Waco Connect

Health Plan Referrals Evaluation Report

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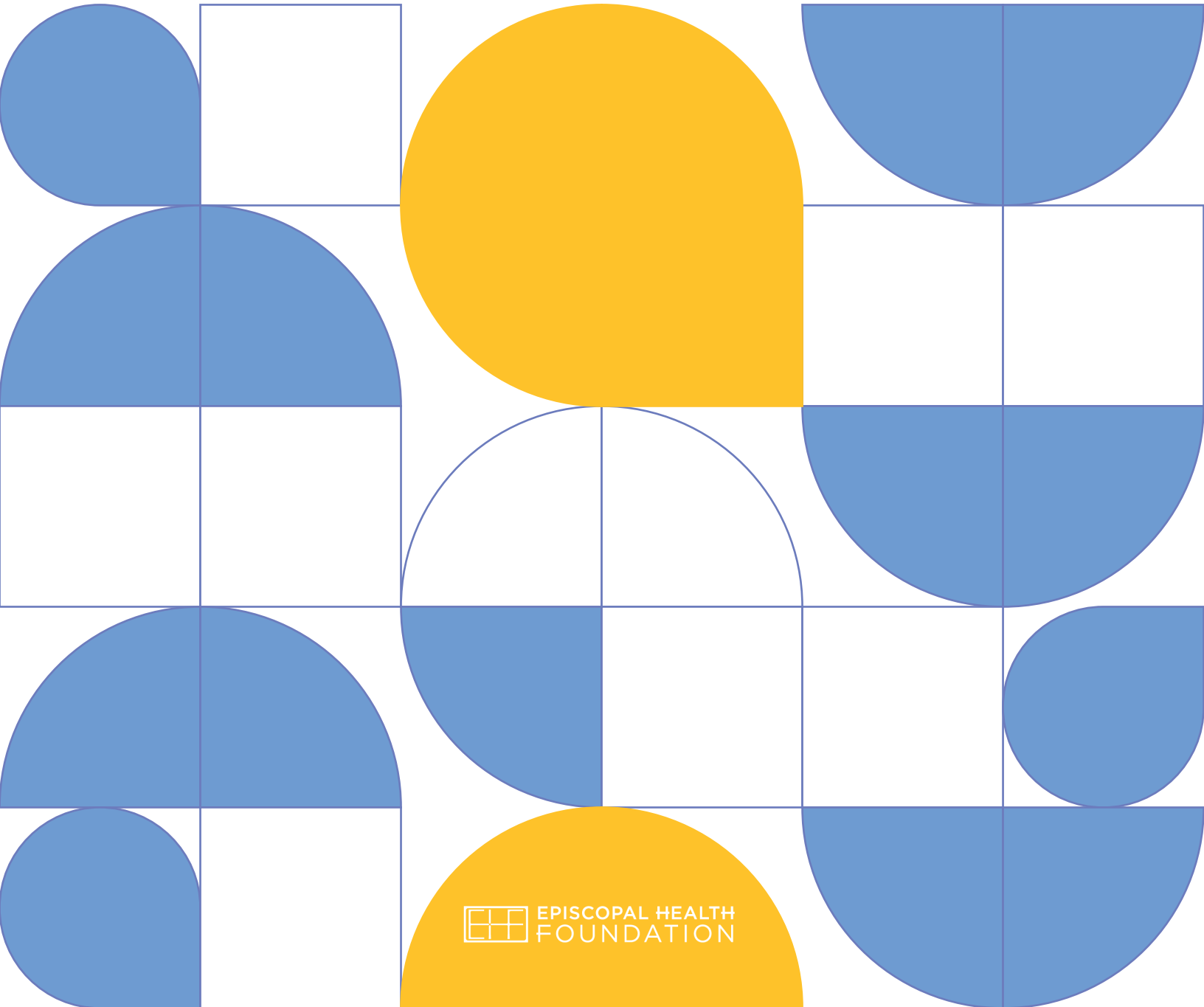

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Submitted to the Episcopal Health Foundation

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Executive Summary

Growing evidence suggests the importance of economic stability, physical environment, education, food, and social context in determining one's health before the health system is able to intervene (Nichols & Taylor, 2018; Taylor et al., 2016). Non-medical spending on these social determinants of health (SDOH), including social work interventions, may have an impact on health outcomes. The Waco Connect (WC) project, part of a national series of Collaborative Approach to Public Good Investment (CAPGI) projects, is a social care navigation program coordinated between April 2021 and February 2023 by Prosper Waco in Waco, Texas. WC aims to connect families experiencing mental health needs in McLennan County, Texas, to a network of non-medical resources. In partnership with Baylor Scott & White Health (BSWH), the families of Medicaid-enrolled children (under 19) who have serious anxiety and depression were selected and provided the opportunity to be linked to social care providers through referrals.

