Addressing Social Determinants of Health in the Emergency Department: Strategies from the Front Porch of the Medical Community

Nicholas Gavin, MD[1], Jason Hyde, LMSW, M.Ed., C-ASWCM[2], Richard Akobi RN, BSN, PCC, MBA[2], James Carroll, MPA[2], Anne Meara, RN, MBA[2]
[1]Ronald O. Perelman Department of Emergency Medicine, NYU School of Medicine, [2]NYU Langone Health

INTRODUCTION

In 2014 New York State launched the Delivery System Reform Incentive Payment Program. Goals include improving Medicaid healthcare outcomes by reducing avoidable hospital use by 25% over 5 years (1). Care Coordination program are being used to help achieve these outcomes by addressing Social Determinants of Health (SDOH). NYULH's Patient Navigation Center (PNC) has created a care coordination program using Community Health Workers (CHWs) to help achieve these goals.

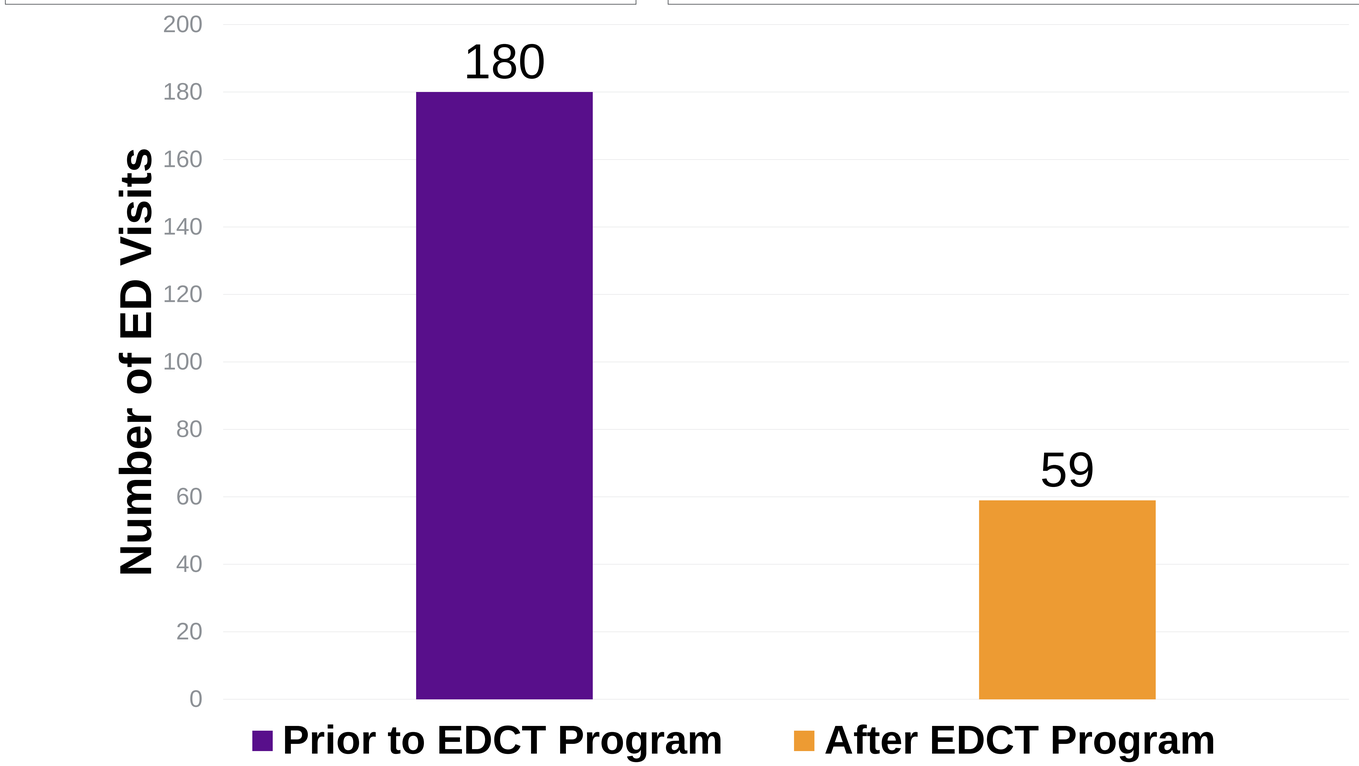
PURPOSE

To improve health outcomes of high risk patients by providing 30 day transitional support from the Brooklyn Emergency Room to community. Emphasis is placed on identifying both medical and psychosocial drivers of utilization and connecting patients to appropriate community-based services

METHOD

The NYULH Patient Navigation Center (PNC) has deployed an evidenced based CHW program (2) with the following key components:

- Patient Identification: EPIC registry that flags high-risk patients in the ED.
- Engagement: Outreach to these patients in the ED for enrollment.
- Assessment: Screen to identify SDOH that impact patient's wellbeing.
- Care Plan & Care Coordination: Create goals prioritized by patient to address during 30-day transition period. Support provided remotely and in-person in the community.
- Closure: Outcomes documented and warm handoff to the next level of care when needed.



RESULTS

Top 5 High Risk Identification Criteria of Engaged Patients through September 2018

Problem List: Mental Health	235
Chief Complaint: Medication Refill	230
3 or more Hospital Visits in Past 6 Months	179
Chief Complaint: Depression	92
Chief Complaint: Asthma	82

Top 5 Social Determinants Identified* of Engaged Patients through September 2018

Unstable Housing	153
Food Insecurity	142
Transportation	107
Isolation	62
Unemployment	38

Top 5 Goals Selected by Patients (Completed/Identified) through September 2018**

Acquired Medical Care	337/468	72%
Acquired Transportation	171/228	75%
Acquired Housing Services	123/187	65%
Acquired Food Support	123/161	76%
Acquired Financial/Benefits	121/179	67%

CONCLUSIONS

Early analysis shows intervention may reduce ED utilization by two-thirds (180 visits pre/59 visits post, N=53). The intervention was randomized in March of 2018 and the team is working on analyzing impact at three months, six months, and one year post-intervention.

REFERENCES

1. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm
2. http://chw.upenn.edu/about/

Contact: Nicholas.gavin@nyulangone.org