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# Transformative Healthcare Delivery: Health Systems Addressing Social Needs

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# Learning Objectives

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- Identify opportunities to integrate health-related social need interventions into health systems.

- Discuss the value of collaborative partnerships between healthcare providers and social service agencies in fostering a holistic and community-centric approach to care delivery.

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# Breaking Barriers: Health-System Integrated Childcare to Improve Access to Care

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# Childcare Needs

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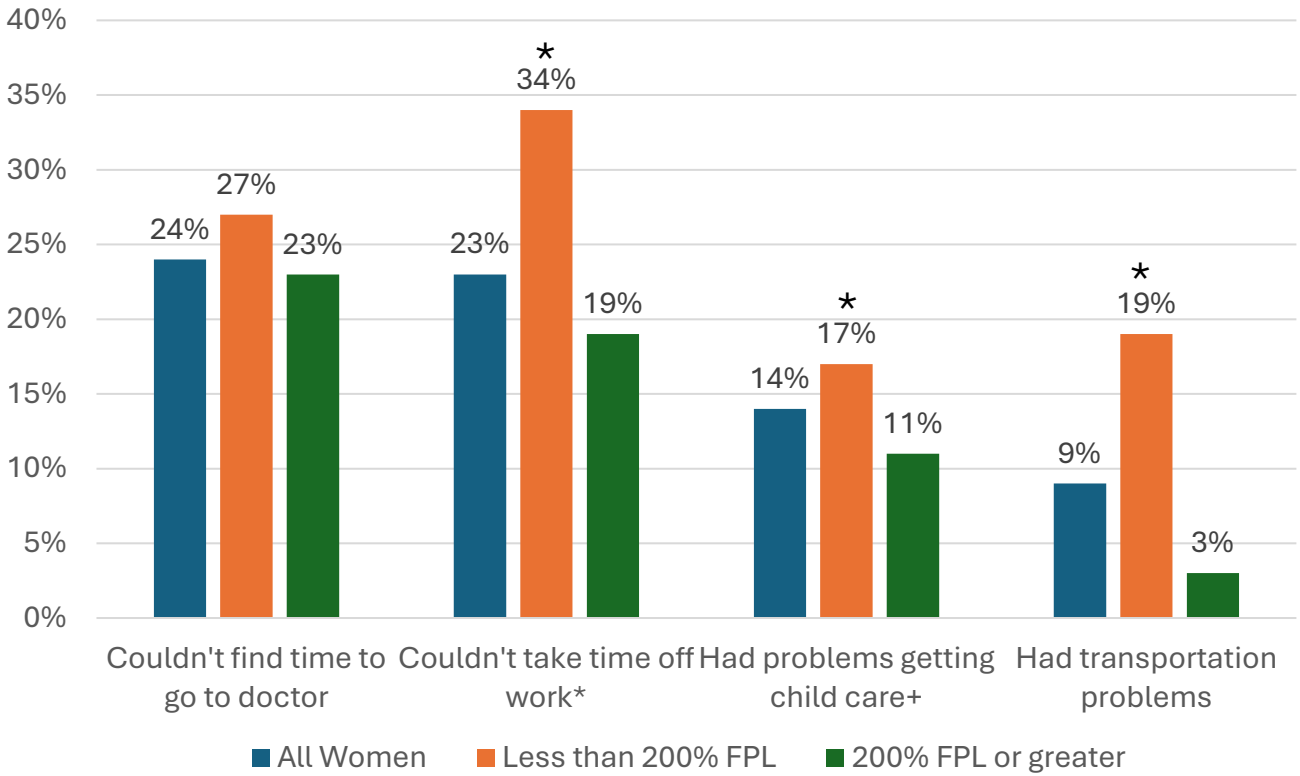
**Logistical problems such as time and transportation pose barriers to care, particularly for low-income women**

Share of women reporting they delayed or went without care in past 12 months because:

