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BRIDGING ACCESS TO BENEFITS AND CARE IN COMMUNITIES AFFECTED BY DRUG USE

Findings from a Pilot Program in New York City

Substance use disorders involving illicit and highly addictive drugs — such as heroin and other opioids, methamphetamines, and cocaine — take a high toll on the individuals who use the drugs, their families and communities, and the health care system. In addition to facing higher risks for serious diseases, chronic users of illicit drugs are more likely to delay seeking care for their health needs and to rely on hospital emergency rooms when their needs become pressing, both of which contribute to poor health outcomes and high health care costs.[1] A recent analysis suggests that a large share of the health care costs related to the opioid crisis in the last two decades stemmed from emergency room visits to treat patients after overdoses, along with costs associated with the health complications of opioid use.[2]

In New York City, deaths related to unintentional drug overdoses rose continuously between 2010 and 2017, before declining slightly from 2017 to 2018. However, rates of overdose deaths continued to increase in the Bronx, which lost more residents to drug overdoses in 2018 than any other New York City borough.[3] Overdose deaths among Bronx residents increased by more than 200 percent between 2010 and 2018, and a majority of those deaths involved heroin or fentanyl, which are types of opioids.[4]

Bridging Access to Benefits and Care (BABC) — an innovative collaboration among three nonprofit organizations that serve low-income and vulnerable communities — was designed to improve connections to public benefits and health care services for people dependent on opioids and intravenous drugs in the Bronx. The pilot program sought to address challenges related to social determinants of health for low-income drug users — challenges such as housing instability, food insecurity, and lack of health coverage — by helping them make use

1 Weiss, McCoy, Kluger, and Finkelstein (2004); Gryczynski et al. (2016); French, McGeary, Chitwood, and McCoy (2000).

2 Altarum (2018).

3 New York City Department of Health and Mental Hygiene (2019).

4 New York City Department of Health and Mental Hygiene (2016, 2018, and 2019); Millan, Lee, Ohlrich, and Sarnoff (2018).

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BUILDING KNOWLEDGE TO IMPROVE SOCIAL POLICY

of benefits and services. The primary goals of the BABC pilot program were to:

- Engage high-risk, high-need intravenous drug users and other opioid-dependent users through compassionate, community-based outreach in the Bronx
- Increase their awareness of and enrollment in public benefits
- Improve their access to and use of health care

Increasing outreach, benefits assistance, and direct connections to health services is expected to improve long-term health outcomes for people who use drugs. It is also expected to increase their use of preventive and mental health care and decrease their reliance on emergency rooms.

BABC was supported by the OneCity Health Innovation Fund, an initiative designed to promote new ideas in New York City that could reduce avoidable hospitalizations, improve community health outcomes, and address social determinants of health such as food security and economic stability.

This brief presents findings from an MDRC study of the implementation of BABC between September 2018 and June 2019, and offers a few lessons for serving a traditionally high-need population with serious health issues.

PILOT PROGRAM PARTNERS

BABC was a collaboration among three nonprofit organizations that brought different expertise and services to the partnership:

- **ACACIA NETWORK** offers an extensive array of services to advance its mission of promoting health and prosperity for individuals and families in low-income communities. These services include primary care, supportive and transitional housing programs, and behavioral health programs that include services related to mental health and substance use disorders. The organization takes a holistic approach to service delivery that is focused on improving the coordination and integration of services to tackle interrelated challenges faced by vulnerable populations (for example, health and housing).
- **ST. ANN'S CORNER FOR HARM REDUCTION (SACHR)** provides "nonjudgmental quality access to health resources" to drug users, homeless people, and people with HIV. Its services include street outreach, syringe exchange, assistance with basic needs, mental health counseling, HIV counseling, case management, and educational workshops. As its name suggests, the organization's approach to services is founded on the concept of harm reduction, which seeks to minimize the adverse consequences of illicit drug use on individual users by meeting their needs, without emphasizing abstinence-oriented treatment options.[5]
- **SEEDCO** seeks to advance economic opportunity for communities in need, primarily through employment services, case management, and improved access to benefits and health insurance for low-income workers and families. The organization has developed proprietary software — EarnBenefits Online (EBO) — that allows case workers to help their clients determine eligibility for more than 20 public benefits, including Medicaid, the Supplemental Nutrition Assistance Program (also known as food stamps), cash assistance, tax preparation, tax credits, prescription drug discounts, housing assistance, and telephone access. EBO also allows case workers to populate benefit

5 Leslie (2008).

applications with their clients' information for easier submission, and to track the status of the applications by following up with clients.

