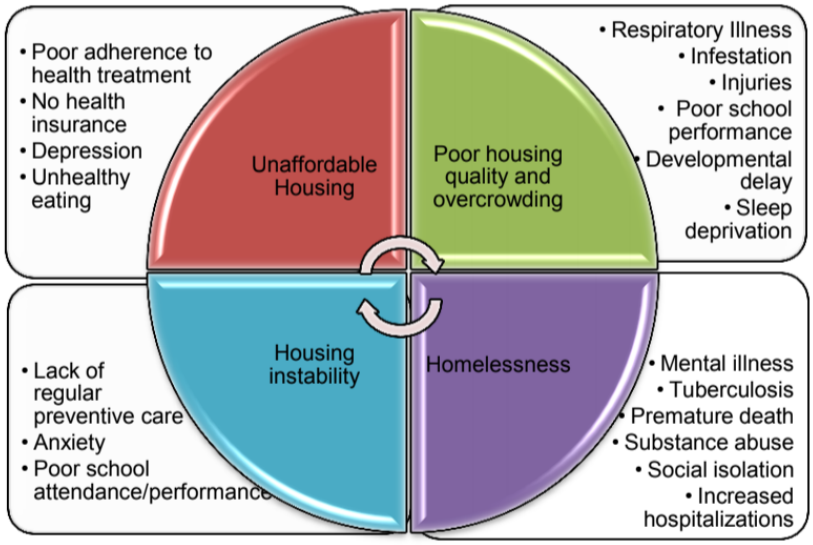
HOUSING INSECURITY

- High housing costs in proportion to income (>30%)
- Poor quality
- Unstable housing
- Overcrowding
- Homelessness

This was particularly distressing because HI is inextricably linked to poor physical and mental health.[3] Moreover, low-income minority families are disproportionately affected, partly due to housing discrimination and racial segregation.[4] This wicked problem of HI, while prevalent in many US communities, would require a unique approach given the size and sociodemographic makeup of the population served by Northwell Health. Northwell is the 14th largest clinically-integrated health care system in the US and serves >8 million people, with the majority residing in Queens and Nassau. Queens is the most diverse county in the country, with 46% immigrants and no racial/ethnic majority. Half of the population are limited English proficient and 22% are uninsured - higher than NYC (18%).[2] Almost 75% of emergency room visits in Queens are avoidable. In Nassau, county-level health data completely masks major health disparities of severely underserved communities and almost 66% of our Nassau Medicaid patients are Hispanic or Black, with 20% uninsured.[5]

These communities are particularly vulnerable to comorbidities including higher rates of asthma, type 2 diabetes hospitalizations, and late prenatal care. Community needs assessments in 2016 revealed frequent reports from residents repeatedly reported lack of smoke-free, stable and affordable housing, difficulties in managing chronic illnesses and frequent exacerbations of respiratory and cardiovascular illness due to substandard housing. Health providers reported high levels of housing instability, a major obstacle to care coordination, leading to high no-show rates. Housing vouchers were inadequate to cover costs. Current local emergency housing programs have waitlists and inadequate numbers of housing units. In our communities, HI has led to a trifecta of poor access, low use of preventive care and suboptimal chronic disease management, resulting in poor health.

Figure 1: HI domains - health and social consequences



Given this information, our team believed that a major way to strengthen the health of these communities would be addressing the wicked problem of HI. In order to do this successfully, we were aware that a multi-level approach would be key- clinical, education and community. First, we decided addressing HI in the clinical setting would be paramount and would include leveraging the existing social determinants of health (SDH) screening program to provide a robust package of services for patients facing housing insecurity (HI) and related needs; those services include legal aid, referrals to community based organizations, and services for additional unmet needs (e.g. unemployment, food insecurity). Second, we knew a knowledge gap would have to be filled for clinical practitioners to make sure that the connections between SDH and health outcomes and evidence-based interventions were clear. Using low-touch and high-touch modalities, train and build interprofessional healthcare staff, with the awareness, knowledge and skills needed to effectively screen, identify and address adverse SDH, including HI. Lastly, the most crucial component would be moving outside of our four walls of the healthcare system and understanding the upstream drivers for HI in the communities we serve. We sought to create community-informed and community-engaged solutions to address HI within the communities that were most vulnerable.

KEY SKILL SETS

It became clear that we needed team members whose skill sets spanned the multitude of domains that would be needed for the project. We needed someone with program expertise in building and implementing SDH screening programs, but also someone with a system-level role and the network to expand the program to scale and attain buy-in from health system leadership for sustainability. We also needed skills in program evaluation research and building databases for effective monitoring and quality improvement. Another key skill was mastery of the SDH and health disparities content areas and developing high and low-touch curricula to clinician and non-clinician audiences. Last, we needed someone with skills in building community-based partnerships and community engagement to ensure that the program development and evolution would always be community-informed.

- Christine Chim had robust experience in educating families and staff in navigating housing related issues and the impact of medication related problems for frequent ER utilizers. Her experience in education made her the right fit for leading the educational initiative to scale SDH training to the health system and developing curriculum for our educational workgroup. Dr. Johanna Martinez, who currently serves in graduate medical education leading curricula focused on health equity was pivotal in providing support and content expertise.
- Johanna Martinez the medical director of the medical legal partnership and internist, was also a major part of this team, due to her skills at program implementation and building/ facilitating large teams. In addition, as Director of Diversity and Equity for the Graduate Medical Education department at Northwell Health, she already had the network and buy-in with leadership at the health system level to ensure that our work could scale and identify a home for sustainability within the system.

TEAM COMPOSITION

- Christine Chim, PharmD, BCACP: Educational Workgroup Lead and Pharmacist
- Johanna Martinez, MD, MS, GME: Clinical Workgroup Lead and Internist
- Omolara Uwemediimo, MD, MPH: Project Lead, Community Workgroup Lead and Pediatrician
- Shari Jardine, MPH: Program Manager

LOGIC MODEL

- See Appendix A

- Omolara Uwemedimo, the founder of the SDH screening program, pediatrician and community health researcher, was able to bring the expertise in the structure and format of the program during the planning phases of expansion. Moreover, her expertise in building community partnerships was crucial for ensuring that the work would be at- all times community-engaged and community-informed.
- Shari Jardine served as the program manager that provided oversight of the decentralization and expansion of the team to include program coordinators for each of our workgroups as well as the addition of our own dedicated social worker. Given her expertise, working previously with large, complex organizations including the Centers for Disease Control & Prevention, her role was extremely essential in ensuring that the projects were all moving forward and achieving anticipated milestones.

COMMUNITY PARTNERSHIPS

Multiple community partners have been engaged throughout the implementation of this project. In order to support individuals and families with identified HI and related unmet social needs, we worked closely with community-based organization partner The Child Center of New York (CCNY). CCNY is a non-profit dedicated to improving the lives of children and families with over 70 programs focused in the areas of youth development, behavioral health, early childhood, home visitation and family support. CCNY accepts referrals from Patient Navigators at our practices for patients with resource needs they can assist with. We have a Collaborative Program Evaluation Intern placed at CCNY who coordinates all of the referrals from our clinical program and conducts evaluations of the outcomes of those referrals. We then expanded this model with a second community-based organization, Interfaith Nutrition Network (INN) which serves Hempstead, through their social service agency, The Center for Transformative Care. In addition, we partnered with Child Center of NY, which oversees youth development programs in public housing community centers within Far Rockaway and the Interfaith Nutrition Network. This allowed for us to expand our partnership to include educational activities for physicians in SDH management, using a community-engagement approach. We developed ENHANCE (Engaging Health Advocacy in Neighborhoods for Collaborative Education), where physician residents from Family Medicine, Internal Medicine, and Pediatrics were placed at CCNY and the INN to learn about community medicine and complete a collaborative project with the CBO partner.

