Bridging Medical and Social Care: University Health and Family Service

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WHO WE ARE...
COMPREHENSIVE NETWORK

12,000+ Employees

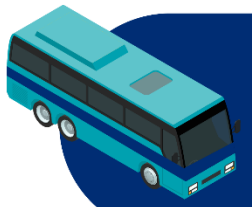
2,200+ Physicians

2 Hospitals:
- University Hospital
- Women's & Children's Hospital

6 School-based Health Centers

More than 30 Outpatient Care Centers

University Health

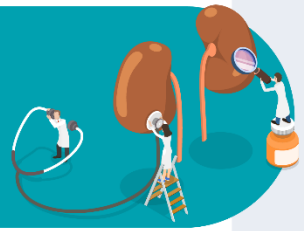


3 Mobile Units
- Mammograms
- Primary care
- Blood donations

3 ExpressMed Walk-in Clinics

3 Ambulatory Surgery Centers

5 Dialysis Centers

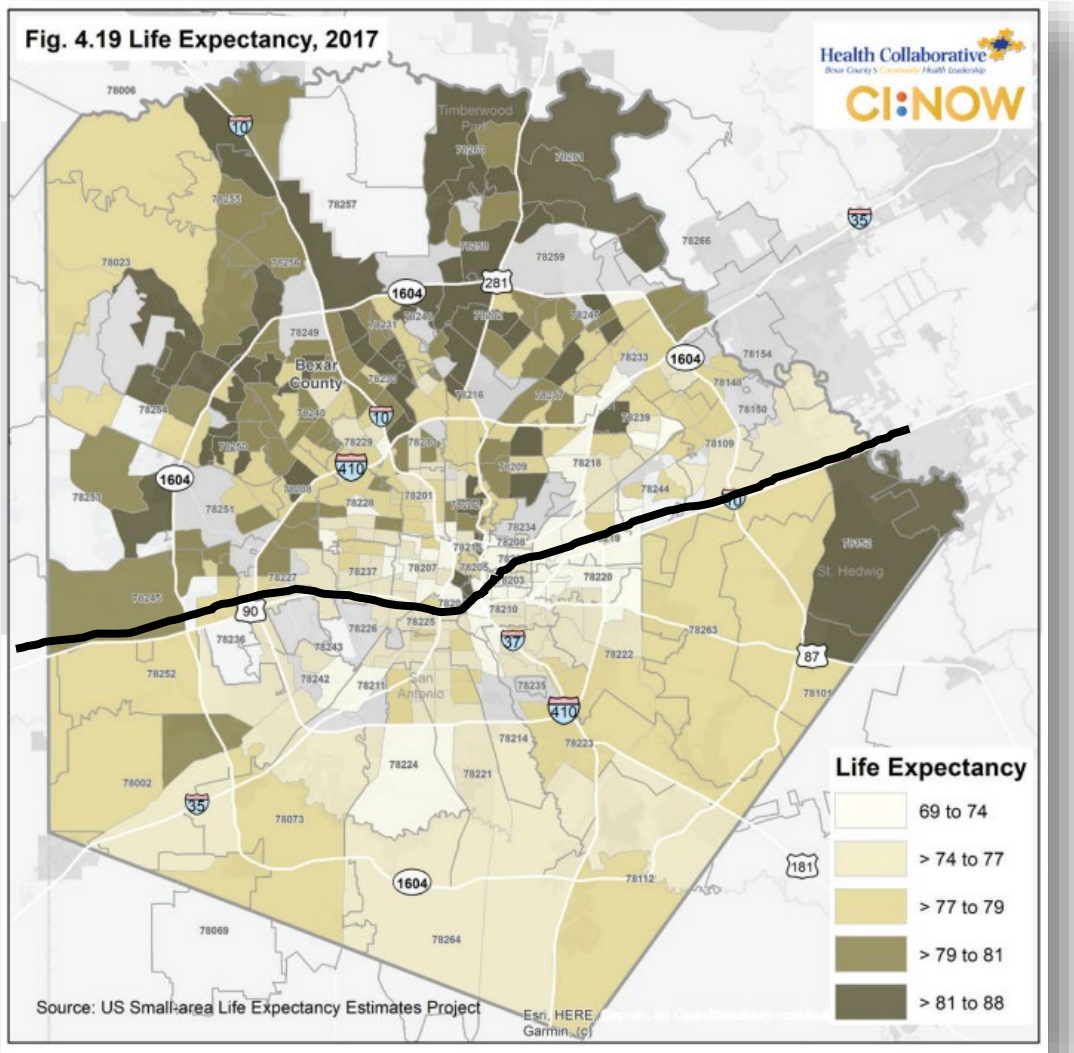


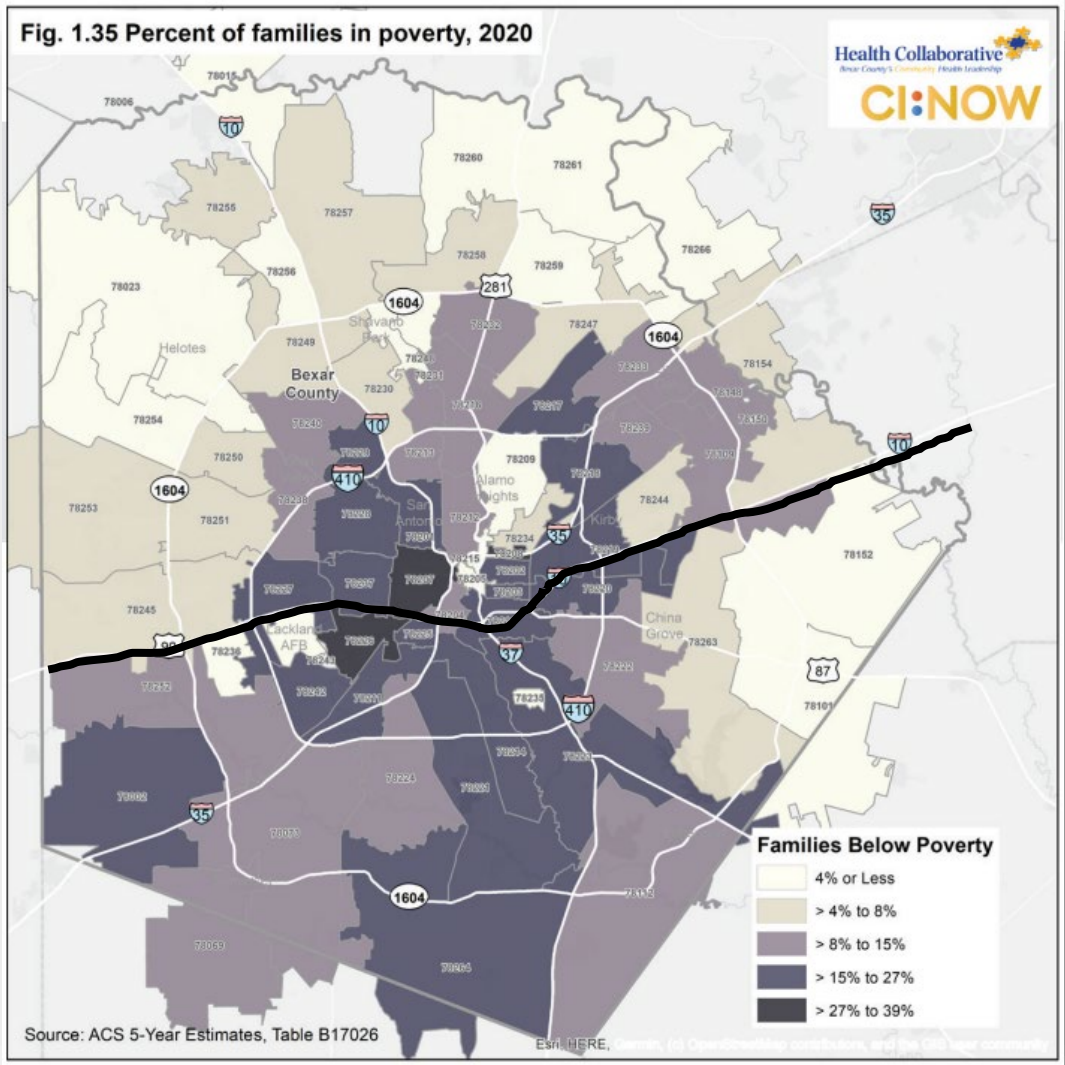
University Medicine Associates
Primary and specialty care group practice