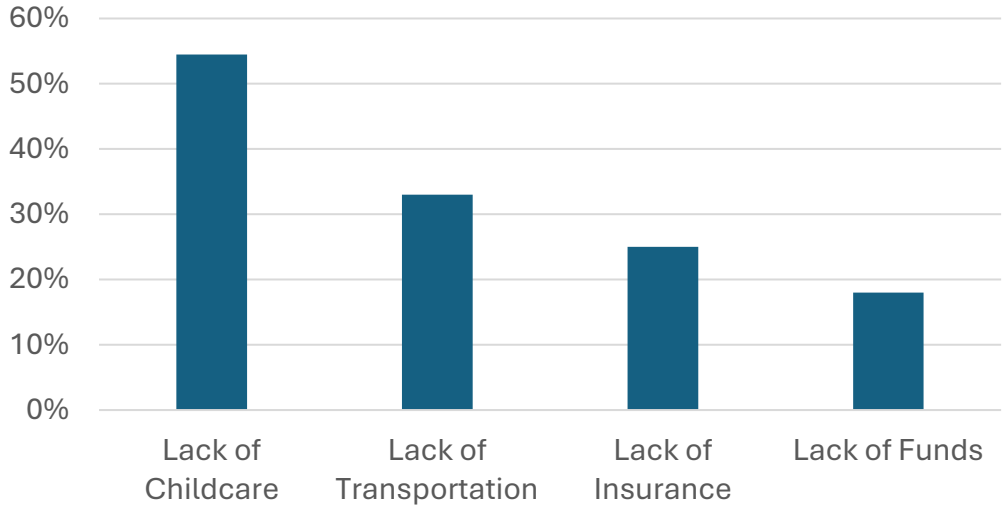



NOTE: Among women ages 18-64. +Among women employed full- or part-time. +Among women with children. The Federal Poverty Level (FPL) was $20,420 for a family of three in 2017. *Indicates a statistically significant difference from 200% FPL or greater; p<.05.
SOURCE: Kaiser Family Foundation, *2017 Kaiser Women's Health Survey.*

https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/

**336 women**
36% delayed/missed
avg 3.7 appts/yr

Reasons for Delayed/Missed Appointments (N=121)




Gaur, P., Ganguly, A.P., Kuo, M. *et al.* Childcare needs as a barrier to healthcare among women in a safety-net health system. *BMC Public Health* 24, 1608 (2024). https://doi.org/10.1186/s12889-024-19125-1