PROGRAM IMPLEMENTATION

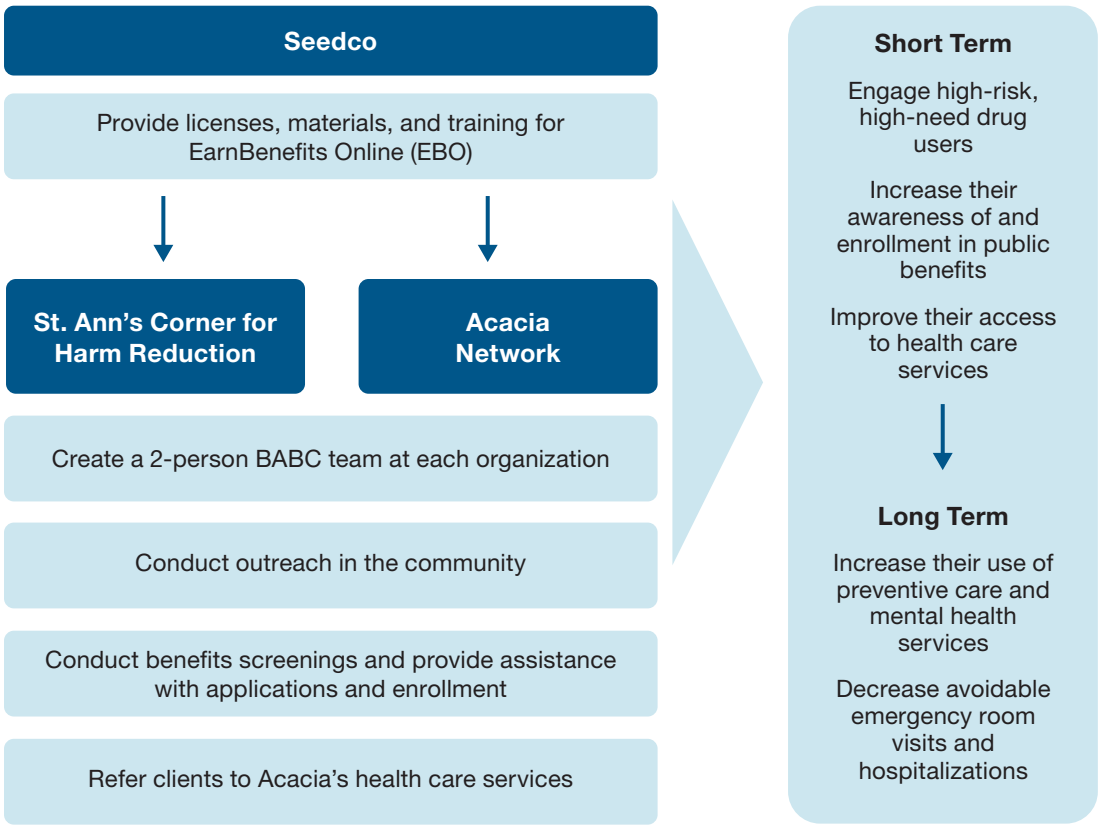
As illustrated in Figure 1, BABC sought to increase Acacia and SACHR's ability to reach the program's target population, to provide timely and efficient benefits screening, and to collaborate on care coordination and health care referrals. BABC helped both agencies hire new people and train new and existing staff members to use EBO, and gave them access to EBO for their clients. Seedco provided EBO licenses, materials, and training to Acacia and SACHR, which implemented the screening, referrals, and care coordination.

MDRC evaluated how BABC was implemented. The implementation analysis primarily relies on interviews with program staff members and leaders at Acacia and SACHR, as well as some quantitative indicators of service delivery at each organization. The evaluation was not designed to assess the short-term or long-term outcomes of pilot participants, and consistent data on participants' use of program services at both agencies were not available at the time this brief was written.