We were also able to expand our work into building a CBO Network comprised of over 20 community organizations serving Nassau County, particularly to neighborhoods with concentrated poverty. Our work included being able to create a Health and Housing Town Hall to start the discussion of how to collaboratively effect change and reduce HI in our communities, as well as being able to develop and provide a COVID-19 resource guide to keep the network informed about new resources and legal rights for those with unmet social needs. In this role, we have been able to get connected with local government, including the county legislature and leverage our expertise to provide information to community residents, as well as begin the process of becoming an invited member to a new county-wide taskforce focused on homeless prevention.

HEALTH AND HOUSING TOWN HALL

FUNDING

As we started to get more clarity around the vision of the intervention that we wanted to implement, we quickly realized the need to rapidly diversify our funding streams. We actively sought out more external funding including private foundations and governmental funders.

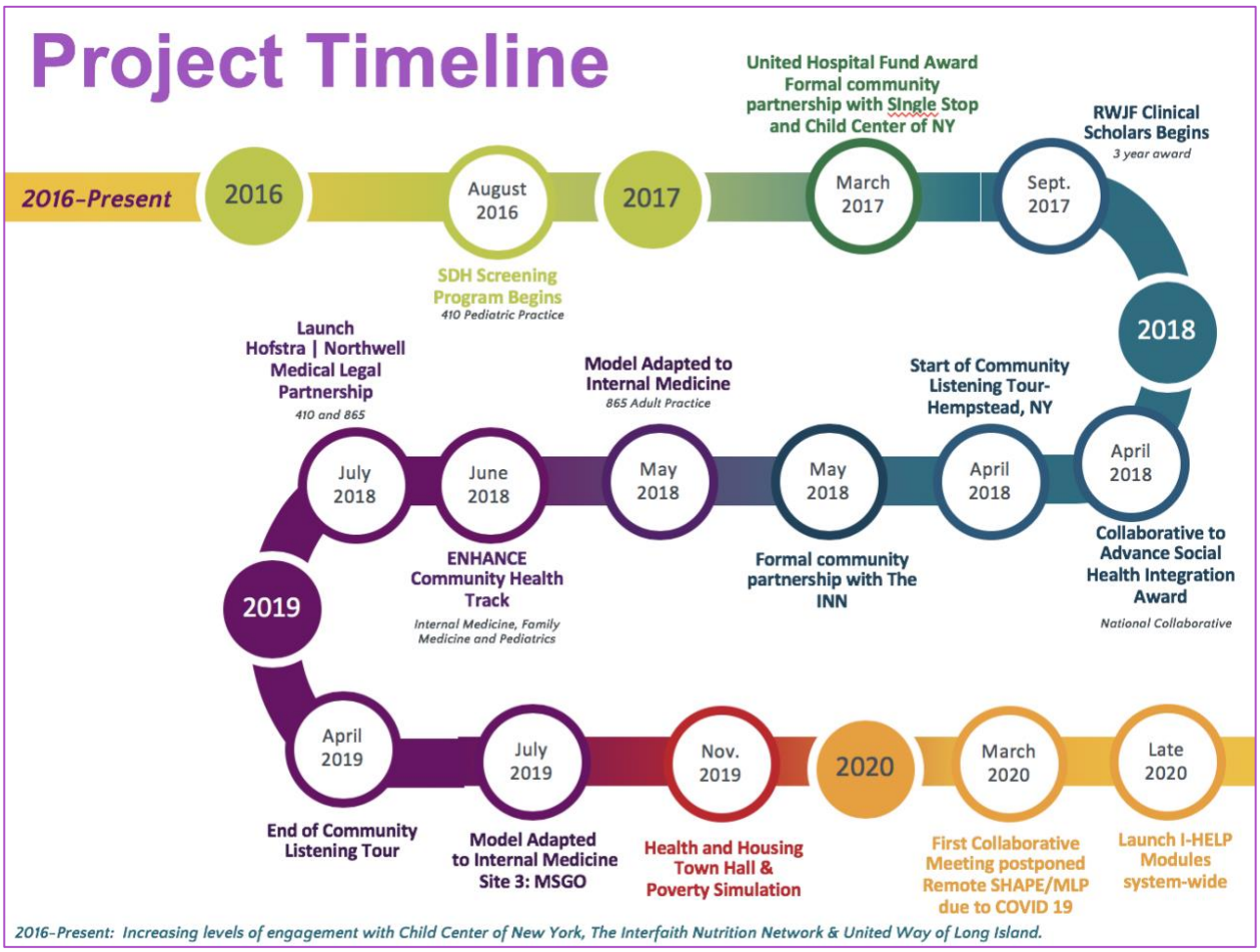
Our team was able to secure funding from the Social Determinants of Health organization, Health Leads, through their Collaborative to Advance Social health integration (CASHI). We were also able to secure funding from New York State designated for programs to create innovative models for transforming healthcare for Medicaid-eligible populations through our state's Delivery System Reform incentive Program (DSRIP). Throughout our time, we also accrued funding from additional private organizations including the Greater New York Hospital Association, NY Community Trust, United Hospital Fund, and the New York State Children's Environmental Center.

Project work

As discussed earlier, our work consisted of three arms. Clinically, we were able to expand the SDH screening and care management program started in the pediatrics department to the adult medicine ambulatory practices within our health system and build the Social Health Alliance to Promote Equity as the entity that housed this interdepartmental program. The program uses the patient navigator model where students from local universities conduct screening. These navigators help to administer a one-page SDH screen *(Appendix B),* provide referrals to local resources, and conduct the follow ups via phone or in person.

Our proposed educational activities take an interprofessional approach: our main activity was to develop an SDH curriculum to raise awareness and increase knowledge of SDHs amongst our interprofessional learners. The curriculum would take shape in the form of online modules as well as in-person learning. Our end goal through the education arm is to become an interdisciplinary center that strives to eliminate health disparities through education, partnership, and access.

In terms of our community activities, our initial 12 months were used to engage with over two dozen community-based organizations in the village of Hempstead and build a network of community organizations including The United Way LI, Interfaith Nutrition Network, and The Woman's Opportunity Rehabilitation Center. In addition to working with local community organizations, we were able to liaise with Nassau County Office of Housing and Community Development programs to deepen our understanding of the contributing factors to HI in our catchment population. We then used this information to set up a health and housing town hall bringing all of these organizations together to establish discussion/education forums in dialogue around housing insecurity and facilitate community-led solutions to address HI. *(Appendix C)*



Given the multi-disciplinary approach of our work, we decided to house it under one entity, called the Community Health and Social Medicine (CHASM) Lab. The CHASM Lab became our think-tank and hub that involved various projects, stakeholders, funders and departments within and external to Northwell Health and became the conduit within the health system for our work centered on ameliorating the ill health effects attributable to social determinants of health and health harming legal needs.

CHASM is comprised of multiple components: The Social Health Alliance to Promote Equity (SHAPE), Project SHELTER, The Hofstra | Northwell Medical Legal Partnership, system-wide social determinants of health education projects, and lastly The Engaging in Health Advocacy and Neighborhood Collaboratives and Education (ENHANCE) Residency Track. The CHASM Lab became the main hub from which our work stemmed from, including provision of socially-responsive clinical care delivery, resident education and training in social equity, community collaboration and engagement, data dissemination and content creation through a social justice informed lens.

CLINICAL WORK

Starting out as a pilot program in 2017, Dr. Omolara Uwemedimo used a small grant to initiate the first SDH screening and referral program at Northwell. Dr. Uwemedimo began screening for social determinants of health in the 410 Lakeville Road pediatric clinic, the largest pediatric clinic in the health system. The pilot used undergraduate students as patient navigators to conduct screening, intake interviews, and resource and follow up calls. Our screening algorithm was formalized into a protocol and using PDSA cycles, our processes, techniques and screening tools have been revised and updated.

