A Community Health Worker Centered Transitional Multi-Visit Patient Clinic Addressing Social Determinants of Health Hospital Readmissions Reduction Effort

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**POPULATION**
- Temple University Hospital serves the North Philadelphia community
- Average life expectancy of men is 67 and women is 75; compared to 76 and 81, the life expectancy of men and women who live in center city Philadelphia.
- Social determinants of health (SDOH) have been shown to be independent predictors for poorer health outcomes.1,3

**TEAM STRATEGY**
- MVP clinic was opened February 2020, initially as a CHF pilot then expanded to all cause readmissions
- Remained payor agnostic
- Patients identified by clinicians during admission
- All patients who enter the program are attempted to be screened for SDOH needs
- If no SDOH identified patients were still offered transportation to and from clinic appointments, parcels of fresh food, health education, and access to social work services at clinic visits

**OBJECTIVES**
- Create a program for multi-visit patients (MVP) that supports the specific needs of this population
- Implement a pilot CHW-centered transitional clinic that identifies and addresses SDOH needs for our patient population through longitudinal CHW involvement in care coordination
- Demonstrate impact on emergency department visits and hospital readmissions after participation

**PROGRAM OUTCOMES:**
- Total patients enrolled: 383 (2/27/2020-3/31/2022), 73% had a full SDOH assessment prior to clinic visit
- 90-day pre and post enrollment all-cause emergency department visits, readmissions, and clinic show rates were tracked and noted in the graphs by average patient visit
- 12.9% patient identified transportation as a barrier, but 37.9% utilized the car service when offered; concluded that SDOH needs are unreported by patients

**LESSONS & CONCLUSIONS**
- Data based conclusions:
  - Innovative model led to decreased inpatient and ED visit utilization, sustained over a year
  - Increased outpatient engagement leads to better disease management outcomes for patients: patients have received life vests, bridged to bariatric surgery, placement of advanced cardiac device placements such as mitral clip, and multiple patients have a recovered ejection fraction and no longer require AICD/lifevest consideration
- Limitations in data:
  - Difficult to discern patients with multiple visits vs patients with singular admissions
  - Impact of CHW’s has many qualitative outcomes difficult to map
- Lessons learned & key take aways:
  - In a high risk patient population traditional clinic models are unable to support the needs of MVP patients: meet the patient where they are
  - MVP program is not a substitute for longitudinal primary care, meant to supplement and support care plans for patients
  - Multi-faceted team is needed for equitable care delivery and sustainable decreases in readmissions and improved patient engagement
  - Build data based dashboards with meaningful and quantifiable data to leverage for program needs

**FUTURE DIRECTIONS**
- Expanded from 2 days a week to 5 days a week staffed by a hospitalist physician and expanded CHW services
- New programs and partnership with health system initiatives around quality incentive programs, chronic care management and transitions of care programs within TUHS
- Creating formal communication and formal hand off processes to primary care physicians
- Educational initiatives to shift culture to embed uniformity in transitions of care within our inpatient clinicians

**REFERENCES**