Our team was contracted to serve as the local evaluator for WC. The purpose of this evaluation is to assess whether the WC project – as an intervention to invest in SDOH – reduced the utilization and costs of medical services for high-risk patients with social needs. The implementation process of WC, as described in this report, is based on internal reports from and conversations with key personnel at Prosper Waco. Using fully de-identified data on referrals provided by Prosper Waco and on utilization from BSWH, we use matching on observables methods to estimate the impact of the WC intervention. We interpret these results in the context of prior literature on SDOH social care interventions, including referral interventions.

Overall, 311 referrals were made by BSWH to Prosper Waco between April 2021 and February 2023, of which 291 clients resulted in successful contact and 232 clients had their social needs identified. A majority of WC clients were in need of assistance with housing (143 clients) and utilities (131 clients), and other notable social needs included food (79 clients) and childcare (60 clients), followed by employment, social/emotional support, healthcare, and transportation. Of these clients, 100 of them reported having at least one of their social needs met during the study period. We conducted an evaluation of the WC intervention on the health outcomes of 258 WC clients that had complete healthcare data, compared to 12,504 matched controls in the

BSWH Medicaid plan, and found no evidence of reduced cost of care but some evidence of reductions in the number of emergency department (ED) visits following WC referrals.

Social care interventions and health

Social care interventions that aim to improve SDOH, such as economic stability, physical environment, education, food, and social context, may reduce the potential need for healthcare utilization and the resulting cost (Nichols & Taylor, 2018). These interventions often involve social workers or community health workers well-versed in the communities they serve, which differentiates them from traditional healthcare workers, who would connect high-risk patients with social resources in the community, such as housing assistance, income support, subsidies for utilities, and nutritional support (Markossian, 2023). Previous studies find that such interventions delivered by community health workers are effective in improving mental health outcomes and reducing healthcare utilization, particularly when partnering with low-income communities (Osborne et al., 2018; Kim et al., 2016; Barnett et al., 2018).

However, existing evaluation research on social care interventions commonly faces empirical challenges (Steketee et al., 2017; Gottlieb et al., 2017). Limitations in comparison groups and analytic methods to address potential confounding influences are likely to overestimate the impact of such interventions. A major concern is that those selected to participate may be experiencing particularly difficult periods resulting in, for example, high healthcare utilization, and a simple pre-post comparison will be vulnerable to mean reversion. Several systematic reviews also point out the lack of readily available data on healthcare costs for the potential comparison group (Jack et al., 2017; Viswanathan et al., 2010). Small sample sizes, which limit statistical power to detect effects for outcomes that are rare, are another typical problem.

Studies from randomized controlled trials (RCTs), often considered the "gold standard" for evaluation methods, mostly find that social care interventions reduce healthcare utilization but provide mixed evidence on their returns on investment. For example, in one RCT study by Kangovi et al. (2014), 224 out of 446 uninsured or publicly insured patients in two urban hospitals were randomly assigned to community health workers who would provide individualized action plans for the patients' state goals. The study finds that the treatment group experienced improvements in mental health and reductions in re-admissions of around 25 percentage points. A similar study, where 302 uninsured and publicly insured patients from high-poverty neighborhoods were randomly assigned to tailored social support from community health workers, finds that such intervention led to positive average returns of approximately $2.47 for every dollar invested (Kangovi et al., 2020). A larger RCT of 49,592 Medicaid patients, however, finds negative returns on investment (Brown et al., 2022). High-risk patients in the San Francisco Bay area were randomly assigned to case managers who aimed at identifying the patients' social needs, developing individualized care plans, and supporting the goals through coaching, help with applications for public benefits, and referrals. Brown et al. (2022) find that while case management reduced the odds of ED visits and hospitalizations, the savings were not enough to cover the full program cost.

Other studies further suggest that successful interventions require a more nuanced understanding of the care provided by social workers, highlighting the role of support beyond referrals. Kangovi et al. (2017) focus on 302 patients, either uninsured or publicly insured, in Philadelphia's high-poverty neighborhood and compare those who were randomly assigned to tailored support to those who only have goals set by community health workers. They find that patients who received support (vs. goal setting alone) experienced improvements in several chronic diseases, self-rated mental health, and a reduction in hospitalization by around 28 percent. A qualitative study supports these findings. Interviewing staff members of a program that was implemented to identify and address the social needs of patients with frequent ED visits finds that connecting patients with community services was not sufficient and that resources were insufficient to resolve their needs (Renaud et al., 2023).