Patient navigators are recruited from local colleges and universities and complete an application to serve a one-year term as a volunteer with the SHAPE program. Eligibility requirements dictate that candidates have a major in the health professions, be bilingual, and be willing to commit eight hours per week to the program. Patient Navigators undergo a one-week training to acclimate them to the screening tools, data management systems, partner community organizations and clinic settings and procedures. Two years later, the program has screened over three thousand patients for social needs. Through a research partnership with Dr. Johanna Martinez, The SHAPE program has expanded to include two internal medicine practices and has fully integrated the Hofstra | Northwell Medical Legal Partnership at each location. We have connected over two thousand patients to services and followed their outcomes 12 weeks post intervention.

COMMUNITY WORK

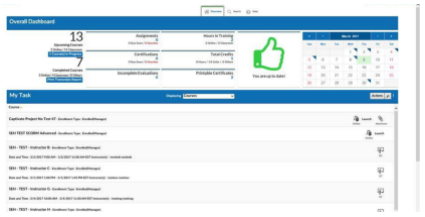
In order to better understand the drivers of housing insecurity in Hempstead, we decided to connect to community-based organizations who care for the majority of the unmet social needs for Hempstead and the larger Nassau County. In order to identify the organizations that would be ideal, we started with the Hempstead Community Development Agency, which served as both a convener and referral source to the wide array of organizations serving this catchment area. From this meeting, we were able to identify organizations that not only provided resources for housing insecurity but related unmet needs. We also attempted to ensure there was diversity in the list, including marginalized populations such as the homeless, recently incarcerated, young adults with learning disabilities, immigrants and racial/ethnic minorities. We also ensured that we also were able to meet with governmental organizations, including the Housing Authority and Department of Social Services. Lastly, we were able to leverage ongoing partnerships that were developed due to a recent state grant funded initiative and present to that group In total, using this model, we were able to interface with over 30 organizations. In total, this process took a total of 9 months.

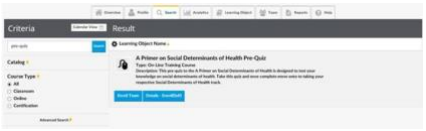
We were then able to gather our data and start to identify themes from the meetings about the challenges and areas for intervention. Given this information, we were able to create a Health and Housing Town Hall to allow for all of these organizations to convene and, using the framework of priority challenges, develop solutions collaboratively. The event was a full day of interactive activities focused on problem solving and sharing ideas. With this information, we started the process of identifying a neutral convener that would be able to develop a taskforce to begin project planning and implementation, using a collective impact strategy. Our efforts were halted by the COVID-19 pandemic and forced us to transition to virtual support of organizations. We created a COVID-19 resource guide that was constantly updated to provide our CBO partners with up-to-date information to help them with assisting their clientele. Given our work, we were invited to join the Nassau County Homeless Prevention Taskforce in August 2019 and also work with the Nassau County District 1 Legislature (which includes Hempstead) to provide targeted webinars to the public and community about a myriad of social needs that intersect with housing insecurity including unemployment resources, employment rights, antiracism strategies, food insecurity and more.

EDUCATION WORK

In planning for our SDH curriculum, we established a team of various stakeholders from within the health system, including those directly involved in our CHASM work, and those who were working in different divisions of the health system to address SDHs. We also needed to understand the audience of learners we intended on disseminating our ultimate modules to, so we determined that our audience would be broken into three main sets of learners: clinical providers, social workers/case workers, and general staff/employees. With that, we outlined an SDH primer that would serve as an underlying foundation for all types of learners and then tailored it according to each subset of learners. We thus would create three different SDH primers. We were able to assess and gather existing tools and resources from subject matter experts and stakeholders on the team to create the initial framework of the SDH primer. Because we wanted to evaluate a change in knowledge before and after learning from the SDH primer, we also developed quiz questions to be answered prior to learning from the module, as well as after. We established deadlines and delegated different components of the SDH primer to team members to create and review. We also had a team member who had experience working with the health system's online learning management system (iLearn), to lead us in getting the modules narrated and uploaded onto the platform for testing and eventual publication. We asked several stakeholders to pilot-test the modules and review the content before we finalized them for official release. Our various stakeholders - hailing from different departments across the health system - were our initial disseminators of the SDH primer to their respective departments. We created a one-page handout with instructions on accessing the module that could be available on the health system website and also be digitally disseminated. To date, over 3,000 team members have taken the SDH primer.

With an existing medical-legal partnership, and lawyers integrated into our interprofessional medical practices, it was also logical to create learning modules for





CURRICULUM CONTENT

- Social determinants of health
- Behavioral health screening and interventions
- Community engagement
- Health disparities
- Unconscious bias
- Behavioral change communication
- Patient-centered communication skills
- Health literacy
- Cultural competency/humility
- Health disparities 101
- Use of interpreters
- LGBTQ Health
- Mistrust
- Structuralism/institutional racism

Graduate Medical Education (GME) trainees focused on health-harming social and legal needs. Specifically, the National Center for Medical Legal Partnership created the I-HELP framework, broken into five domains categorizing the types of health-harming needs a patient may experience in their day to day life. The five domains correspond to the letters of I-HELP and represent income, housing and utilities, education/employment, legal status, and personal and family safety. These were intended to be SDH deep-dives for our GME trainees, so more extensive modules in the form of PowerPoint presentations were developed by team members of our education workgroup. These presentations include interactive case scenarios, videos, and questions for discussion throughout each presentation. We also determined that a general I-HELP primer would be helpful for the health system, so we utilized slides from the extensive I-HELP modules to build the primer for the health system's ILearn training platform. This I-HELP primer would undergo the same process of publication as the three SDH primers mentioned earlier.

As part of our education work, we also incorporated a three-hour interprofessional, interactive Poverty Simulation into the curriculum. It was a collaboration between our law, pharmacy, medical, physician assistant, and psychology training programs. The goal was to increase awareness among the learners and trainees about the various challenges and scenarios that one living in poverty commonly face, and promote change to better serve underserved communities. The tool kit we used was purchased from the Community Action Poverty Simulation from the Missouri Community Action Network. We modified the tool kit by adding additional props such as toy guns for police officers, stuffed dolls to mimic babies and poster images of community locations like the courthouse. To be more inclusive, we modified families to represent those that were Mandarin speaking, of Muslim religious faith, and from the LGBTQ community.

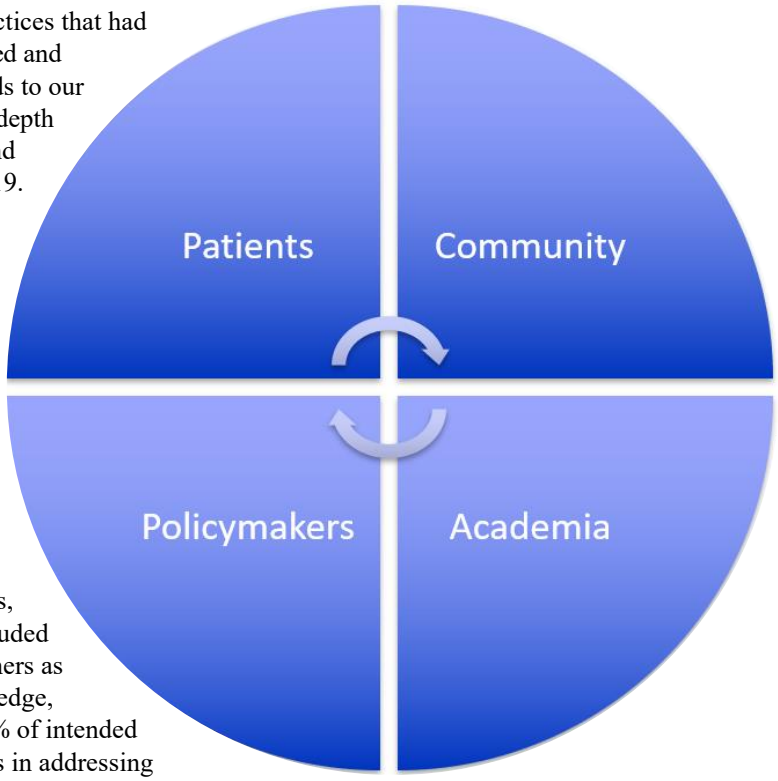
Lastly, we also created and established the ENHANCE community education residency track. The ENHANCE track is a joint 2-year track for residents in internal medicine, pediatrics, and family medicine interested in learning more about how to evaluate populations by partnering with community-based organizations (CBOs) to improve the health of those populations in the community. The ENHANCE track is an interdisciplinary longitudinal experience for residents interested in learning more about the various facets of primary care, with a focus on community engagement. The track consists of three main components: (1) professional development, (2) systems-based practice/quality improvement at the population level, and (3) community engagement. Participants in the ENHANCE track will have the opportunity to interact and collaborate with members of other departments and disciplines including pharmacy, nursing, and behavioral health. The track builds on the skills learned through the existing residency curricula on community health.