Outreach and Recruitment

BABC staff members at Acacia and SACHR used mobile vans to offer benefits screening and referrals at different locations in their communities, and visited locations typically frequented by homeless people and drug users. So that staff

Figure 1: Overview of the BABC Pilot Program



members could use EBO's online platform in the field, both agencies used vans equipped with internet access. Staff members at SACHR also used mobile hotspots and tablets to reach people in their communities, and recruited people who visited their offices for other services. While BABC targeted intravenous drug users and other opioid-dependent users, there were no eligibility requirements for the program. Staff members provided screening and referral services to all individuals who wanted help visiting doctors or were interested in learning about benefits they might be eligible to receive.

Access to Benefits

Both agencies used the EBO software to conduct comprehensive benefits screening for participants. Staff members could submit participants' demographic and income information and the software assessed their likely eligibility for multiple benefits at once. After the screening, staff members reviewed with participants the benefits that they may have been eligible for; helped them decide which to apply for; gave them printouts of application forms populated with their information, along with guidance on the documents they needed to submit with the applications; and referred them to social service agencies to complete the enrollment process.

Staff members said they attempted to follow up with participants after the referrals to learn whether they visited the agencies to submit their application packages, whether they encountered any problems, and whether they wanted additional help. In some cases, staff members accompanied participants to social service agencies to help them complete enrollment processes. The pilot program did not set requirements for how often or how intensely staff members should follow up with participants after they made referrals. Based on the interviews with staff members, it appears that follow-up activities largely responded to participants' needs and desires, and that those activities varied between the two providers.

Between September 2018 and June 2019, Acacia and SACHR provided benefits screenings to 610 individuals; about 60 percent of them were men, 76 percent were of Hispanic origin, and 13 percent were black. Everyone was screened for multiple types of benefits in the areas of health insurance, discounted prescription coverage, housing assistance, income support, taxes, and telephone access. Of the 610 participants who were screened for benefits, 111 received referrals during the pilot period, and staff members were able to confirm that 47 enrolled in benefit programs. This number only captures the benefit enrollment of participants whom staff members were able to reach to follow up; some participants may have enrolled in benefits without letting staff members know. Staff members also reported that participants faced several barriers to enrolling in benefits, including long wait times at social service agencies and challenges with document requirements. While staff members attempted to provide follow-up support to help people overcome these barriers, they were not always able to reach participants.

Access to Care

BABC staff members at both agencies referred participants to Acacia providers for a range of health services. While EBO screenings for BABC began in September 2018, a specific referral process between SACHR and Acacia for the pilot program did not begin until February 2019 due to changes in staffing and leadership at the agencies.

Staff members at SACHR used a form to help Acacia identify participants they referred, to provide relevant information about their needs, and to facilitate a smooth and seamless transition in care. They also developed relationships with staff members at Acacia to determine where to send participants for different services and so that they could notify people at Acacia directly when making referrals. SACHR staff members felt that the referral partnership and coordination shortened the time participants waited to see medical

providers, potentially making it more likely that they would get care. Staff members reported that long wait times can make participants anxious and prompt them to leave a provider location without receiving care.

As part of this pilot program, 32 individuals referred by SACHR received health care services from Acacia. Based on data received from Acacia, these individuals made a total of 98 visits to Acacia provider locations during this time — an average of about 3 visits per participant. Primary care visits accounted for most of these visits (63 percent), followed by mental health visits (33 percent) and dental visits (4 percent). BABC staff members at Acacia also referred participants for health care services internally within the organization, but data on those referrals were not available to MDRC. Acacia staff members also referred some participants to SACHR for harm-reduction programs based on their needs.

LESSONS LEARNED

While MDRC's evaluation of the BABC pilot program is modest in its scope, the implementation findings offer a few lessons that may be helpful for community-based organizations that serve people affected by substance use disorders and that seek to partner with other organizations to expand their offerings.

Meeting people "where they are" is an important strategy to engage people who use drugs and other disenfranchised populations who may benefit from increased access to benefits and health care.

Staff members at SACHR and Acacia engaged participants at different locations in the community, instead of waiting for them to come into the agencies' offices for services. Doing so allowed them to reach people who otherwise would not have received information about the support available to them.

Technology can help practitioners engage their clients in the community, but to use new technology, organizations must build additional capabilities.