A recent set of RCT studies that particularly focus on children – the population of interest for the WC intervention – also suggests that referrals to social care resources may not be enough. In one study, caregivers of pediatric patients were either given written information about relevant local resources related to the social needs of the patients (control group) or met with a patient navigator who would help them resolve their social needs through referrals to local resources (treatment). Gottlieb et al. (2016) find that, after 4 months following enrollment, the treatment significantly improved children's overall health status reported by caregivers. In a longer-term study following 12 months after enrollment, Pantell et al. (2020) find that children in the treatment group were less likely to be hospitalized after the treatment but equally likely to have an emergency department visit.

Overall, previous studies suggest that sound evaluation of the WC intervention is essential to ensure that we understand the causal effects of such SDOH interventions and understand its return on investment. A simple pre-post comparison will be vulnerable to mean reversion, resulting in the intervention appearing to have a higher return on investment than would truly occur if rolled out to a broader group. As such, we work to identify appropriate control groups that maximize sound evaluation possibilities and also stay cautious of the WC intervention's differences from prior interventions, which are discussed in the following section (relying on referrals rather than case management or direct support for patients' social needs), when interpreting the evaluation results.

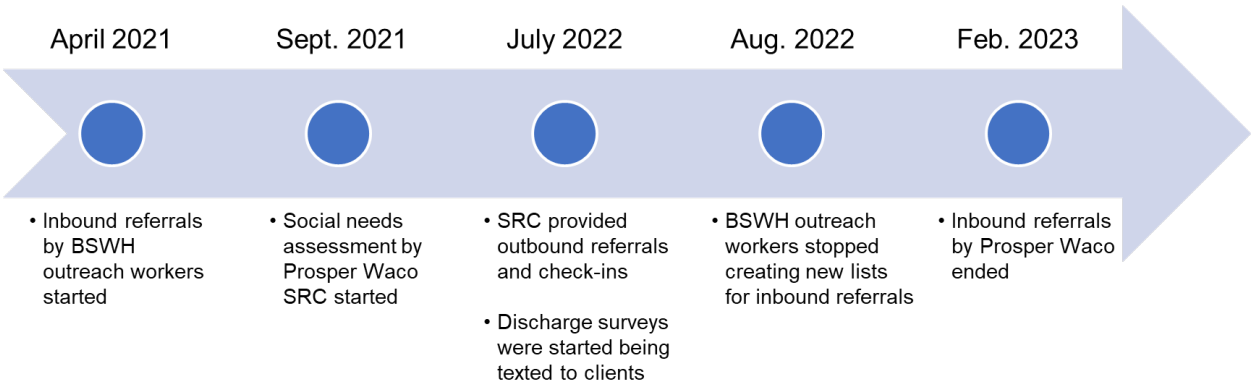
Waco Connect client referral and tracking procedures

In this section, we outline the client referral and tracking procedures of the WC project, sourced from internal reports and conversations with key personnel at Prosper Waco, including its social resource coordinators (SRC).

Inbound referrals to the WC project were made to families of Medicaid-enrolled children under the age of 19 at BSWH with a history of multiple emergency department visits, high utilization of medical services, potentially avoidable hospitalizations, and diagnosis of anxiety or depression. BSWH outreach workers would call and ask if families of the patients would like assistance. If the patients agreed, the SRCs at Prosper Waco would call to assess the participant's social needs

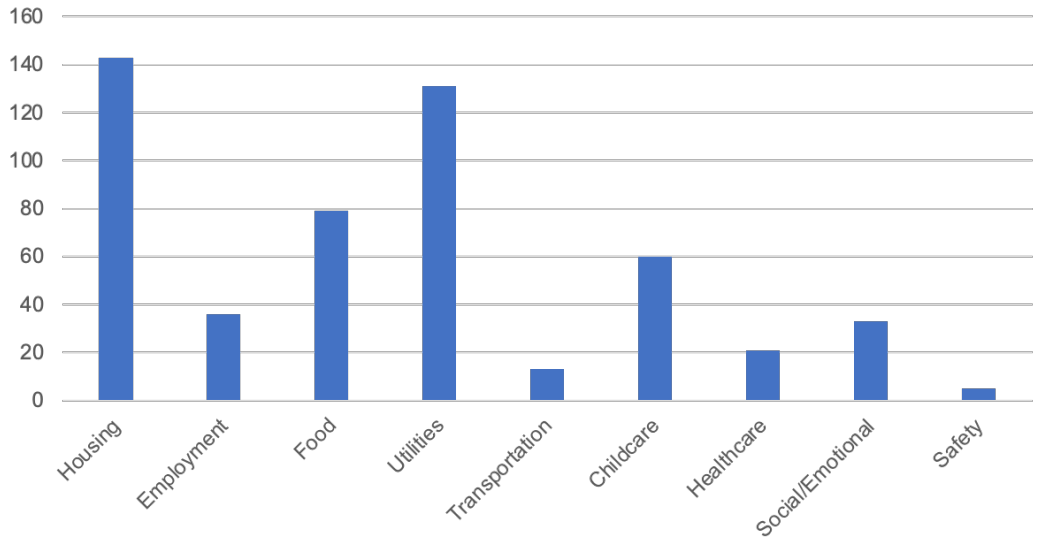
(see appendix for full screening assessment questionnaires) and follow up with links to safety net resources and programs that match individual needs ("outbound referrals"), as well as the generic link for resources (FindHelp.org). SRCs would follow up on enrolled clients and discharge those who no longer need assistance or could not be contacted after multiple attempts.