POVERTY SIMULATION

- Click link to watch video recap

Evaluation and dissemination

For our clinical arm, we utilized dashboards for each of the practices that had SHAPE and MLP activities available. Our total patients screened and referrals made are summarized in the attached figures. In regards to our community work, we were able to identify themes from our in-depth interviews with dozens of organizations and from our Health and Housing Town Hall at Hofstra University on November 14, 2019. Our initial findings included: lack of affordability as the strongest root cause for housing insecurity, with some participants describing "high cost of living", "high demand", and developers who are "not incentivized to build for lower income groups" as contributing factors. In addition, county officials stated that "local governments maintain control" over zoning laws that govern development in their communities. Lastly, lack of tenant protections limits reporting of unsafe conditions and is a barrier to safe housing conditions, particularly among immigrant or undocumented populations. In regards to our educational arm, we had short, medium, and long-term goals. Our short-term goals included a basic needs assessment of learners' current knowledge, attitudes, and skills of the proposed content. Our medium-term goals included completion of the developed curricula by 80% of intended learners as well as a collection of baseline data of learners' baseline knowledge, attitudes, and skills on SDH. Our long-term goals were that 85% of intended learners would have increased awareness, knowledge, and skills in addressing SDH impacts.



Our dissemination over the course of our project has touched patients, the community, policymakers, and academia. The attached figure provides a comprehensive overview of our dissemination to-date, as well as our brochure. However, key dissemination of our clinical activities included a webpage of HI resources and information for community organizations, so that patients can self-refer. In regards to educational activities including our Poverty Simulation, a manuscript was written (and has been submitted for publication in a peer-reviewed journal) to highlight the findings resulting from the simulation. All of the educational curricula created was disseminated via an online learning platform accessible to all health system employees. Non-health system employees (e.g. guests, contractors, interns, volunteers) also have complete access to these modules. The deep-dive SDH I-HELP curricula has been disseminated to all of the GME programs in the health system. In regards to disseminating work to the community, we gave multiple presentations about HI and other unmet social needs, including unemployment at the community level to both the public and community leaders in formal settings as well as on social media to distribute quarterly collaborative meetings with CBOs and governmental leaders. Academically, our work has been presented at conferences and we have published a manuscript. Lastly, we are actively working on developing factsheets summarizing our outcomes and impact of our program.

- **Patients**: CHASM website; updates on new resources and events to assist families with HI
- **Community**: Quarterly collaborative meetings with CBOs and governmental leaders
- **Academia**: Rigorous program evaluation and data analysis/geomapping with dissemination of findings through presentations at scientific conferences and publishing manuscripts
- **Policymakers**: Factsheets summarizing community ideas from Health and Housing Town Hall for meetings with city and state officials

Challenges, successes, and lessons learned

The multifaceted structure of our program allows us to tackle difficult cases. It has been an invaluable experience interacting with multiple community partners and resources in our own institution. We have encountered a few complex cases where we were able to assist patients utilizing multiple in-house referrals, the MLP, and our INN partnership. In one case, we were able to assist the patient and family with secure housing, food, a wheel chair for school, and are actively working on their immigration case. Complex cases like this would not be able to be tackled by one facet of our organization alone; it is truly the collaboration of many individuals that has made our success possible.

Building true community partnerships allowed us to grow our relationship beyond the scope of this project. Because of the partnerships gained from this project and the focus on meaningful relationships, we have been able to forge connections with our community partners on other projects. Examples of this include medical resident education projects that allow for community experiences and bidirectional referrals, including referrals from community organizations to our clinic for medical care.

CHALLENGES

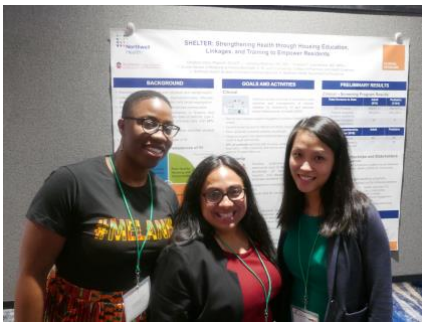
Identifying an institutional home for our work and continued funding was extremely difficult despite our successes. Given the current climate of COVID-19 and how it has exacerbated unmet social needs among so many, the importance of our work is finally being noticed and how crucial it will be for ensuring patients are successfully able to avoid costly hospitalizations and ER visits. This has allowed for us to raise the profile of our work but it has still been challenging to get committed funding.

Being realistic about the time needed to engage with community partners was a big challenge for us. We were unaware of the persistence needed to maintain communication with community stakeholders and ensure committed participation to the problem that we were addressing due to the many competing priorities of needs that neighborhoods have.

Unexpectedly, our education workgroup had to engage with stakeholders within the health system who had not been part of the original planning phase. These stakeholders provided input that created more work for the team, thereby delaying the dissemination of the final work. Also, given the nature of the work, technology and time were barriers.

SUCCESSES

- Expanded our clinical activities successfully to 3 of the largest practices in the health system and serve as the model for the health system to replicate for addressing SDH at scale
- Utilized our team and our partnerships to create a robust resource guide for families affected by COVID, that was disseminated throughout Northwell Health and with community partners (accessed 500+ times to date)
- Up until 2019, the total number of interprofessional learners receiving all the education curriculum content was 1150. As of August 2020, over 5000 people within the health system have enrolled into the online SDH module and over 3000 people have completed the module.



KEY MESSAGES

- **Community Arm**: Bringing community organizations together with governmental leaders for community solutions to eliminating housing insecurity and related unmet social needs
- **Clinical Arm**: Building a culture shift within the healthcare system that values treating both medical & social needs and integrating a workforce to include navigators and lawyers to expand the capacity for healthcare to do this effectively.
- **Education Arm**: We created an interprofessional curriculum to train health workers to effectively identify and manage vulnerable populations, with the primary mission to eliminate health disparities through education, partnership and access.

HOFSTRA | NORTHWELL MEDICAL LEGAL PARTNERSHIP REPORT

- See Appendix D

LESSONS LEARNED

- It is challenging working with stakeholders outside your immediate team, even within the same health system. It is imperative to have goals and strategic planning from the onset.
- Start thinking about funding early and diversifying your funding streams as much as possible, to ensure you can maintain activities long enough to see the health impact of work (usually 3-5 years).
- Ensure that you find ways to make sure your work is visible to system leadership and keep them informed about milestones and accomplishments often to ensure that they are knowledgeable about the impact of your work and thus, more likely to consider it as part of the strategic planning for the overall institution.
- Improving communication between social work, patient navigators, MLP and other complex care/community health resources in the practice. We had one big meeting where we spoke about cleaning up the communication efficiency between all the different community/social resources we have available in our practice.
- We have worked on improving our REDCap system and data evaluation methods. We are working to clean up some of the data in our database and come up with new reports in REDCap to better capture process and outcome measures. Individual cases are now assigned to patient navigators in the database. Assigned Navigators are responsible for ensuring data quality of their cases and ensuring the case is properly closed out. We also make sure to do bimonthly data quality checks.