Community First
Nonprofit managed care organization

CareLink
Coverage program for uninsured residents

There are **significant health and social needs** in our communities





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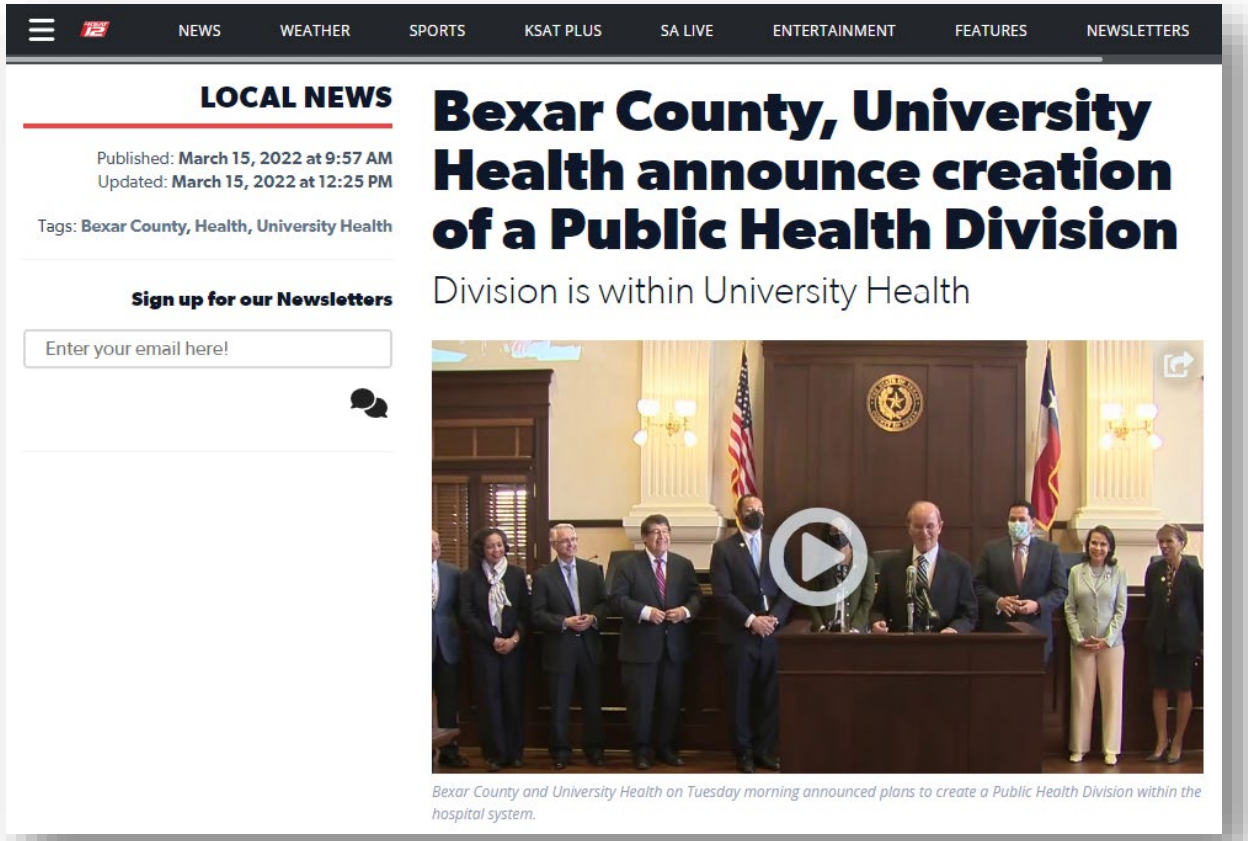
Institute for Public Health

- Established March 2022
- **Mission:** Promote health, prevent disease and prolong life in our community.
- **Identify and address priority needs** through programs, policy and community engagement
- **“Connects the dots”** between programs and services provided by University Health and community partners to reduce health disparities.