Figure 1. Timeline of WC project implementation



As a result, 311 inbound referrals were made by BSWH to Prosper Waco between April 2021 and February 2023, of which 291 clients resulted in successful contact and 232 clients had their social needs identified. Figure 2 shows the number of WC clients by their identified social needs. A majority of WC clients were in need of assistance with housing (143 clients) and utilities (131 clients), and other notable social needs included food (79 clients) and childcare (60 clients), followed by employment, social/emotional support, healthcare, and transportation. More than 730 outbound referrals to over 70 different agencies were made, and 100 clients reported in their follow-up that at least one of the social needs was met.

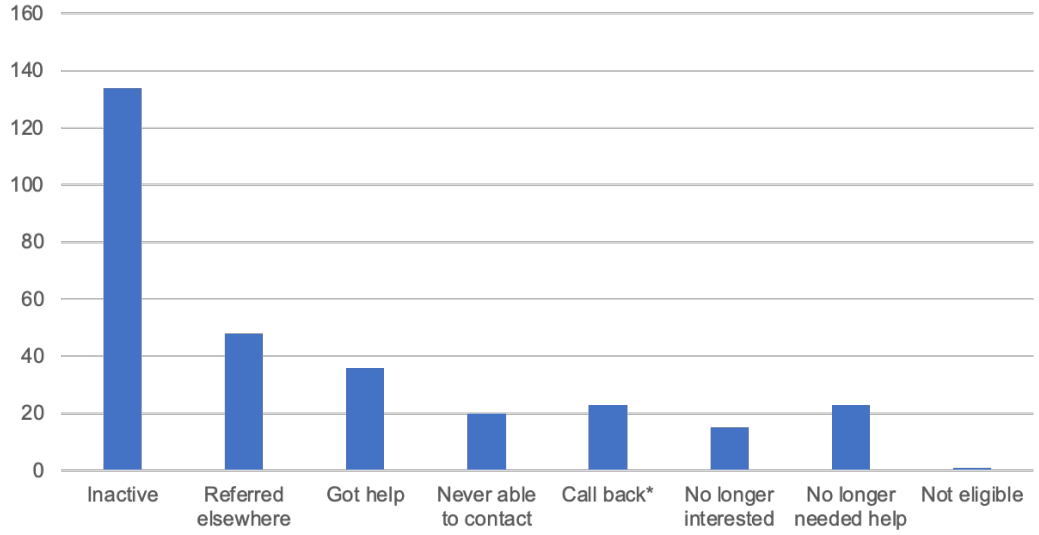
Figure 2. Number of WC clients by social needs



The WC project differentiates from other social care interventions by selecting clients from Medicaid-enrolled individuals, instead of being referred from other social service agencies. This process has the advantage of serving clients who are not familiar with reaching out for help or navigating social services. SRCs, in addition to outbound referrals to safety net resources, would provide regular check-ins. Many clients expressed appreciation for the regular check-ins and having someone to talk to, even if they did not require assistance at the time of the check-in.