SHIFTS IN THINKING

A number of shifts in thinking occurred through the project. We realized how important it was to build not only an infrastructure to do the clinical screening at each of our participating sites, but also site champions-particularly those with influence and at leadership levels to build a culture of accepting that addressing social needs are core to addressing health.

We realized that community work takes time and is founded on relationship building and trust. We realized that there was no way to rush that process, but to realize that we were planting seeds and fostering relationships that would be sustainable for years to come.

Lastly, we also realized that the sustainability of our educational work would be much stronger when creating modules and curricula for the entire health system, although it required more work, than solely limiting it to physician trainees.

"I get a call [from CBO]:

'Can you come over, make an appointment, we'd like to help you guys, just got a referral from the navigators here at Northwell...'

So okay... that was **pretty quick**... and then I went there to the community center and **they know everything about me**, like the navigators explained everything to them and they were like we know this part and we would want to help you. **It was really impressive**."

– Parent at 410 Lakeville Road General Pediatrics Practice (Pediatric SHAPE program site)

Recommendations

The complexity of housing insecurity and all of the unmet social needs that are connected to it cannot be understated. We recommend that you use the toolkit to think about how your team can explore the internal (downstream) factors within the healthcare system that impede the ability to help patients effectively address housing insecurity and other unmet social needs. However, we hope the toolkit also allows clinicians to think outside of the four walls of their hospitals and institutions to learn from organizations that serve communities in these areas and provide tangible resources, money, services and training to help them expand the work they do for broader reach.

GETTING STARTED

We recommend that you ensure that as you build the team that you are allowing for them to be mentored and not managed. Cultivating ownership is key and comes from providing some autonomy to team members and not penalizing them for risks that they take to do something without your guidance. Allow team members to be a part of the idea development process. It is also critically important to collaborate early and often If developing a curriculum of any sort, create an outline, gather all stakeholders, and assess current landscape/resources/references before creating any new content/work.

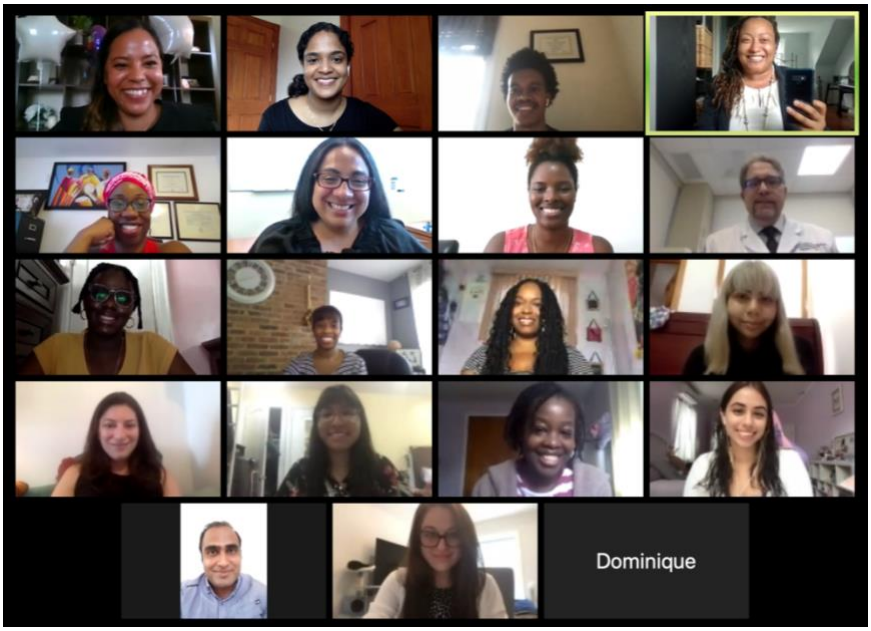
We recommend that teams do not recreate the wheel – work with what you have and spend the time to research existing resources. Others may have done similar work but you will add your own spin to it and tailor it to the needs or your audience. Make your intended outcomes too grandiose and complex, but rather focus on small wins incrementally to build momentum for the team and motivate them for stretching themselves for even bigger returns.

BEST PRACTICES

- Invest time, money and attention in dissemination and evaluation early. your sustainability and scalability are inextricably linked to this.
- Gather all possible stakeholders from the onset – everyone will have ideas and resources.
- Have frequent, regular standing meetings in place so that all are kept in the loop, especially in the beginning, as ideas are being hashed out, and before creation of the work starts.

FINAL PIECES OF ADVICE

- Cultivate ownership and decentralize as much as possible to allow people to have specific roles and tasks that they can improve on and be adept at
- Be patient when it comes to community partnerships and realize you are planting seeds for trees that will last well into the future
- Strategic planning is critical to any delivery of a curriculum that is meant to be disseminated within a large health system



Appendix

APPENDIX A: LOGIC MODEL

SHELTER Program Logic Model

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Personnel RWJF SHELTER Clinical Scholars (Johanna, Omolara and Christine) and Project Team Clinical Project Coordinator (Abigail & Tyra) CHASM Internal Medicine Champion (Leah) Lead Patient Navigators (Brittany) Patient Navigator Team Community Workgroup Coordinator (Kaye-Lani) Educational Workgroup Coordinator (Kaye-Lani) Data, Dissemination and Evaluation Workgroup Lead (Eun Ji Kim) Multi-Site Social Worker (Tyra Busigo) Hofstra|Northwell Medical Legal Partnership **Funding** RWJF, UHF, DSRIP, CASHI, Northwell Center for Equity of Care	**Refined Screening/Navigation Protocol** Implementation of SDH Screening and Medical Legal Partnership at 3 clinical sites -Finalized SDH screening tool embedded in the EMR -~50 trained staff at 3 clinical sites (865, 410 & MSGO) **SDH Educational Curricula** -Social Determinants of Health Digital Curriculum available to all NWH employees via ILearn -Finalized SDH screening tool embedded into the EMR -Five Social Determinants of Health I-HELP Curricula for Residents, Fellows and Practitioners	**Hempstead Collaborative** -Met broadly across CBO's in Nassau and Suffolk Counties -Brainstorming with existing community advisory boards to develop collaborative membership -MPH advisory board: Hofstra - "From the Community" CHW Advisory Committee **EVALUATION** -IRB approved data registry for process and impact evaluation	Clinical -Site-specific SHAPE screening tools -Screening/referral protocol for each clinical site, -Completed screening for 90% of target patients -Site-specific patient databases outlining demographic, health and SDH data Community -Stakeholder buy-in and engagement from identified community partners -Plan SHELTER Hempstead Health and Housing Town Hall -Meeting with over 20 organizations in Hempstead; building relationships Education -Basic needs assessment of learners' current knowledge, attitudes and skills of the proposed content. -System-wide web-based SDH primer education module -High-touch deep dive SDH learning modules for residency programs	Clinical -Trained cohort of Patient Navigators -Establish formal agreements with community partners for referral Community -Leverage existing relationship with Hofstra law to offer community based MLP services -Host SHELTER Health and Housing Town Hall Education -Established ENHANCE community education track -Collection of baseline data on SDH knowledge, skills and attitudes for all intended learners -Completion of curricula by 80% of intended learners	Clinical -SHELTER services will be sustained under into Northwell Health Solutions Community -Sustainability plan for Hempstead Collaborative – 1 community forum to disseminate SHELTER project findings -Identify and collaborate on grants for projects to address housing insecurity in Hempstead -Leverage information gathered during Health and Housing town Hall to liaise with local policy leaders Education -85% of intended learners will have increased awareness, knowledge and skills in addressing SDH health impacts