[Bexar County, University Health announce creation of a Public Health Division (ksat.com)]

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We are **integrating medical and social care** to improve health.

- Standardize screening and referral processes
- Educating staff and patients on services available
- Engaging with partners to address root causes of poor health in the community

Graphic from: [Healthy People 2030]

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Family Service Mission

Empowering individuals and families to **transform** their lives and **strengthen** our communities.
We are working to address the **social determinants of health** through a **trauma informed care** lens.

Oldest human service nonprofit in San Antonio

- Founded in 1903
- Celebrating 122 years in San Antonio and surrounding Counties
- 27 years in Rural Communities
- Served almost 50,000 clients in 2024
- Supported more than 90,000 lives in 2024

Family Service
SUPPORT. STRENGTHEN. SERVE.

Family Service Organizational Chart

Based on the Social Determinants of Health

President/CEO
Mary E. Garr

Communications & Public Relations
Wynn Hoke

Sr. Executive Assistant to CEO / Board Liaison
Angie Oviedo

Controller
Hector Perez-Luevano

- Business Office
- Procurement

Chief Operating Officer
Richard Davidson

- Evaluation & Data

Chief Learning Officer
Chris Rodriguez

PROGRAM | CAPACITY BUILDING | PROGRAM

Sr VP of Quality & Systems
Mylinda Swierc

- Human Resources
  Evelyn Carvajal
  - Human Resources
    Cynthia Mota
  - Information Technology
    Ian Mendez Rivas
  - Facilities
    Terry Taylor
  - Impact Analyst
    VACANT

Development & Donor Engagement
Lupita Castrejon Tijerina

- Community Development (Corporate)
  Debora Guzman Perez
- Community Development (Community)
  Jacqueline Guerrero

Client Experience
Laura Mata-Delgado

Health & Healthcare

- Behavioral Health
  Veronica Salgado
- Early Childhood Well-Being
  Fred Cardenas
- SDOH Program
  Gudellia Ramon

Economic Stability
Kim Arispe

- Financial Empowerment
  Pat Huedepohl
- Workforce Development (General)
  VACANT
- Workforce Development (Early Childhood)
  Marcella Escobedo
- Recovery Center
- Economic Mobility
  Scarlette Blair

Education
Sandra Garza

- Head Start/EarlyHead Start – Child Care Partnerships
  Tasha McMullan
- Youth Education / Career Services / Teen Tech Center
  Sara Santiago
- Texas School Ready
  Tanyia McCall

Social & Community Engagement
Fabi Avila

- Parent Engagement
  Tara Powell
- Promotoras / Parent Education
  Sarai Morales
- Family Strengthening
  Laura Mata-Delgado
- Older Adults
  Bernadette Vasquez
- KidShare
  Martha Roberts

