CASE STUDY

Building Bridges to Improve Patient Outcomes for Vulnerable Populations

Providence **reduced ED utilization 41%** by coordinating care for SDOH patients with organizations in the community.

"We hold regular multidisciplinary team meetings to collaborate on writing care plans for our patients. But many of these patients are going to multiple hospitals, so being able to communicate plans across almost every hospital system in our area with Collective has been invaluable in our work to bring in the community."

- **Becky Wilkinson,**
MSW, CSWA, and Outreach Program Supervisor for the BOB program, Providence Health

Providence Health

Providence Health (Providence) is a health system that serves patients throughout Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. With 50 hospitals, 829 clinics, and a small army of locally-driven programs, it works across traditional provider silos to achieve a higher and more holistic approach to caring for the nation's most vulnerable patient populations.

The Challenge: Navigating Social Determinants of Health

The physicians and staff in Providence emergency departments (EDs) were seeing an unusually high rate of patients with frequent patterns of utilization—or patients visiting the ED at least six times in six months, or 20 visits in 12 months. Knowing that many of these patients had needs that extended beyond the walls of the ED, they began looking at ways to involve others in the care of these patients.

Providence started by collaborating with other healthcare providers, including primary care, behavioral health, and specialty providers through Collective Medical's ADT-based care collaboration platform. With the platform, staff could quickly view and communicate patient needs—including existing conditions, comorbid behaviors, patterns of SUD, safety concerns, and other key information. But soon they realized that to really help these patients—especially those with behavioral health conditions—they needed to look past traditional patient histories and begin focusing on other factors impacting patient health. They needed to look into social determinants of health (SDOH).

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Becky Wilkinson, MSW, CSWA, and Outreach Program Supervisor for the BOB program explains:

"We started looking at our more vulnerable populations, and asked ourselves how we could help these patients who were coming in over and over who we couldn't do much for while they were here. We could treat their immediate needs, but the things we saw as emergency care providers were really only a snapshot of the patient's situation. We needed help addressing their health and behavioral health needs in the community once they left the hospital doors."

To help facilitate community-centered care, Providence launched the Better Outcomes [thru] Bridges, or BOB, program in its Oregon locations. Unlike other collaborative care initiatives, BOB focused on the importance of involving key community members in the care of behavioral health patients with SDOH.

The Solution: Building Bridges for Better Outcomes

With the BOB program, ED physicians met with case managers, behavioral health specialists, primary care providers, and members of churches and other community leaders to discuss the needs of these individuals frequenting the ED. Together, they identified solutions both inside and out of the traditional healthcare spectrum to ensure that patients were not only provided with the behavioral health treatment they needed, but the steady support required for lasting health.

Each plan was logged as a care guideline within the Collective platform, enabling physicians and staff to quickly identify patients affected by SDOH and contact the assigned case manager to connect these patients with appropriate help once they were discharged from the hospital. Outreach specialists and peer support outreach specialists could then contact community organizations to work on securing housing, mental health support, and employment for these patients.

Helping the Homeless

With homeless populations accounting for approximately 18 percent[1] of ED visits in urban areas, leaders of the BOB program knew that little long-term progress could be made for SDOH patients without a way to help address the homeless. Their solution? A combination of efforts with local churches to provide shelter for these individuals until more permanent housing could be obtained.

Those organizations willing to partner with Providence agreed to dedicate a certain amount of property to temporary housing. Some organizations were able to install tiny homes as transitional housing for these individuals, while others allowed a set area of the parking lot to be used for car camping and provided access to running water and bathrooms.

A percentage of these resources are set aside for patients participating in the Providence BOB program, helping ensure outreach specialists have a way to place their patients. In return, Providence providers agree to help monitor and assist all residents in these camps or tiny homes—regardless of their regular provider or participation in the BOB program.

Providing appropriate housing for these patients has been huge. An elderly woman living on the street with her daughter frequented the ED an average of 65 times a year before getting help through the BOB program. Once enrolled, an outreach specialist helped her find shelter as well as needed mental health care. Since then, the woman has not needed to return to the ED.

The BOB program connects patients with a number of different resources to help address various SDOH. Housing partnerships with local churches provide temporary sites for homeless populations. Peer support programs give those who have been through the BOB program an opportunity to help others navigate challenges like finding a job, sobriety following substance use disorder, or various mental and behavioral health challenges. In addition, BOB is piloting a program that works with high-risk youth from families affected by SDOH to help ensure basic needs are met, including food, shelter, and opportunities for education.

Clinical Outcomes

With increased coordination between providers and communities, patient health is improving, and unnecessary ED utilization is decreasing.

In 2018, BOB program patients saw a **41 percent reduction in ED utilization**.

Ultimately, Wilkinson believes this comes down to empathy. As medical providers are able to better understand a patient's situation, they become more empathetic and able to work with these patients effectively, and without judgment.

As patients feel understood, they're more willing to comply with case managers and follow care instructions. Wilkinson explains:

"Everyone wants to feel heard, and by taking the time to collaborate and understand the patient's full story, that patient feels important and more open to letting us help guide their care. These patients begin realizing the impact of their substance use patterns and agree to go to detox, or they understand the benefits of seeing their behavioral health provider—even when they're worried about basic needs like where their next meal is going to come from. This collaboration is about more than just care—it's about building relationships, investing in these patients as people, and guiding them back to better health."

Providence is continuing to build bridges, including developing connections with local medication assisted treatment (MAT) facilities and expanding its current network in the community and with other providers.

1. Feldmen, Brett. et al. "Prevelance of Homelessness in the Emergency Department." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5391885/

About Collective Medical

Collective Medical provides the nation's largest and most effective ADT-based network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings.

Collective's platform helps identify at-risk, complex patients and share actionable, real-time information with diverse care teams across the network, leading to better care decisions.