

2022

STRONGER

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Sept. 19–21, 2022

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**Regional One  
Health**

# **One Health: Building a New Ecosystem of Care for the Uninsured**

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Chief Integration Officer, Senior Vice President

**Megan Williams, MSN, RN, CNL**

Director, Complex Care

Regional One Health

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# Learning Objectives

- Identify two benefits of team-based screening of patients for social risk factors
- Describe how to utilize social risk data to engage community partners in community care planning



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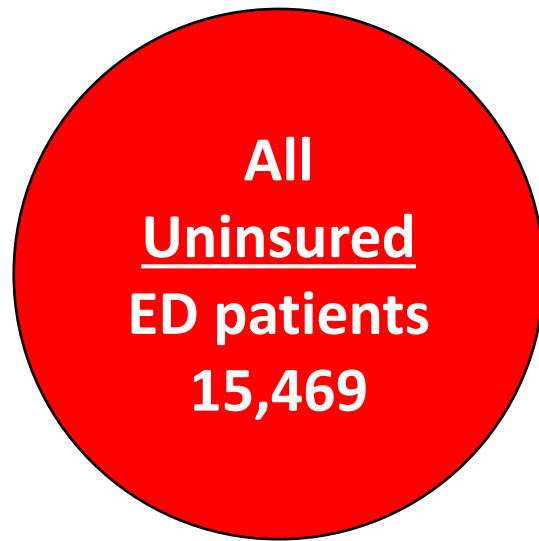
# Regional One Health

- Oldest Hospital in the state
- Serves as the safety net or essential hospital for a multistate region
- Not a Medicaid expansion state
- Uninsured as a percent of gross charges 30%
- Medicaid as primary payer (27%)
- Requires new way of thinking:
  - Uninsured as our largest capitated population

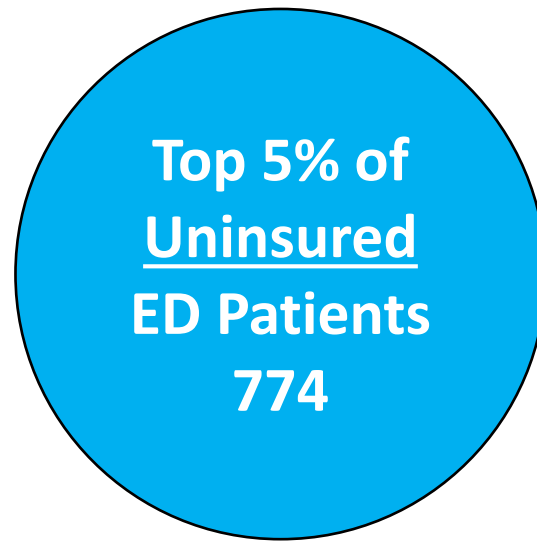


# Total Cost of Care

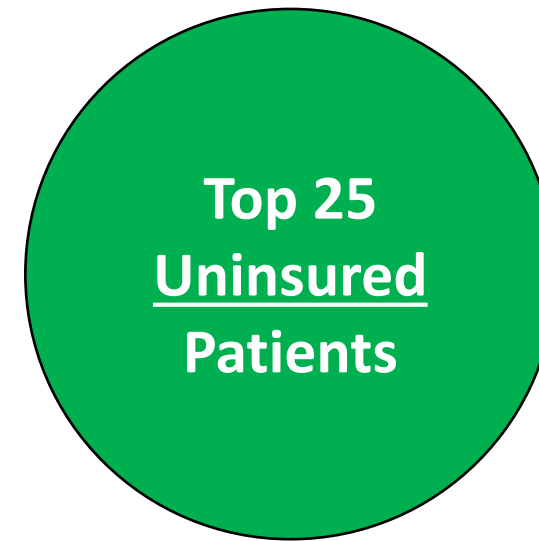
## All Uninsured Patients Utilizing Medicine Emergency Department