Assumptions
Northwell-based Collaborators will include:
- Northwell Health Solutions (clinical delivery)
- Center of Equity of Care (education)

Non-Northwell Collaborators: Hofstra Law, The INN, Single Stop Child Center for New York

External Factors
- Hofstra University
- Meetings with over 25 commiunity based orgnaizations in Nassau and Suffolk County including: United Way Long Island: Youth Build, Communiy Development Corporation of Long Island, Rebuilding Together Home Remediation, Hempstead Community Development Agency (CDA), Hempstead Housing Authority, Women's Opportunity Rehabilitation Center (WORC), Town of Hempstead Department of Occupational Resources (DOOR), Hispanic Counseling Center, Morrison Mentors, Hempstead PAL, Leadership Training Institute, Family and Children's Association, Office of Housing and Intergovernmental Affairs, Erase Racism, Salvation Army of Hempstead, NY, Long Island Progressive Coalition, Nassau Suffolk Law Services, Long Island Housing Services, Inc., NYCHA and Child Center of New York, Community School Director and QIRT High School

Evaluation Plan

Improve access/care by addressing HI and associated adverse SDH

- 1) Pre and post data on SHELTER participant health outcomes (type of chronic medical conditions, ER utilization and compliance with primary care) and SDH outcomes (successful resolution of needs); 2) Process outcomes will also be tracked (number of referrals, resources utilized and patients enrolled); 3) Health outcome measures will be compared to those patients who screened positive on SDH screening tool but were not deemed eligible for SHELTER services

SHELTER Hempstead Collaborative

- 1) Number of participants in the collaborative and meeting attendance and community members' perceived success; 2) Evaluation of the community education campaign will include metrics around awareness, measured by social media volume (e.g. retweets, Facebook likes, local media coverage). 3) For the community at-large, evaluation will include metrics of trust and engagement using the validated, Relationships in Community Groups Trust Scale (RCG-TS) pre-post project.

Expand and deliver SDH curriculum

- 1) Tracking of number of learners and completion of training/curricula. 2) Pre-post curricula evaluation of learners' knowledge, attitudes and skills in SDH advocacy

APPENDIX B: SDH SCREEN

Where are you living now?
☐ Private House/ Apartment ☐Room (in apartment/house) ☐Shelter ☐Hotel/Motel ☐No regular place ☐Car
☐Other_____

Do you worry that the place you are living now is making you sick? ☐YES ☐NO
IF YES, choose all that apply: ☐ Cigarette smoke ☐Mold or dampness ☐Rodents/bugs ☐Peeling paint
☐Broken appliances ☐ Open cracks/holes/wires ☐Not enough heat ☐Water leaks ☐None

To provide you with the best care possible, we would like to learn more about you and your household:

YES	NO	
☐	☐	Do you worry that you will run out of food before you have money to buy more?
☐	☐	Do you or your family need clothing, diapers, car seats, school supplies, or other items?
☐	☐	Do you have trouble paying your bills (rent, gas, medical, electricity, water, telephone)?
☐	☐	Do problems with transport stop you from going to medical visits or getting medications?
☐	☐	Do you need help getting health or dental insurance?
☐	☐	As an adult, have you wanted more education but were unable to get it?
☐	☐	Do you want help getting public benefits: food stamps (SNAP), WIC, welfare or disability (SSI)?
☐	☐	Do you need help getting childcare, care for an elderly or sick adult, or more school services for your child?

YES	NO	
☐	☐	Do you need help finding a job?
☐	☐	Do you feel as though you've been unfairly fired from your job?
☐	☐	Do you ever need help understanding what your doctor tells you, or reading health information?
☐	☐	Have you often felt treated or judged unfairly because of your race, ethnicity, religion or sexual orientation?
☐	☐	Do you worry that in the next 2 months, you/your family may not have a safe or stable place to live?
☐	☐	Do you feel unsafe or has anyone ever hurt/ humiliated you or tried to control what you do?
☐	☐	Do you need help from a lawyer with housing, immigration, public benefits, or other problems?

OUR PRACTICE IS ABLE TO CONNECT YOU TO LOCAL RESOURCES THAT CAN HELP

If you answered yes to any of the questions above, do you need help immediately within the next 48 hours? ☐ YES ☐ NO

Would you be interested in getting help from our practice for anything above? ☐YES ☐NO
If YES, how would you like to be contacted? ☐TELEPHONE ☐EMAIL
Best time of day to be contacted: ☐Morning ☐ Afternoon ☐Evening

We also partner with community organizations, can we share your information with them to get you help?
☐YES ☐NO

APPENDIX C: LANDSCAPE ANALYSIS FROM CBO MEETINGS

Org	Strengths	Weaknesses	Opportunities	Threats
Hempstead Housing Authority	Financial management classes through CDC-LI rep Inspections happen regularly	No database of tenant complaints	Peer ambassadors program to help identify high-risk residents and refer	Very few supports for tenants who are unable to pay Mental health supports
Hispanic Counseling Center	Has affordable housing options	Difficulty working with landlords Lack of legal help for tenants	Strong connections with marginalized Latinx immigrant communities	Attacks on tenants if complaining- discontinuing lease or raising rent
Mental Association Nassau County	Have services which provide financial housing assistance		Have services that take place in the patient's home- Assertive Community Treatment (ACT) evidenced-based practice that offers treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals that have been diagnosed with serious mental illness	
South Shore Association for Independent Living	Housing for adult children with psychiatric disabilities	No housing to other high risk groups	Also offers ACT	
CDC-LI	Offers education- tenant rights, financial counseling	No actual housing, no support initiatives		ESPRI grant contingent
VOH Community Development Agency	Has a wide network of connections to social support services	No support services in house- solely referral center Hempstead focused	May be able to get landlords to the table	Government run- there is focus on landlord rights'
WORC (Women's Opportunity Rehabilitation Center)	Has client advocate- focused on women in the criminal justice system; exposed to drugs or women who have mental issues.	Limited legal assistance, no affordable housing provision	Does have a lawyer on the team	
Hempstead Department of Occupational Resources (DOOR)	Has youth focused programming		Can connect clients to work opportunities, a significant barrier to securing housing	Governmental-run, lots of paperwork; integrating something will have to be very small

Specific needs shared by CBOs:

Policy and protections

- State legislation to make rent regulated
- Some form of penalty for landlords who doesn't make repairs

Legal assistance

- increase awareness and pathways for complaints/rectifying issues
- difficult for lay people to file in district court to make repairs Lack of available housing- for special populations
- Particularly difficult for those who have been involved incarcerated (If you have a criminal charge you can't receive Section 8 vouchers)
- Immigrant families now may be penalized if using section 8 or may have less access to public housing
- Barriers for homeless and housing unstable youth to receive the help they need

Inefficient use of funding for populations needing emergency housing:

- Town of Hempstead paying $2-3000 to put clients in shelters/hotels, Every 14 days client have to resubmit to receive shelter- people are being foreclosed on, people not getting eviction notice/lack of eviction notices.

More advocacy to enforce better housing availability for those with section 8 vouchers.

- Few landlords accept it (now illegal given the current housing law) because the way it's being paid
- Landlords report bad experience with section 8 vouchers holders
- Landlords practicing unethical behaviors- cut off lights, water Unjust evictions-Very prevalent,

Lack of Code enforcement, violations, inhabitable housing No data is transparent, information is fragmented

Unable to locate Collection of data to document what happens and track housing violations, repairs, etc.

APPENDIX D: HOFSTRA | NORTHWELL MEDICAL LEGAL PARTNERSHIP REPORT

HOFSTRA UNIVERSITY. MAURICE A. DEANE SCHOOL OF LAW | Northwell Health®

Hofstra | Northwell Medical Legal Partnership

Our Unique Position
Center of Excellence

Discover how this fully integrated partnership has expanded the paradigm by forming this multi-sectoral collaboration to advance health equity on Long Island.