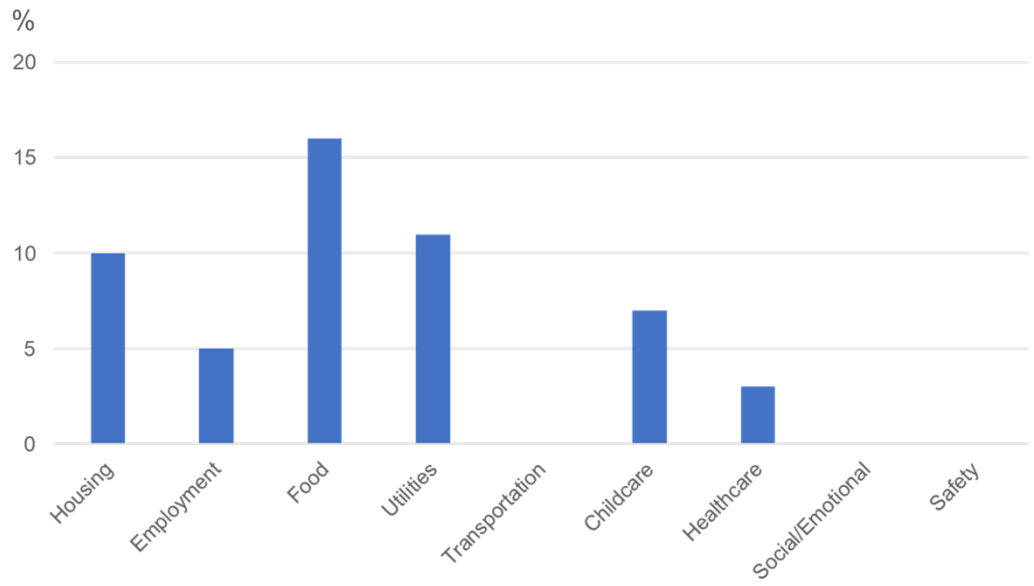
Despite the benefits, there were challenges presented in the client selection and referral processes. First, support was only provided through phone (including texting) with no face-to-face support. Limited client communication resulted in having SRCs never being able to contact 20 clients from the list of inbound referrals from BSWH, 134 clients who remained "inactive" where there was at least one contact with the client but were never able to complete the assessment due to five failed follow-up attempts by SRCs, and another 23 clients who repeatedly asked for a "call back" and resulted in five failed attempts to complete the assessment. These cases all resulted in a "discharge." Other reasons for discharge include being referred elsewhere, getting the help they need, no longer interested, and no longer needing help. All reasons for discharge and the number of WC clients for each reason are shown in Figure 3.

Figure 3. Number of WC clients by reason for discharge



Second, resources provided by SRCs were limited to referrals. For clients that may need immediate help, sending links for resources may not be enough. SRCs were not able to provide case management, such as helping clients fill out applications or helping them check application statuses. Despite the limitation, at least 43% of the clients had at least one of their social needs met during the intervention period. Broken down by the type of social needs, social needs for food were most likely to be met (16%), followed by utilities (11%) and housing (10%). These three categories are also the social needs that were most prevalent among WC clients at the beginning of the interventions.

Figure 4. Probability of having goals met by the type of social needs (%)



Note: The above bar graphs are based on a subset of WC clients with complete data on goals met (N=201).

Data and Methods

In order to understand the potential impact of the intervention, we evaluate fully de-identified data from BSWH on their Medicaid plan members, including their demographic information, as well as healthcare information on enrollment, chronic conditions, cost of care, and incidences of ED visits and in-patient hospitalization, provided to and analyzed by a trusted intermediary (Altarum). Both referral time and follow-up observation time varied by individual. We, therefore, selected as our main treated sample 258 inbound WC client referrals made since April 2021 that had complete data on their cost of care at least 3 months before and after their initial ED visit or in-patient hospitalization, which we term the "trigger visit". Of these 258 WC clients, 198 clients had at least one contact with the SRCs at Waco Prosper.

Table 1 column 1 shows the summary statistics of the WC referral group. Note that while program descriptions indicated that referrals would be children, this is not always true in the data; 33% were ages 0-5, 31% were 6-17, 16% were 18-24, 11% were 25-34, and 6% were 35-64. Most WC clients are racial minorities – around 33.7 percent are Black, and 22 percent are Hispanic. Approximately 34.5 percent are male. Most clients (82.9 percent) are from zip codes starting in 767, and the others are in either 765 or 766. Average cost of care per member per month (PMPM) is around $377, and more than half were classified as diagnosed (58.5 percent) with a psychological condition and/or depression.
Among WC clients, housing (39.1 percent) was the most common social need, followed by utilities (36 percent). In total, more than 700 outbound referrals to safety net resources are estimated to be made to these WC clients. Of the 258 WC clients in our data, 58 clients have completed at least one of their stated needs and goals.

Table 1. Summary statistics – WC referral group and control group with at least 3 months pre- and post-trigger visit

Variables	Treated	Controls
Age		
0-5	0.329	0.219
6-17	0.306	0.451
18-24	0.163	0.164
25-34	0.108	0.107
35-64	0.058	0.057
Race		
Black	0.337	0.221
Hispanic	0.220	0.312
White	0.224	0.263
Other/unknown	0.217	0.203
Gender		
Male	0.345	0.400
Zip code		
765	0.062	0.040
766	0.108	0.174
767	0.829	0.785
Healthcare data		
PMPM (pre-period)	$377	$375
PMPM ED visits (pre-period)	0.089	0.137
Chronic Condition Diagnoses		
Total Chronic Condition Count	1.520	1.270
Psychological Condition / Depression	0.585	0.433
Social needs		
Housing	0.391	
Employment	0.096	
Food	0.182	
Utilities	0.360	
Transportation	<0.050	
Childcare	0.170	
Healthcare	0.069	
Social & emotional	0.085	
Safety	<0.050	
N observations	258	12,504

Note: Social needs data based on a smaller subset of the sample (N=176).