Rural Area Services
(Encompasses all 5 SDOH Pillars)
Alejandra Castro

Neighborhood Support
Jeremy Camacho

- Neighborhood Place
- Margaret's Place I & II
  Laura Mata-Delgado

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REVISED: April 1, 2025

2024 DEMOGRAPHICS

GENDER

ANNUAL INCOME

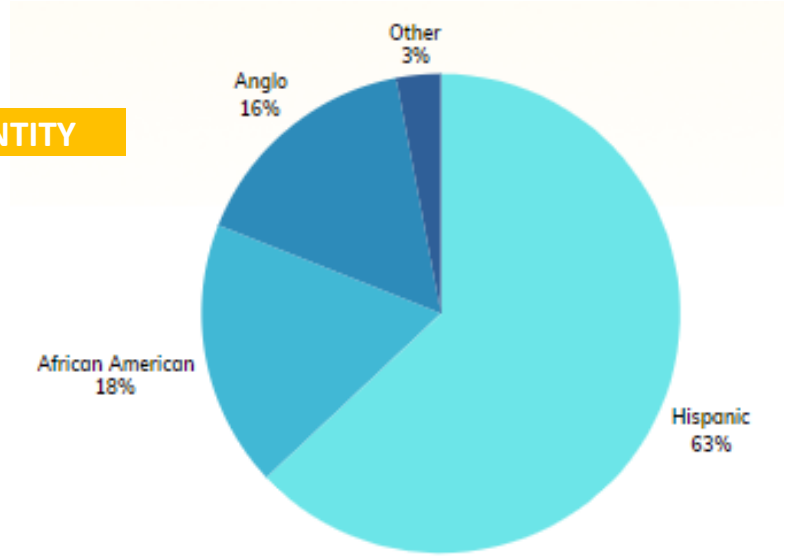
Of the clients we serve:

34%
Make less than $5,000

66%
Make less than $10,000

90%
Make less than $25,000

IDENTITY



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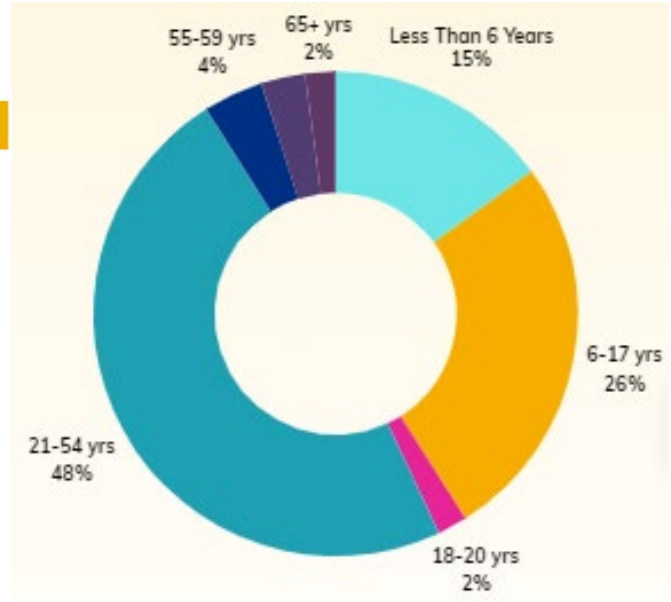