**\$35,410,908**



**\$20,228,920**

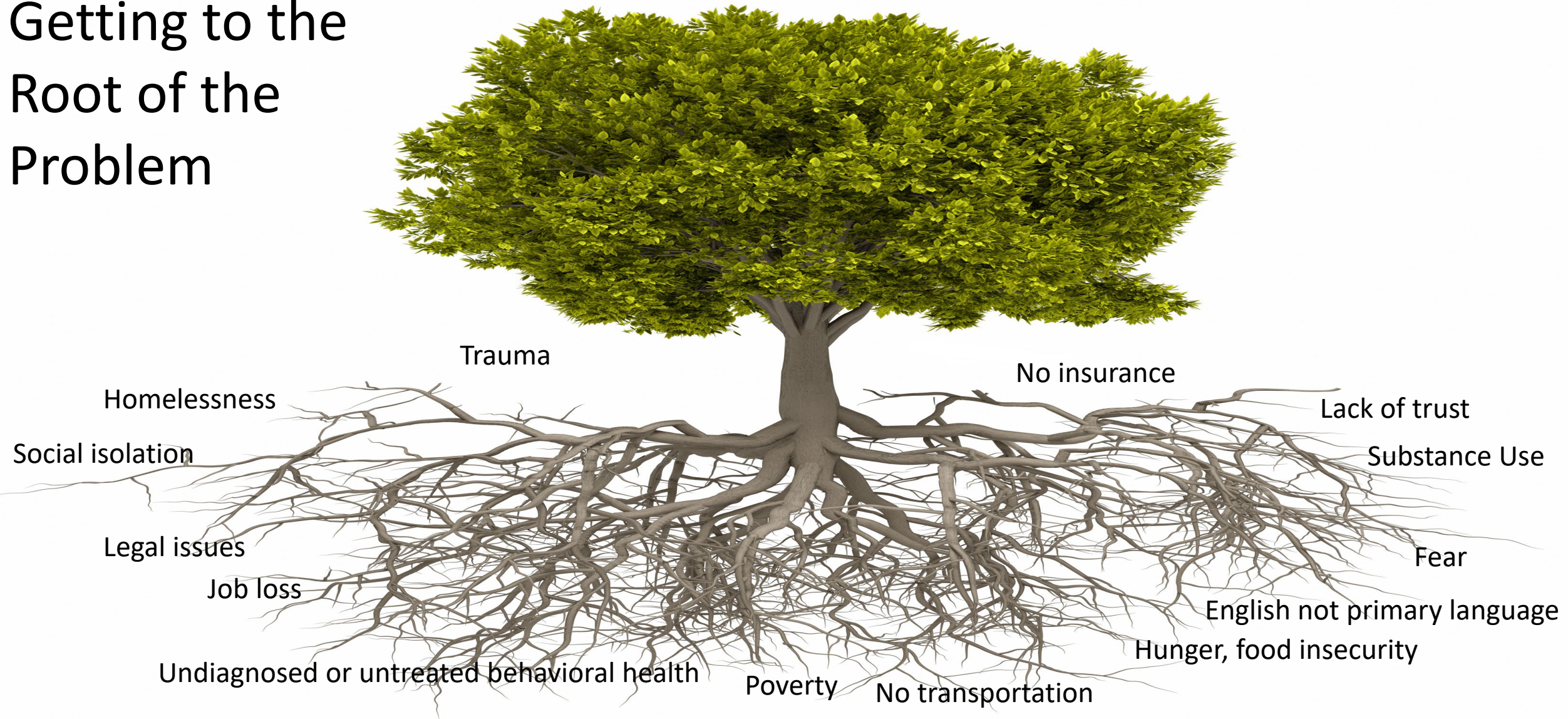


**\$4,012,605**

\*18-month lookback



# Getting to the Root of the Problem







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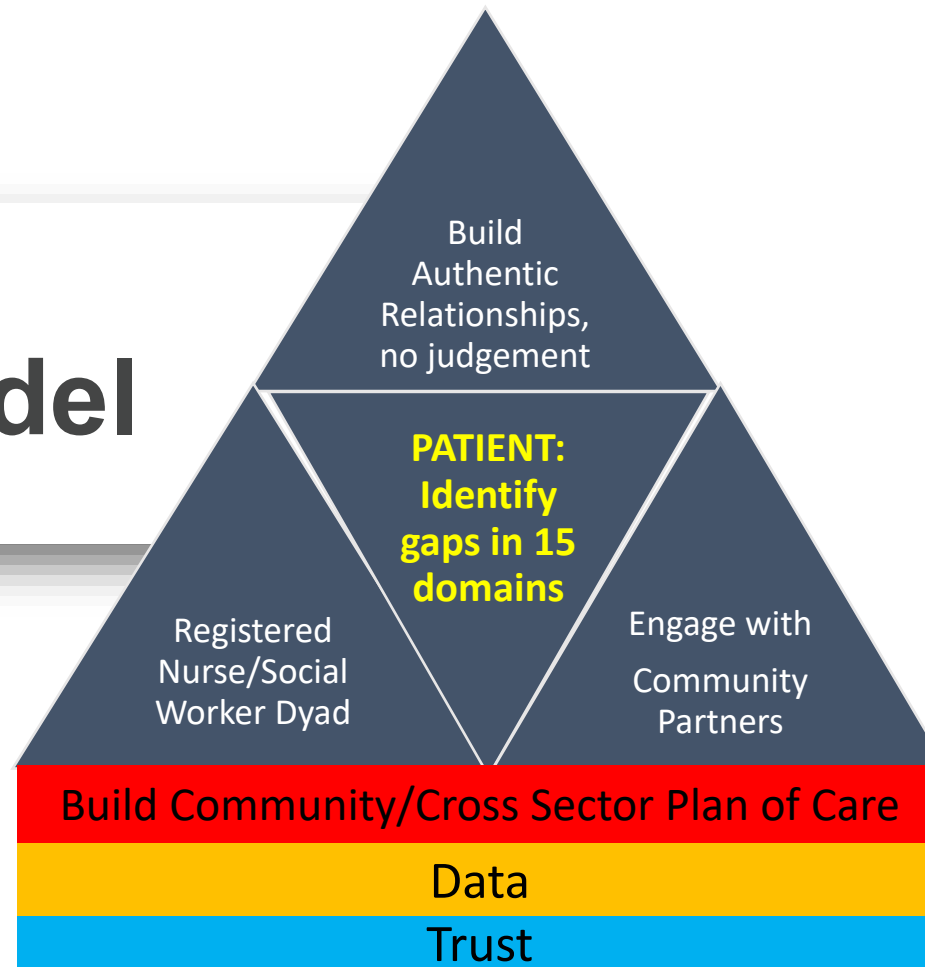
# Vision and Goals for One Health

- Vision:
  - Every Memphian Deserves Great Health
- Goals:
  - To improve the health of our uninsured, medically and social complex patients
  - To bend the financial cost curve for this population

# Creating a New Ecosystem of Care

- Data Analysis
- Community Asset Mapping
  - Create a common vision and sense of urgency
  - Strategic conversations
  - Learn what success looks like from partners view
  - Let the experts be the experts
  - Relationships take time, don't rush
- Clinical and Community Plans of Care