The aim of our analysis is to construct a control group for WC referrals, who would have experienced similar medical outcomes before and after the "trigger visit" in the absence of WC

referrals. An important challenge is that participants selected for the project were experiencing particularly difficult periods and were selected on having recent high healthcare utilization. A simple before and after comparison will be vulnerable to mean reversion and may result in the intervention appearing to have a higher return on investment than would truly occur if rolled out to a broader group. Therefore, we conduct a matching process to identify appropriate control groups based on client demographic characteristics and pre-intervention medical records to maximize sound evaluation possibilities. We assess whether the WC project reduces the total cost of care associated with target patients, as well as the frequency of emergency department (ED) visits.

We created a potential control group from a pool of individuals on BSWH Medicaid Plan in McLennan County using a propensity score matching method. The BSWH Medicaid Plan had 12,504 individuals from McLennan County over the same period who are not a member of the WC project, with an average age of 13. We match WC referral group with these individuals based on their demographic characteristics (race/ethnicity, age, gender, and zip code), type of initial visit to the BSWH (whether ED visit or an in-patient hospitalization in pre-period), whether they had a previous diagnosis of psychological depression, and initial month of inbound referral. We match each Waco Connect client to the five nearest neighbors (and their ties) based on their characteristics.

Table 1 column 2 shows the summary statistics of individual characteristics of the control group. We further compare the characteristics of these matching criteria between the WC clients and the matched control group using a logit model to examine the differences between the treatment and control group (see Table 2). While there are statistically significant differences in race, age, and diagnosis for psychological depression between WC clients and the matched control group, the two groups are not statistically different in terms of the initial visit reason, as well as gender.

Table 2. Differences in WC referral group and potential control group

	WC treatment	
	(1)	(2)
Age 0-5	-0.760***	-0.504***
	(0.164)	(0.176)
Age 6-17	-0.867***	-1.000***
	(0.234)	(0.252)
Age 18-24	-0.116	-0.475*
	(0.217)	(0.243)
Age 25-34	0.138	-0.137
	(0.240)	(0.269)
Hispanic	-0.667***	-0.623***
	(0.174)	(0.182)
Race unknown/other	-0.449**	-0.466**
	(0.185)	(0.194)
White	-0.527***	-0.493***
	(0.179)	(0.188)
Male	-0.140	-0.191
	(0.144)	(0.153)
Zip code 766	-0.942***	-1.033***
	(0.318)	(0.333)
Zip code 767	-0.549**	-0.652**
	(0.269)	(0.284)
Pre-period ED visit		0.194
		(0.238)
No trigger visits		-0.548
		(0.318)
Psychological disorder		0.498***
		(0.146)
Call date		0.403***
		(0.027)
Pseudo R2	0.028	0.243
N observations	12,762	12,762

Notes: Standard errors are shown in parentheses (* 0.1>p, ** 0.05>p, *** 0.01>p).

Results: Propensity score matching

Conditional on observables, comprising information on patient demographic and medical characteristics, we compare the differences in cost of care before and after WC treatment. Based on the conditional probability of selection into treatment, i.e., propensity score, we match the

WC clients to a subset of patients under the BSWH Medicaid plan with recent medical records based on their observable characteristics.

Table 3. Treatment effects of WC referrals on *cost of care* – propensity score matching results

Sample:	Difference in *ln(payment per month)*		
	3 months pre- and post- (1)	6 months pre- and post- (2)	12 months pre- and post- (3)
Panel A: all WC enrolled			
WC referral	1.067**	-0.050	-0.278
	(0.457)	(0.630)	(1.023)
N observations	12,664	12,419	7,236
Panel B: only with initial WC contact			
WC referral	1.451***	0.740	0.224
	(0.186)	(0.755)	(0.912)
N observations	12,620	12,377	7,357

Notes: Standard errors are shown in parentheses (* 0.1>p, ** 0.05>p, *** 0.01>p).

We document the estimated effects of WC referral (treatment) on the cost of care in Table 3. WC clients with at least 3 months pre- and post-period visits find a statistically significant increase in their cost of care following WC referral intervention when compared to otherwise similar BSWH Medicaid patients who were not enrolled in the program. However, when expanding the time window to at least 6 months or 12 months of pre- and post-period visit records, we mostly find no significant differences in the cost of care, with some evidence of reduction in cost of care (although still not statistically significant). Note that the group with 12 months of pre- and post-period visits only include 30 WC clients in the analytic sample for the results in Panel A and 24 WC clients for the results in Panel B.