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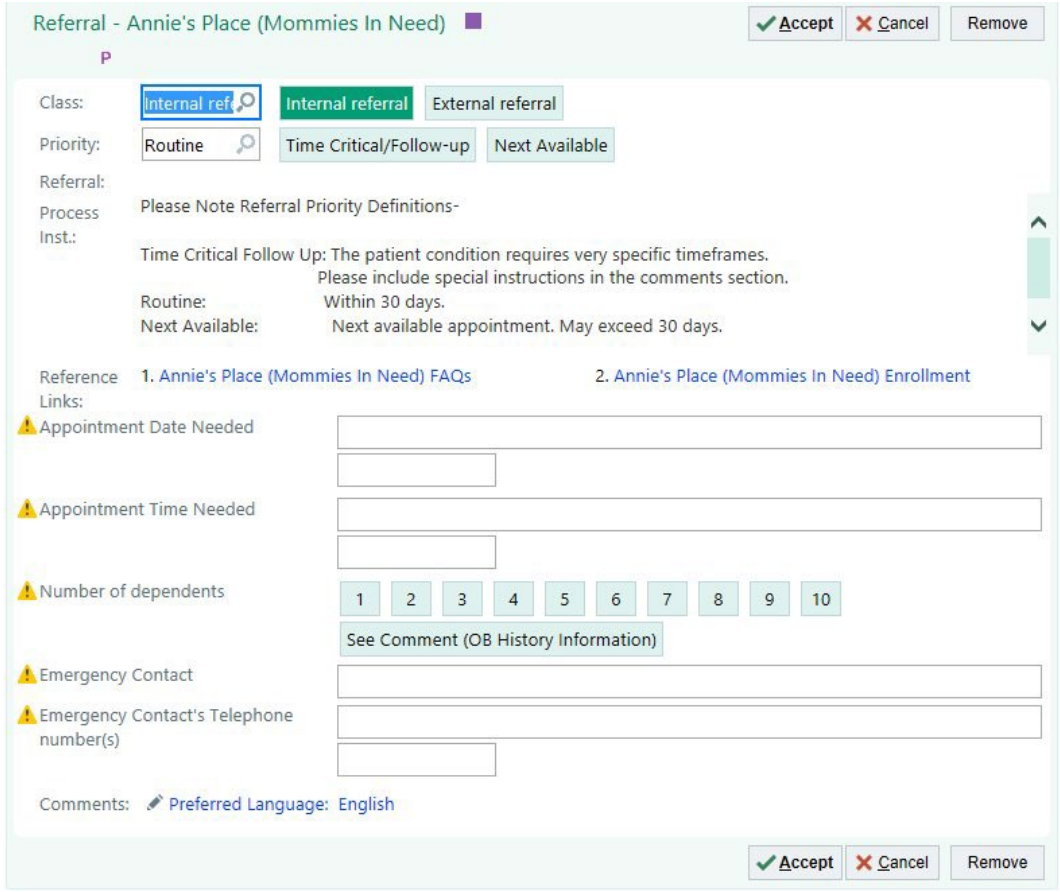
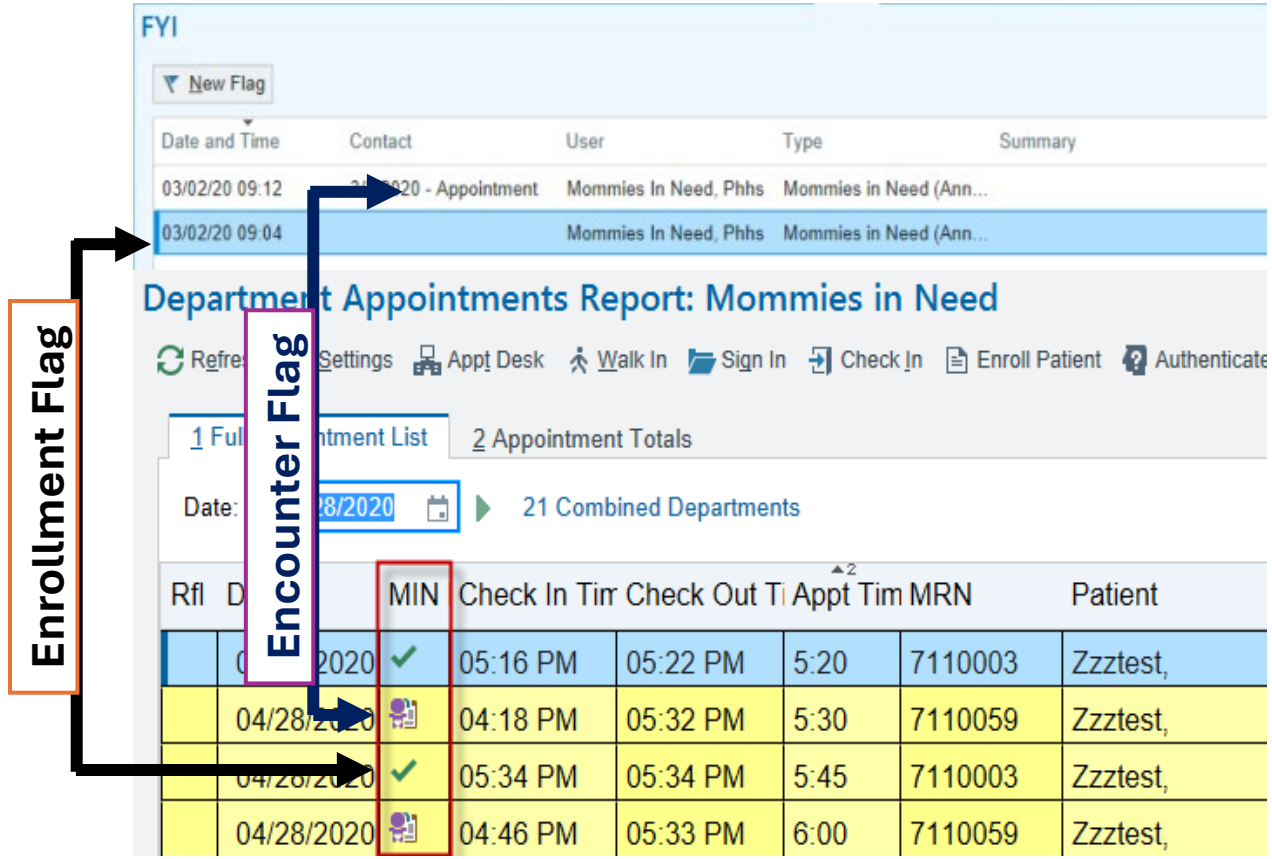
# Community Based Organization Partnerships