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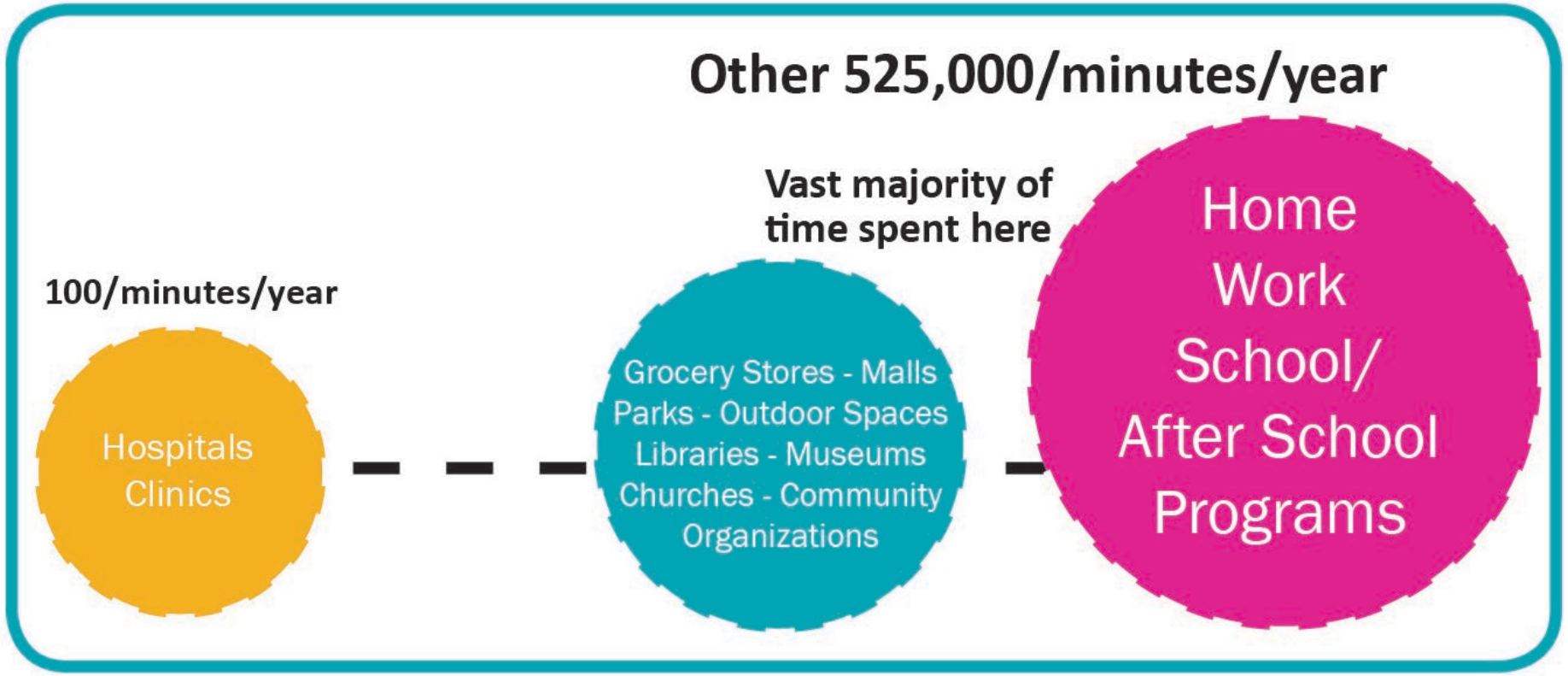
Influencers of Health



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NMDOH Partnership with University Health

History:

- NMDOH Conversations and Relationship Building
- Shared Grants
- UH NMDOH Assessment Tool
- UH and Family Service Partnership and Investment in addressing NMDOH

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Unique Cross-Sector Relationship

- Launched NMDOH Task Force in April 2023 to guide integration of medical and social care
- Program launched October 2023
- Fully integrated into electronic health record (EHR) system
- Family Service is not co-located within University Health facilities
- Staff refer patients to Family Service within Epic and communicate directly with staff

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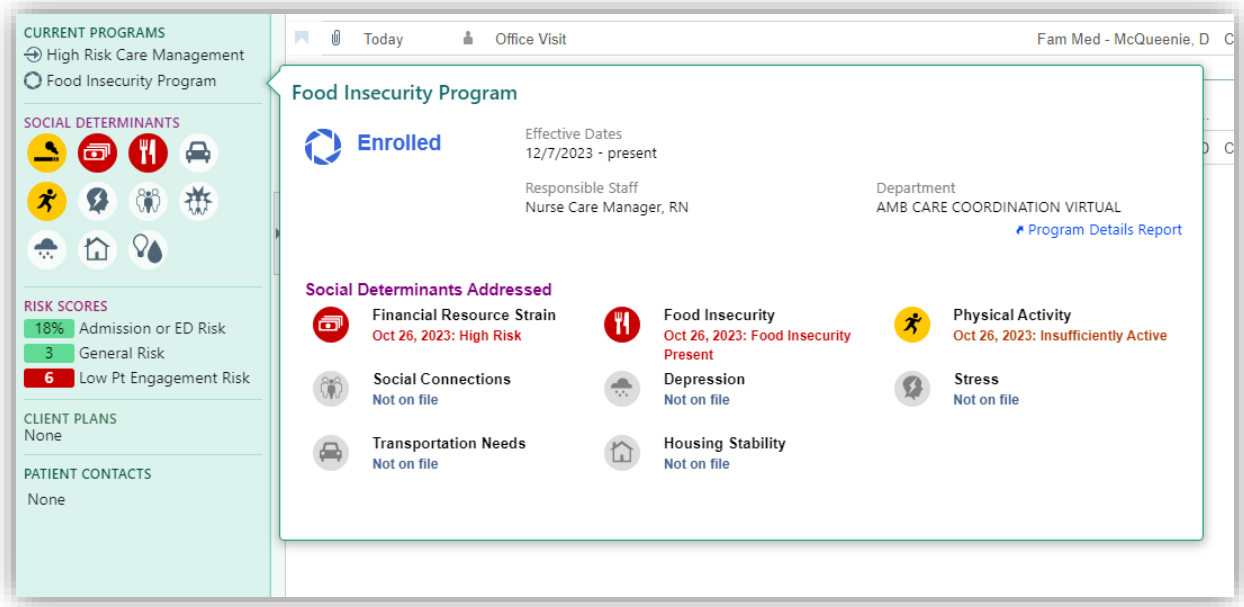
Leveraging Features within an EHR