Read more on page 2

Case Vignettes
Success All Around

Read about the successful implementation of our patient-centered model.

Read more on page 3

In the news
Nationally Recognized

Our Medical Legal Partnership is emerging as a national leader and innovator demonstrating to other health systems novel approaches to achieving health equity.

Read more on page 5

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HOFSTRA UNIVERSITY. MAURICE A. DEANE SCHOOL OF LAW | Northwell Health®

OUR UNIQUE POSITION

Northwell Health and Hofstra Law School have formed the only Medical Legal Partnership on Long Island to serve those who have complex health-harming legal needs.

Our Committed Partners:

Working in collaboration, Hofstra Law School and Northwell Health share a common vision to eradicate the adverse social conditions that lead to illness here at home and across New York State. Our unique model is fully integrated, which allows us to share data and resources, creating patient centered engagement.

Our Shared Mission:

We seek to deliver holistic care to underserved patients in our community by uniting social, medical, legal, community and academic resources.

Our Domains:

Our work doesn't stop at medical care and legal counsel. Beyond service delivery, we are committed to educating a pipeline of students from various professions who will incorporate health equity into their practice. We share a profound commitment to the communities that house our institutions and have longitudinal relationships with local government and community based organizations. We value the voices of our community members, we listen and leverage our position to advocate.

Our Future Vision:

- Together, we have embedded lawyers who specialize in income, housing, education, immigration and disability law services in three of Northwell's largest ambulatory clinics.
- Our work won't stop here! We plan to expand on the law content areas offered as well as increase access by scaling up.
- We aim to create a best practice model for population health that is based on a collaboration between hospitals systems, universities and communities.

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Case Vignettes

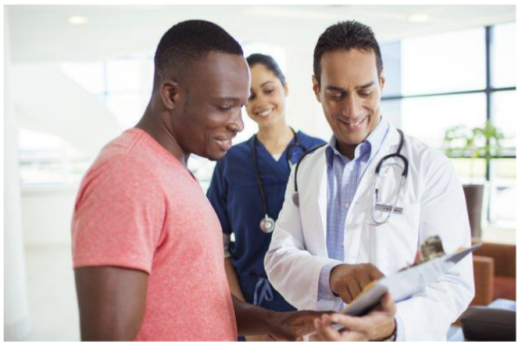
Vignette 1 – Disability & Housing Eviction

A father and his daughter who had multiple, severe disabilities presented to the clinic and advised staff that they were in imminent danger of losing their housing, which was, unbeknownst to them, an unauthorized apartment. They had been ordered to vacate by Monday of the upcoming week. The daughter's disabilities are significant and require a readily adaptable living environment.

Staff worked with a trusted community organization partner to secure a placement, and an interprofessional team meeting consisting of the on-site social worker, a resource coordinator, a physician, on-site translator and a lawyer established a comprehensive plan for the patient and their family. This plan prevented a family separation and the interruption of the child's schooling.

Vignette 2 – Chronic Disease & Transportation

A woman with multiple chronic medical conditions presented to the office concerned that she would not be able to afford cab fare to a required medical examination in connection with a pending disability claim. **The MLP attorney counseled her on how to access the Medicaid transportation benefit, and he arranged transportation to and from the appointment on behalf of the client**.



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Vignette 3 – Post Traumatic Stress & Educational Accommodation

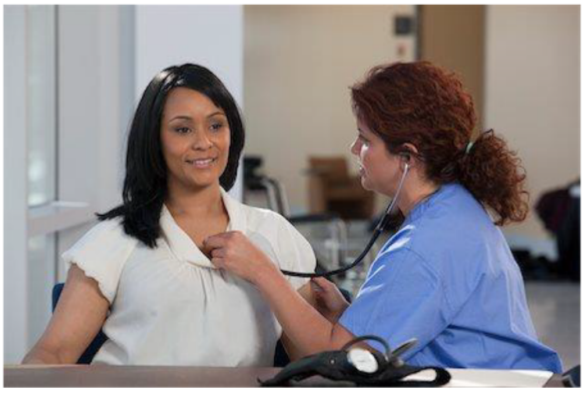
A mother and her teenage son presented to the MLP attorney at 410 Lakeville Road, describing three incidents of school bullying that turned violent and required the son to be medically treated and placed on home instruction for the duration of the school year. Concerned about the ongoing effects of post-traumatic stress, the mother consulted the MLP for assistance in securing an appropriate educational placement next year that will meet the child's educational needs. **Discussions are now ongoing between the school, the parent, and the MLP attorney regarding next steps**.

Vignette 4 – Kidney Failure & Immigration

A Northwell attending physician and on-site Patient Navigator referred a 16-year-old patient to the medical-legal partnership. She and her mother had come to the U.S. on visitor visas. They entered the country with the intention of vacationing, only to find out later that the child was in kidney failure. The child was accruing time on the transplant list but ineligible to receive transplant offers because of the clouding of her status in the country – time was running out.

The MLP attorney helped the client file a visa extension to assure the client could remain within a period of authorized stay under the law. This preliminary legal intervention took two weeks, and this remarkable result was made possible by a fully-integrated delivery model that included the attorney, the lead pediatrician and the supervising nephrologist.

More recently, the team received word that the visa extension was approved. This extension cleared the way for her kidney transplantation once a kidney becomes available.



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HOFSTRA UNIVERSITY. MAURICE A. DEANE SCHOOL OF LAW | Northwell Health®

IN THE NEWS

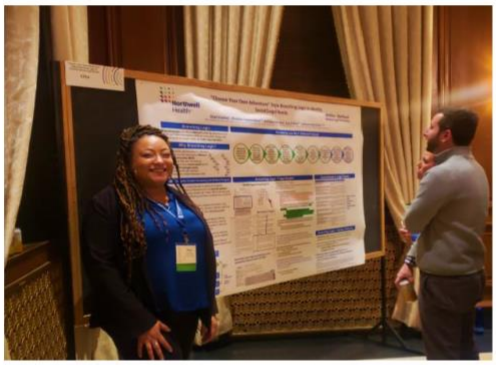
National Recognition

The Hofstra|Northwell Medical Legal Partnership is new, but has gained nation attention. We have enjoyed the privilege of having our work highlighted through various conferences and media outlets.

Academic Conferences Including:

Society of General Internal Medicine	Pediatric Academic Societies
American Public Health Association	National Center for Medical Legal Partnership
National Center for Health and Social Needs, Putting Care at the Center conference	4th Annual National Summit on the Social Determinants of Health

Total of fifteen national presentations to date



IN THE NEWS

Newsweek SIGN IN SUBSCRIBE >

OPINION

HERE'S MY MEDICAL OPINION: THE PUBLIC CHARGE RULE THREATENS THE HEALTH OF EVERY SINGLE PERSON IN AMERICA

OMOLARA THOMAS UWEMEDIMO, M.D.
ON 8/16/19 AT 2:07 PM EDT

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"Johanna Martinez, the Co-Director of Medicine for the Medical-Legal Partnership, brought the idea to Northwell.

Medical-legal partnerships operate at 373 health care organizations nationwide, including 31 in New York State, but this will be **the first on Long island,** according to the National Center for Medical-Legal Partnership.

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Hofstra University and Northwell Health form medical-legal partnership

Posted July 12, 2018

MENU THE Hospitalist

CONFERENCE COVERAGE

Pilot program addresses social determinants of health

Publish date: May 21, 2019
Author(s): Jennifer Reising; MDedge News

In November 2019, at the Zucker School of Medicine at Hofstra/Northwell, Northwell's Office of Academic Affairs in conjunction with the **Hofstra | Northwell Medical Legal Partnership** sponsored Northwell's first Community Action Poverty Simulation experience. The simulation involved learners across multiple disciplines and professions. The Poverty Simulation was an interactive scholarship activity that promotes awareness, increases understanding, and inspires change in how learners and practitioners can best serve our communities.