# Electronic Medical Record Integration




Alvarez KS, Bhavan K, Mathew S, *et al* Addressing childcare as a barrier to healthcare access through community partnerships in a large public health system. *BMJ Open Quality* 2022;**11:**e001964. doi: 10.1136/bmjoq-2022-001964

# Data Sharing

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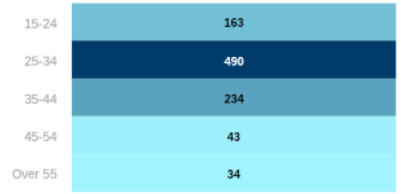
**Patient FYI Enrollment Flag Cumulative Volume**

964

**Age at Enrollment**




**Patient Average Age at Initial Enrollment**

32.38

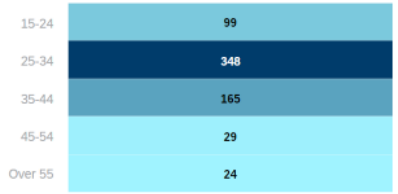
**Current Enrollments**

1 Filter

665

**Age at Most Recent FYI Flag**

1 Filter

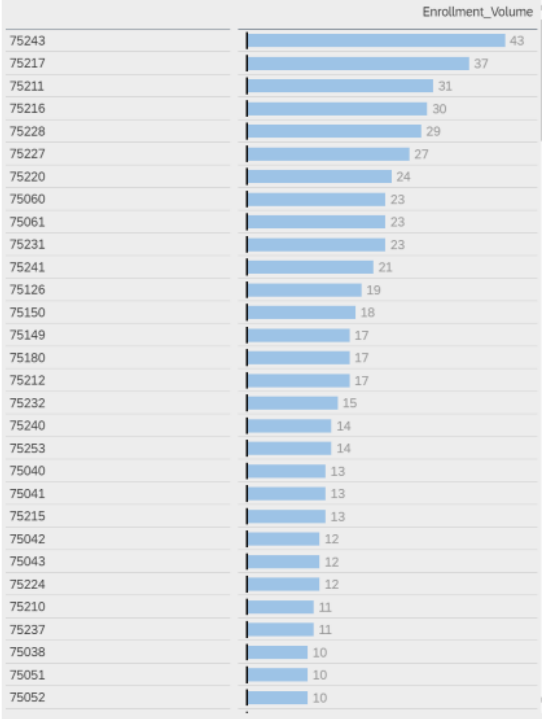



**Patient Average Age at Last FYI Flag**

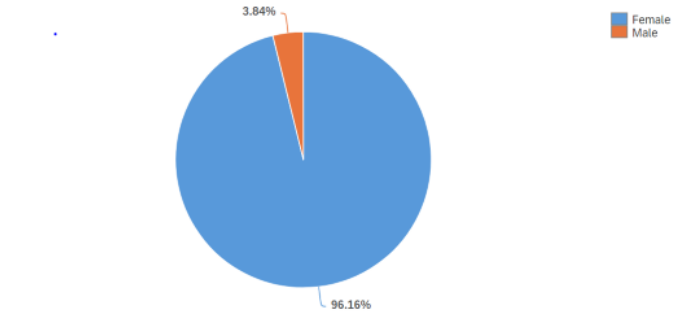
1 Filter

32.75

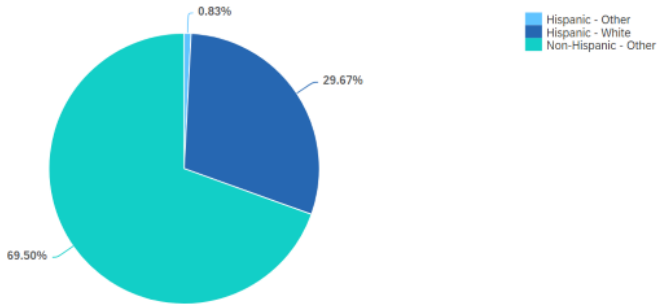
**All Cumulative Enrollments by Zip Code**




**Patients by Gender**




**Patients by Ethnicity/Race**




**Enrollments w/ any FYI Appt Flag %**

1 Filter

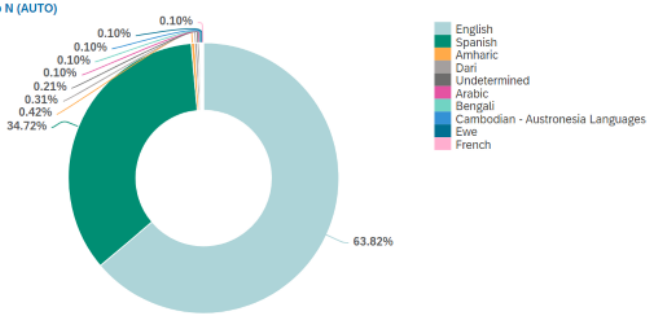
82.8%

**FYI Appt Flag Volume**

5,623

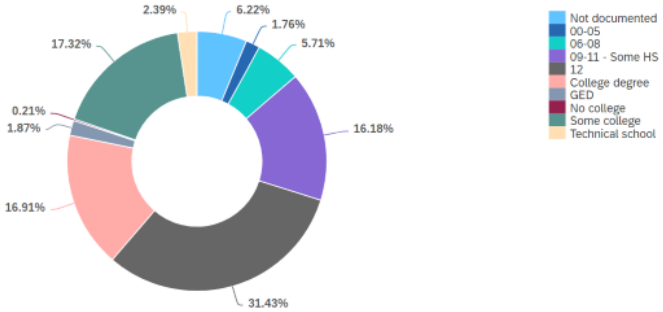
**Patients by Primary Language**

Top N (AUTO)




**Patients by Education Level**

Top 20 - Edu Level




| | |
|---|---|
| With Encounter | 4,299 |
| Without Encounter | 1,324 |

**# of Children Cared For**

5,336

**Avg Age of Children**

3.28

# Lessons Learned

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- Clearly define what measurements will be used to prove efficacy