A comprehensive digital tool — EBO — allowed BABC staff members to provide immediate benefits screening to participants in the community and to offer more informed guidance to support their decision-making. Staff members reported that the software was easy to use and that it provided participants with accurate information they could use to take action. They also reported that participants were often surprised to learn about the benefits available to them. However, to access EBO's online platform in the field, Acacia and SACHR had to build additional technological capabilities, such as the ability to use mobile hotspots and tablets. SACHR staff members did not have access to a printer in the field; they printed documents in their office and returned to the field with information about participants' benefits eligibility and application paperwork.

Improving access to benefits for vulnerable groups may require intensive, continuing engagement to help people navigate enrollment requirements and processes.

As discussed above, EBO proved to be a valuable tool for staff members to engage members of a high-need population in benefits screening and to help them complete application forms. EBO also provided staff members with automated reminders to follow up with participants and a data system to track their enrollment status. However, BABC staff members reported that they followed up with varying frequency and intensity depending on participants' needs and desires to engage, and that they were not always able to reach participants after the screening for various reasons. For example, some participants were transient, and the addresses or phone numbers available for them were not current.

Staff members provided participants with completed application forms, guidance with documentation, and referrals to social service agencies. But, as mentioned above, they also reported that participants faced other barriers when trying to enroll in benefits, such as lack of transportation, long wait times, and challenges with paperwork. Their observations are in line with evidence from prior research that vulnerable groups — such as people who use drugs or face housing instability — may require substantial, ongoing support to help them navigate the complex application processes and extensive documentation requirements of many benefit programs.[6]

Building strong partnerships among multiple organizations to establish a continuum of care requires leadership and training to get everyone to pursue common goals.

Acacia and SACHR share some common goals. They both aim to improve outcomes for vulnerable and disadvantaged communities in the Bronx, and both strive to serve the whole person, rather than focusing on a person's problems individually. But there are some important differences in their approach to serving drug users: SACHR largely serves drug users through harm-reduction programs, whereas Acacia serves a broader population with a wide range of programs that include abstinence-focused treatment services.

A major objective of the partnership was to strengthen collaboration between these two organizations, allowing SACHR to increase access to health care for its clients and Acacia to engage more people who could benefit from increased access to health care. Both organizations were ultimately successful in engaging participants in health care services during the last few months of the pilot period. However, in the beginning, the differences between the two organizations in their approach to serving drug users made it challenging for them to collaborate effectively and efficiently. They had different understandings about how best to work with drug users to achieve the pilot program's desired outcomes. Both organizations also experienced some leadership and staff transitions toward the beginning of the pilot period. Those transitions delayed the referral partnership between Acacia and SACHR, in part because they made it more difficult for the organizations to reach a shared understanding of BABC's goals and a sense of joint ownership over the program.

It takes leadership and work to get people across organizations to agree about what an initiative will look like or how to best support a target population, so that these types of collaborations can operate as intended. Findings from the implementation analysis suggest that the pilot program could have benefited if there had been a broader effort in both organizations to educate a larger number of staff members and leaders about BABC and its goals, and to establish a shared understanding of how the two partners could contribute to those goals. While the pilot project provided training to the staff members designated to carry out program services, referrals and care coordination involved many other people in both organizations. Educating more staff members and leaders in both organizations at the beginning of the pilot period may have mitigated the gaps created by staff transitions and the lack of shared understanding about the service approach and outcome goals.

LOOKING AHEAD

The BABC pilot program increased the ability of two community-based organizations to engage members of vulnerable groups and expand their

6 Annie E. Casey Foundation, Ford Foundation, and Open Society Institute (2010); Burt et al. (2010); Wu and Eamon (2010).

access to benefits screening and health care services. Despite some implementation challenges, the pilot program successfully offered benefits screening and health care referrals to many people during the short implementation period. BABC staff members found EBO to be a valuable tool in providing real-time assistance with numerous benefits, and the referral partnership and care coordination between SACHR and Acacia is believed to have shortened the time program participants waited to see medical providers and may have increased the likelihood that participants would get care. The partnership has provided lessons and tools to the participating organizations that could make them better able to serve a growing number of people who are dependent on opioids or use other intravenous drugs.

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