Table 4. Treatment effects of WC referrals on *ED visits* – propensity score matching results

Sample:	Difference in *ED visits*		
	3 months pre- and post- (1)	6 months pre- and post- (2)	12 months pre- and post- (3)
Panel A: all WC enrolled			
WC referral	-0.037	-0.041*	0.004
	(0.022)	(0.023)	(0.048)
N observations	12,715	12,419	7,534
Panel B: only with initial WC contact			
WC referral	-0.052***	-0.053***	0.021
	(0.008)	(0.008)	(0.057)
N observations	12,656	12,377	7,361

Notes: Standard errors are shown in parentheses (* 0.1>p, ** 0.05>p, *** 0.01>p).

Table 4 shows the estimated effects of WC referral (treatment) on the frequency of ED visits. We mostly find reductions in the number of ED visits following WC referral. For all WC enrolled clients in Panel A, we find a statistically significant reduction in the number of ED visits by 0.041 among members with 6 months pre- and post-period data. Based on an average of 0.089 pre-period ED visits among WC clients (see Table 1), the coefficient translates to a 46% decrease in the incidence of ED visits. Among WC clients with initial contact in Panel B, we find similar results for both members with 3 months and 6 months pre- and post-period data, with statistically significant reduction of ED visits of around 0.05. Overall, while there is some evidence of increased cost of care in the short-term, we find mostly no evidence of increased cost of care but decreased ED visits following WC referrals in the longer-term.

Conclusion

In this report, we evaluated the impact of the WC intervention that identified high-risk children experiencing mental health needs and provided them with referrals to a network of non-medical social care services and resources. We find that WC referrals did not result in reduced healthcare costs but found some evidence of potential reductions in the number of ED visits. Since ED visits were declining but overall costs were not, one possible explanation is increased resource use for management of chronic conditions or other types of care that might be more quality focused; we were unable to measure this directly. While the reduced numbers of ED visits following WC referrals are encouraging, a lack of evident impact on healthcare costs should not be interpreted as referrals not having positive impacts on individuals in other, unmeasured ways. More than 200 WC clients were referred to over 70 different agencies, with at least 100 of the clients meeting at least one of their identified social needs. In the process, SRCs received positive testimonials from clients who expressed appreciation for the regular check-ins and having someone to talk to, even if they did not require assistance at the time of the check-in.

Evaluation faced several limitations. First, our ability to interpret these results causally is limited to the extent that it relies on the assumption that our matched controls provide a credible counterfactual for the costs and utilization of the WC participants in the absence of the intervention. Evaluators did not have input into the design of the intervention; this ruled out gold standard evaluation methods for causal inference such as a randomized controlled trial. Given the ultimately small number of referrals, such a trial would have likely been underpowered but may have been more credible evidence interpretable as a pilot study. Second, our ability to define a credible control group was limited due to the structure of the data and selection into referral. Third, available follow-up was limited for some individuals, and in general the time to achieve a goal may be different depending on the timing of referral. If effects took longer than the measurement period to appear, we may be biasing results downward. Fourth, leadership and staffing changes at Prosper Waco occurred during this period and may have resulted in unmeasured changes in the interventions over time. Finally, our team was never granted access to the underlying healthcare utilization data from BSWH, instead obtaining statistical results through a trusted partner intermediary (Altarum), and the data was aggregated to the person-month level. For instance, access to granular patient-level data on the type of costs (e.g.,

prescription, outpatient expenses), as opposed to an aggregate payment per month, could allow evaluators to parse out the changes in healthcare cost. Such additional analyses could shed light on potential cost-savings related to the intervention.

Prosper Waco ceased participation in WC following the end of its contract with BSWH in 2023. The local Goodwill agreed to take on the role of performing referrals, which were open to all individuals in the community. At the time of reporting, discussions were ongoing between BSWH and Goodwill regarding referrals directly from the health plan. New state regulations through Texas HB 1575, which expands Medicaid reimbursement for social care for pregnant women, and HB 113 which requires inclusion of community health workers as quality improvement rather than administrative costs (allowing for higher reimbursement), show that ongoing understanding of the effects of different social care interventions is important for stakeholders in Texas.

We call for continued partnership between BSWH and nonprofit organizations to provide referrals to non-medical social resources, as well as continued evaluation efforts. The impact of current partnership and intervention would improve with more proactive case management beyond referrals, such as helping clients with filling out applications or checking application statuses for social care programs. The intervention would benefit from improved evaluation designs (e.g., randomized controlled trials that could ensure causal inference of the evaluation results). Finally, in order for social care interventions to be successfully implemented by private sector entities with cost and revenue pressures, such intervention will require adequate measures of its return on investment or should be otherwise subsidized.