# The One Health Model



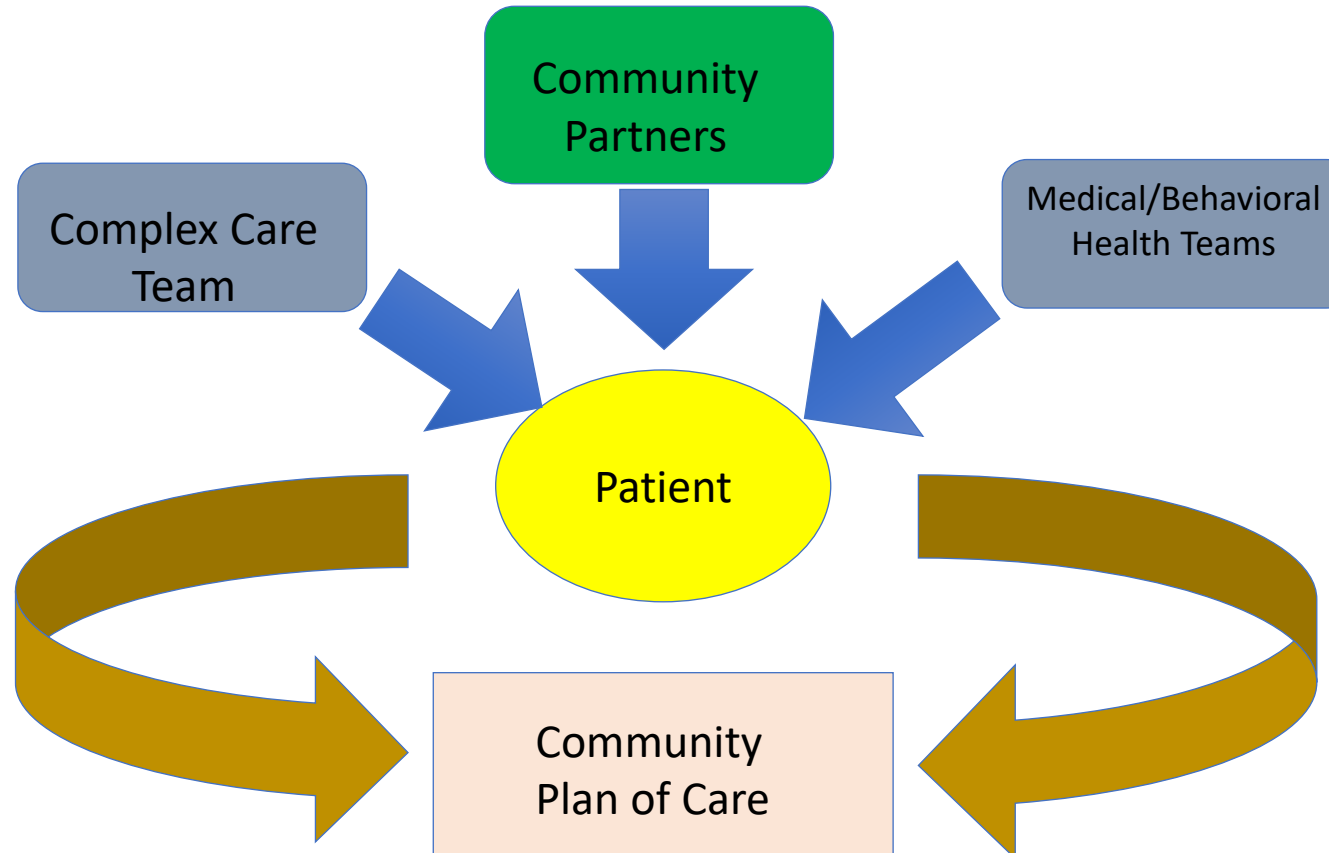
# Finding a Common Language:

Health related social needs screening tool

Domain	Scale
Income	1 = In Crisis
Employment	
Housing	
Food	2 = Vulnerable
Childcare	
Children's Education	
Adult Education	3 = Safe
Legal	
Health Care	
Life Skills	4 = Building Capacity
Mental Health	
Substance Abuse	
Family Relations	5 = Empowered
Mobility	
Community Involvement	



# Community Collaboration



# Outcome Data



15,276 prescriptions filled



180 individuals served medically tailored home delivered meals



360 obtained insurance benefits



82.4% of individuals with open behavioral health domain connected to services



7,043 rides provided



113 Jobs secured



100% connected to primary care home

# Finance and Utilization Metrics



Reduced inpatient admissions by 50%



Reduced inpatient acute care length of stay by 64%



Reduced emergency department visits by 34% (\*includes 2 years of Covid-19 data)



Reduced total cost of care by 51%

# Lessons Learned

- Meet people where they are without judgement
- Seek to understand the lived experiences of the enrollees
- Be patient, it takes time to build trust and relationships
- Create a common vision and sense of urgency
- Let the experts be the expert in their domains
- Build the value case

# Key Takeaways

- You must build authentic relationships not only with the individuals you serve, but also with your community partners
- Data is everything, it tells success, failures, and gives a roadmap for improvements
- There is no one size fits all approach
- The model can be used agnostic of payer and in all settings
- Change your conversation on return on investment





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# Questions?



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