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LONG ISLAND

A lesson in empathy

Hofstra medical students learn about the needy

BY LISA L. COLANGELO
lisa.colangelo@newsday.com

It was a crash course in empathy for a group of fledgling doctors and pharmacists.

More than 100 students and staffers at the Zucker School of Medicine at Hofstra/Northwell shed their white lab coats and stepped into the shoes of patients struggling with financial and social challenges as part of a "poverty simulation" exercise on Thursday.

"This is not a game. This is based on real-life scenarios," Judge Fern Fisher, retired deputy chief administrative judge for New York City Courts, who facilitated the program, told participants. "Don't let the props fool you."

Fisher, special assistant for social justice initiatives to the dean of the Maurice A. Deane School of Law at Hofstra University, helped bring the Community Action Poverty Simulation to the law school. She said she believed it was just as necessary for students who want to enter the medical field.

Students gathered in a conference room on the Hofstra campus and were grouped into "families" that ranged from couples with children to single parents and senior citizens. They donned identification cards with names of the fictitious family members and received a packet of information with biographies, job information and family assets, including money and transportation passes.

The room was lined with staffers manning tables that represented sites the families might interact with, including the courthouse, social service agency, food store, interfaith church, police department and pawnshop.

Some of the families spoke Arabic, Greek, Mandarin and Spanish.

"The idea is that you will go and have to access services and have to find and wait for an interpreter because this is what happens in your life," said Dr. Lyndonna Marrast, one of the lead facilitators and assistant professor of medicine at Zucker.

Medical student Adam Lalley, center, participates in the poverty simulation experience at Hofstra's Zucker School of Medicine Thursday.

JEFF BACHNER

Fisher facilitated the program.

> "This is not a game. This is based on real-life scenarios."
> — Judge Fern Fisher

Medical students Roshawn Johnson, 28, of Port Jefferson; Emma Gugerty, 24, of Bayville; Adam Lalley, 37, of Rego Park, and Jessica Edwards, 24, of Astoria, felt confident when they learned their "family" had a working parent, a house and a car. But there weren't enough transportation passes for the teenage daughter to get to school and the father to work. Things got more complicated when the father was taken in by Immigration and Customs Enforcement officials while at work and their car was stolen.

"I came in expecting it to be challenging and chaotic and frustrating — and it's definitely living up to those expectations," said Gugerty, a first-year medical student. "This is really going to help us understand our patients better and just be more attuned to the problems they are facing."

The simulation kit is licensed by the Missouri Community Action Network and has been used by educational and nonprofit groups around the country.

"This is just part of the effort to make sure the doctors that are produced from Hofstra are aware of the pressures of people who live in poverty and how that impacts their ability to keep up with their health care and to obtain medicines they need," Fisher told Newsday. "For example, a doctor may not understand why somebody can't eat healthy or doesn't take their medication regularly."

Most of the medical school training is focused on biology and pathophysiology, said Dr. Johanna Martinez, associate professor of medicine at Zucker and colead facilitator with Marrast, even though social determinants have the biggest impact on health.

"It's about time that health care starts to realize that these are the things that our future doctors, providers need to know about in order to provide great care," she said.

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LONG ISLAND BUSINESS NEWS

Prudenti: Partnership helps transform healthcare to the vulnerable

By: Commentary March 7, 2019

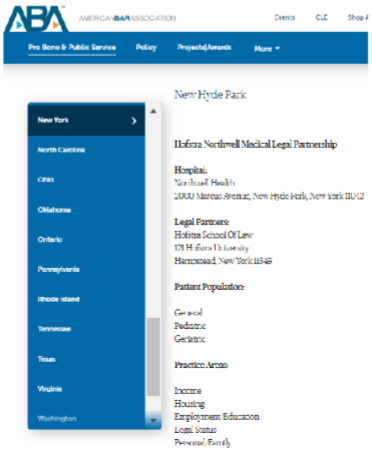
A. Gail PRUDENTI

Just over a year ago, Hofstra Law announced plans for a medical-legal partnership (MLP) with Northwell Health, and some asked: Why would doctors and lawyers engage in such a partnership? Aren't lawyers about as welcome in the corridors of a hospital as a hypodermic needle at a balloon rally?

The work that has been done since commencement of the MLP's work in late 2018 suggests an unexpected answer to that question.

Our MLP leverages existing resources at the Law School and the Gitenstein Institute for Health Law and Policy to transform healthcare for vulnerable populations. Between its initiation in mid-October and mid-February, more than 60 cases were referred to the MLP. Sixty-five percent of the clients our MLP Intake Specialists were able to reach received some form of legal assistance, most often for issues related to benefits, housing, immigration and education. In addition, our MLP attorneys have contributed more than 200 hours on-site, delivering advice and training to medical residents, social workers, physicians and clinic staff.

The Hofstra | Northwell Medical Legal Partnership is featured on the American Bar Associations web site



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ABA AMERICAN BAR ASSOCIATION Health Law Section

THE HEALTH LAWYER

IN THIS ISSUE

UNLAWFUL, UNFAIR AND UNWISE: CONSTITUTIONAL AND RULEMAKING INFIRMITIES IN CMS's ENROLLMENT REVOCATION REGULATIONS AND HOW TO CHALLENGE THEM

Donald H. Romano, Esq.
Foley & Lardner LLP
Washington DC

Welcome to the Medicare Program – Now Get Out

Imagine you are a physician who has been convicted of a minor felony, such as one count of possession of a controlled substance, which was not a crime of dishonesty or had anything to

a proposed revocation for which you would be offered the opportunity to respond, or any other warning from your Medicare contractor, you receive a notice stating your billing privileges are revoked for a period of three years. To make matters worse, the contractor notifies you that it is recouping Medicare payment for all of the services from the date of your conviction through the date of the notice, which amounts to several hundreds of thou-

LESSONS LEARNED FROM A NEW MEDICAL-LEGAL PARTNERSHIP: PATIENT SCREENING, INFORMATION AND COMMUNICATION

Janet Dolgin, PhD, JD
Johanna Martinez, MD
Anthony Serrano, Esq.
Hofstra/Northwell Medical-Legal Partnership
Nassau County, NY

Introduction

The United States spends significantly more on healthcare than any other nation.[1] Yet the health of the nation's population is inferior to that of many other nations that spend significantly less on healthcare.[2] Access to healthcare can be essential to an individual's maintaining or returning to good health. But the social determinants of health are at least as important. Moreover, social determinants play a significant role in facilitating or limiting access to healthcare.[3]

The social determinants of health have been identified as "the condi-

further impact health negatively. For instance, stress has been shown to be an independent risk factor for poor health. Fortunately, it can be mitigated by effective responses to health-harming legal needs.[7]

Medical-legal partnerships respond to these needs and consequently have been able to demonstrate improvements in outcomes.[8] Their interdisciplinary framework offers particular benefits:

> Through training, lawyers teach doctors how to "observe the health effects of socioeconomic factors or detect when such factors detract from their patients' care." When such factors are identified, doctors can turn to their legal partner to provide the knowledge, resources and assistance to remove or mitigate adverse circumstances.[9]

By working together, doctors and lawyers, often in partnership with

been formed and were operating in 46 states.[15] They take several forms. Almost a third of them (121, as of early 2019) had been formed between lawyers and general hospitals and/or health systems. Others were operating in health centers funded through the federal Health Resources and Services Administration[14] (98), children's hospitals (33), veterans affairs medical centers (25), and other healthcare settings (56).[15] Moreover, the majority of existing medical-legal partnerships include health organizations that partner with legal services agencies or academic law clinics.[16] About one-third of the healthcare facilities that participate in medical-legal partnerships have included funding for the partnerships' work in their budgets.[17]

Hofstra/Northwell Medical-Legal Partnership

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