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Appendix A: Initial/Update Screening Assessment

Waco Connect Staff _____ Date_____

Client Information

Member ID#_____ Date of Birth:_____
Name: _____
Primary Language: ☐ English ☐ Spanish ☐ Other
Gender: ☐ Female ☐ Male ☐ Other _____
Race: ☐Black ☐White ☐Asian ☐American Indian/Alaskan Native
☐Native Hawaiian or Pacific Islander
Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Guardian/LAR: _____ Relationship to Member: _____
Military Affiliation: ☐ Yes ☐ No
Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Phone _____ Email _____
Consent Text Message ☐ Yes ☐ No Email ☐ Yes ☐ No

Address_____
_____

Household Information

1. Including yourself, how many people currently live in your household? ____
2. How many adults? ____ How many children under the age of 18? ____
3. Do you or anyone in your household receive any government benefits?
   ☐SNAP ☐TANF ☐WIC ☐Disability ☐SSI ☐SSDI ☐Other
4. What is your household income? _____
5. Is anyone in your household receiving unemployment benefits?
   ☐Yes ☐No

HOUSING

1. What is your housing status today?
   ☐ Rents ☐ Owns ☐ Lives with family ☐ Lives with others ☐ Homeless

2. Are there any potential hazards within the home?
   ☐Yes ☐No

3. On a scale of 1-10, how worried are you about losing your current housing? (1=not worried at all, 10=very worried)

EMPLOYMENT

4. What is your current work situation?
   ☐Full time ☐Part time or temporary

☐Unemployed ☐Looking for employment

5. On a scale of 1-10, how satisfied are you with your current employment situation? (1=very unsatisfied, 10=very satisfied)

FOOD & UTILITIES

6. Currently, do you need assistance with any of the following?
   ☐Food ☐Clothing
   ☐Utilities ☐Phone/internet
   ☐Other_____

TRANSPORTATION

7. Do you currently have access to reliable transportation?

8. On a scale of 1-10, how satisfied are you with your current transportation situation? (1=very unsatisfied, 10=very satisfied)

CHILD CARE

9. Are you currently in need of child care assistance?
   ☐Yes ☐No

10. On a scale of 1-10, how satisfied are you with your current childcare situation? (1=very unsatisfied, 10=very satisfied)

MENTAL HEALTH

11. How often have you felt down, depressed, or hopeless in the last 30 days? (1=not at all, 10=very often)

12. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. On a scale of 1-10, how stressed have you felt over the last 30 days? (1=not stressed at all, 10=very stressed)

13. Do you or anyone in your household want or need to see a mental health professional?
    ☐Yes ☐No

HEALTH CARE

14. Are you and your household members able to go to the doctor when needed?
    ☐Yes ☐No

15. Do you and the members of your household have health care coverage or assistance with medical care costs?
    ☐Yes ☐No

SAFETY

16. Do you have any concerns for your, or other family members of your household's safety?
    ☐Yes ☐No

17. In the past year, how often have you been physically harmed, verbally insulted or threatened by or been afraid of someone close to you?
    ☐Frequently ☐Sometimes ☐Once ☐Never

18. Please tell us more about any other needs or concerns that we can help you with today
    _____
    _____
    _____

19. Do you give verbal consent for Waco Connect to share your information in order to make referrals to community agencies on your behalf?
    ☐Yes ☐No

Pre-intervention Questions:

1. On a scale from 1-10, 1 being not confident at all & 10 being very confident, how confident do you feel in your ability to meet the needs of your household at this time?

2. On a scale from 1-1-0, 1 being not confident at all & 10 being very confident, how confident do you feel in your knowledge of resources and your ability to access them when needed?

Appendix B: detailed timeline of WC implementation

April 2021 Inbound referrals by BSWH outreach workers started.
Sept. 2021 Social needs assessment by SRC started on 9/16.
Oct. 2021 Questions on housing and healthcare added (10/11)
Nov. 2021 Assessment questions shortened, and updates finalized (11/29)
Feb. 2022 No calls were made for two weeks in February 2022.
April 2022 Option for "call back" made for clients who did not complete intakes but asked to be called back (4/28).
July 2022 Discharge surveys that clients could fill out were texted; SRC provides general social support and check-ins.
Aug. 2022 BSWH outreach workers stopped creating new list for inbound referrals.
Oct. 2022 SRC transition (key personnel left) on 10/31.

Appendix C

Table A.1. Share of referrals by goal category

	Goals from final report	Goals from Natalie's data	Goals met from Natalie's data
housing	0.61	0.57	0.10
employment	0.15	0.15	0.05
food	0.34	0.30	0.16
utilities	0.56	0.54	0.11
transportation	0.05	0.05	0.00
child care	0.25	0.26	0.07
healthcare	0.09	0.10	0.03
social & emotional	0.14	0.12	0.00
safety	0.02	0.02	0.00
N	232	201	201