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Photos by Kevin Meynell

Dr. Hemal Kanzaria addresses the Social Medicine team in the Emergency Department.

Social Medicine Team Transforms Care and Culture in San Francisco

Many people in the Bay Area live near public transit. Jane, frail and elderly, lived *on* public transit.

With no income, shelter, or social support, she spent her nights on the street and her days on transit lines in her wheelchair. Jane's chronic incontinence resulted in skin ulcers from sitting in soiled clothing. When other riders made emergency calls about her condition, she was often transported to Zuckerberg San Francisco General (ZSFG). In 2017 alone, Jane logged more than 100 visits to emergency departments (EDs) across the Bay Area. Within hours of being discharged, she would be back on the street, perpetuating an endless cycle.

Thanks to multidisciplinary efforts at ZSFG, that cycle is being broken for Jane and many others. The solution, a new Social Medicine team, is shifting toward a hospital culture focused on healing the whole person, and is reshaping attitudes about what it means to help the vulnerable among us.

Addressing Trends with Research and Action

Life on the streets takes an enormous toll on the health of individuals, the spirit of the community, and on the hospital, where homeless patients frequently come to the ED because they have no place else to go for care. But medical treatment only addresses a portion of their needs. Once discharged, unsheltered patients can be back in the ED within a week, straining healthcare resources.

Reviewing data from 2016, Jack Chase, MD, Hemal Kanzaria, MD, and Jenna Bilinski, RN found that complex social determinants—hunger, isolation, substance abuse, mental illness, homelessness—dramatically affected the health of one third of all patients admitted to the hospital from the ED. In fact, social needs typically account for more than 70% of a patient's overall health,

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and are largely ignored in traditional medical care. Moreover, hospitalizing patients whose medical problems are exacerbated by social complexities does not make a lasting difference in their overall health.

"Many of our patients are experiencing complex medical-psychological-social emergencies—for example, severe heart failure, a psychotic disorder, and ongoing cocaine use while living on the street," says Dr. Chase. "To treat these patients successfully, we have to focus with equal intensity on social, psychological, and medical issues. We must meet patients where they are, address what they identify as their most pressing needs, and engage them progressively over time."

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>
> *Jack Chase, MD*
> *Medical Director of the*
> *Department of Care Coordination at ZSFG*

Because no individual provider or discipline could do this work alone, a multidisciplinary team was formed to create an actionable program. "We saw this as an opportunity to help vulnerable patients, as individuals and as a group, while fostering teamwork at the hospital and across our health network. But it would require a change of culture at ZSFG," says Dr. Kanzaria. The program team engaged more than 50 stakeholders, from frontline staff to executive leadership to community partners. The goal: decrease hospitalizations related to social needs by 50% and increase multidisciplinary teamwork to coordinate care for individual vulnerable patients.

The effort culminated in the creation of the Emergency Department Social Medicine team. Using the ED as a key entry point, this innovative care model addresses the social drivers of health for some of the most fragile patients. Social workers, nurses, patient coordinators, physicians, pharmacists, and other experts collaborate with community social services—for example, food banks, transitional housing, financial and legal resources, case managers, domestic violence resources, and treatment for mental health and substance use—to provide safe alternatives to hospitalization. By engaging patients in identifying their own needs and addressing medical and social needs in parallel, the team opens pathways to more effective care that can improve health while reducing dependence on acute care services.

Since August 2017, the team has developed and implemented ten initiatives, including hiring an ED patient navigator to coordinate medical and social care, creating an ED-based pharmacy, leading multidisciplinary rounds, and offering opportunities for transitional housing directly from the ED.

Jenna Bilinski, RN, Director of the Kaizen Promotion Office, coaches and teaches to align the team's goals with the True North goals of the hospital.

Transformative Results for Patients and Providers

The Social Medicine team represents a profound change in how ZSFG cares for vulnerable patients. Since January 2018, the team has served more than 1,000 patients and prevented more than 200 admissions and 30 readmissions, making more resources available for patients with acute challenges. More than 300 ED patients have been discharged with safe medications in hand. The overall length of stay for ED patients has decreased, and re-visits have been reduced by 10%.

Challenges remain, including the challenge of success: With more than 100 referrals

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each month, the Social Medicine team receives more requests than it can manage. Expansion—more team members, more patient and community resources—is under way. The team is also looking to collaborate beyond the ED, helping care providers across the hospital support patients with complex social needs.

The Social Medicine team is gratified that their initiative has catalyzed a change in culture, shifting providers' focus to take on both medical and social contributors to health. "Feedback shows us that, with social determinants addressed, the hospital is exceeding our patients' expectations," says Bilinski. The individual outcomes are transformative, she adds, helping many patients access medical and social services, get treatment for substance use or mental health challenges, and overcome homelessness.

Dr. Jack Chase addresses his team at a weekly meeting discussing the best strategies to help improve processes and outcomes.

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> *Hemal Kanzaria, MD*
> *Director of Complex Care Analytics for the*
> *San Francisco Health Network*

We're happy to report that Jane connected with the Social Medicine team when she came to the ED. After discharge, she moved to Hummingbird Place, which provides psychiatric respite care. After less than a year, Jane is now clean, well-nourished, and healed. She has worked with social workers to get proper ID and register for Social Security, food stamps, and insurance. Since her contact with the Social Medicine team, she has been to the ED on just four occasions—a tenfold decrease in her monthly visits. Most important, Jane is happy with the care she's receiving. She is no longer suffering. And, for the first time in a long time, she's hopeful about the future.❤

ZSFG Facts: Did You Know?

76,006 medical psychiatry emergency visits

15 primary care clinics in the San Francisco Health network served by ZSFG

1 in 8 San Franciscans treated annually (over 100,000/year)

20+ languages spoken

590,861 outpatient visits

1,200 babies delivered annually