- Early real-time data crucial for community partners to continue to self-fund
- Trust partnering community-based organization to be the experts in the social need being addressed

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# Key Takeaways

- Leverage community partner relationships for socially-driven access needs
- Build platforms where data is shared bi-directionally and equitably
- Share responsibility in screening for multi-level social needs

Ganguly, A.P., Alvarez, K.S., Mathew, S.R. *et al.* Intersecting social determinants of health among patients with childcare needs: a cross-sectional analysis of social vulnerability. *BMC Public Health* **24**, 639 (2024). https://doi.org/10.1186/s12889-024-18168-8

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# Reducing Emergency Department Overuse Among Patients Experiencing Homelessness: A Hospital-Community Collaboration

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# Background Information

- Everyone has a right to life, hope, dignity and respect
- Homelessness is a major public health crisis (APHA, 2017)
- Since 2011, Emergency Department (ED) utilization increased 80% by homeless individuals; three times the US norm (Franco et al., 2021)
- High rates of ED overutilization strain healthcare systems and lead to overcrowding (APHA, 2017)
- Frequent ED users are classified as “frequent users” (≥4 visits/year) or “super users (≥20 visits/year) (Franco et al., 2021)
- Parkland defines high ED utilizers as individuals using ED services 6 or more visits in a 30-day period.

# Background Information – Getting Started

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| Parkland Health High Utilizer Data - February 2021 Demographics<br>Total = 76 High Utilizer Patients |
|---|

| Homeless | Gender | Ages 50-59 |
|---|---|---|
| 60% | 81% Male | 37% |

| Medical Condition | Mental Health Diagnosis | Substance Use |
|---|---|---|
| Multiple | 65% | 68% |

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# A Hospital-Community Collaborative

Program:

- Provides critical interventions and care management services to individuals with high ED utilization in partnership with an emergency homeless shelter

Services/Goal:

- Provide 24/7 shelter with semi-private sleeping quarters
- Crisis stabilization, housing navigation & placement, individual and group counseling, job readiness and placement, financial education, and life skills classes
- Connection to medical, mental health, and substance abuse services onsite
- Connection to onsite partners for employment, legal aid, Supplemental Nutrition Assistance Program, Supplemental Security Income

Discharge Goals:

- Client is no longer a high utilizer of the ED (less than 6 ED visits in a 30-day period), and
- Client has secured stable housing

Tools:

- Daily ED utilization reports, high utilizer committee (interdepartmental), complex case flags in the EMR, psychosocial assessments, patient-centered care plans, ED interdisciplinary team conferences, treatment centers, individual/group therapy, recreational activities, job readiness classes, Housing First Model

Team:

- Providers, Registered Nurses, Licensed Clinical Social Workers, Program Managers, Shelter Crisis Managers, Case Managers, Case Aides

# Program Impact

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| May 1, 2022- June 30, 2024<br>New Clients Enrolled = 162 | | | |
|---|---|---|---|
| **Metric** | **Visits** | **Cost** | **Reduction %** |
| ED Visits One Year Before Program Enrollment | 5,863 | $11,726,000 | |
| ED Visits While Enrolled In Program | 1,009 | $2,018,000 | 83% |
| ED Visits One Year After Discharged From Program | 2,056 | $4,112,000 | 65% |
| Hospital Savings (does not include cost of program) | 2,789 | $5,596,000 | |
| **Total Savings** (annual program cost is $758,983) | | **$4,078,034 (2-year savings)** | |

**Note:**
ED cost calculations based on $2000 per ED visit

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# Lessons Learned

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- Conduct a Needs Assessment (assess for frequent ED visits)
- Develop a high utilizer program
- Secure executive support and program funding
- Identify a homeless shelter partner
- Negotiate a contract
- Hire and train staff
- Enroll clients
- Create, implement, evaluate, and re-evaluate the program

# Key Takeaways

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- It’s Not a Race, It’s a Journey!
- Accept that the work begins with YOU
- Remain open to new ideas and uncommon approaches
- Understand past failures without repeating them
- Be prepared
- Understand the value of your community stakeholders
- Be relentless and supportive
- Celebrate your success

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# References

American Public Health Association. (2017, November 07). *Housing and homelessness as a public health issue*. American Public Health Association - For science. For action. For health. https://apha.org/policies-Aand-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-and-homelessness-as-a-public-health-issue#:~:text=Ending%20homelessness%20is%20a%20public,or%20comply%20with%20prescribed%20medications. Accessed July 26, 2024.

Falvey, A. (2024, January 3). *52 hospitals with the most Ed visits in 2022*. Becker's Hospital Review. https://www.beckershospitalreview.com/rankings-and-ratings/hospitals-with-the-most-ed-visits-in-2022.html. Accessed July 26, 2024.

Franco, A., Meldrum, J., & Ngaruiya, C. (2021, May 5). *Identifying homeless population needs in the emergency department using community-based participatory research - BMC Health Services Research*. BioMed Central. https://doi.org/10.1186/s12913-021-06426-z. Accessed July 26, 2024.

# Questions?

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