- Compass Rose Module
  - Monitor, manage, and maintain information related to NMDOH
  - Assess patient non-medical drivers of health
  - Document efforts in a quantifiable manner
  - Accessible information for care team
- Developed four pathways to guide efforts to address NMDOH
  - Food
  - Housing
  - Transportation
  - Financial



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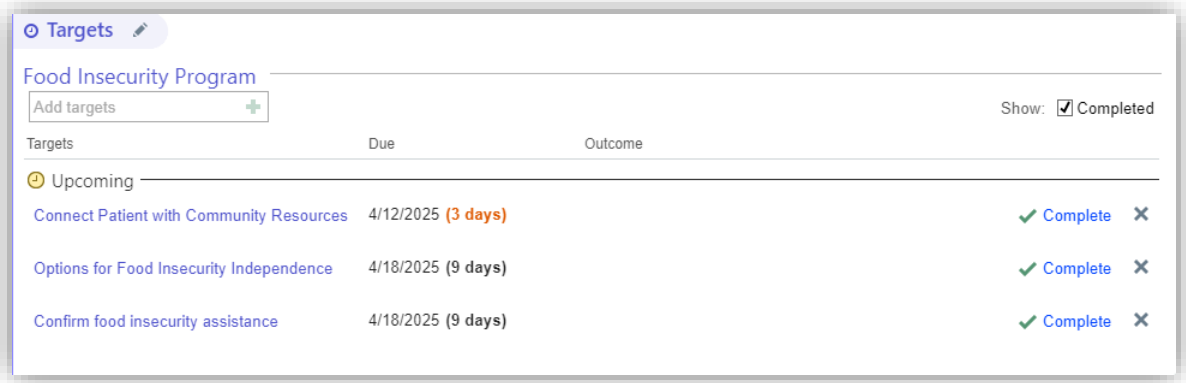
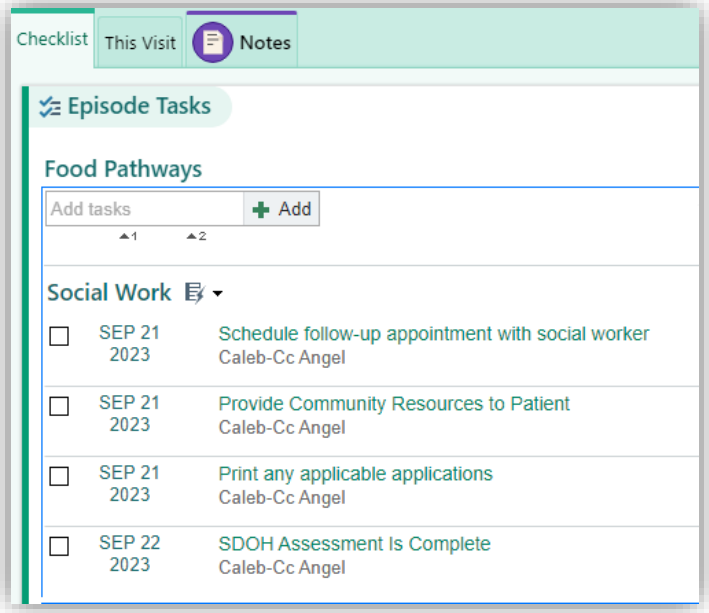
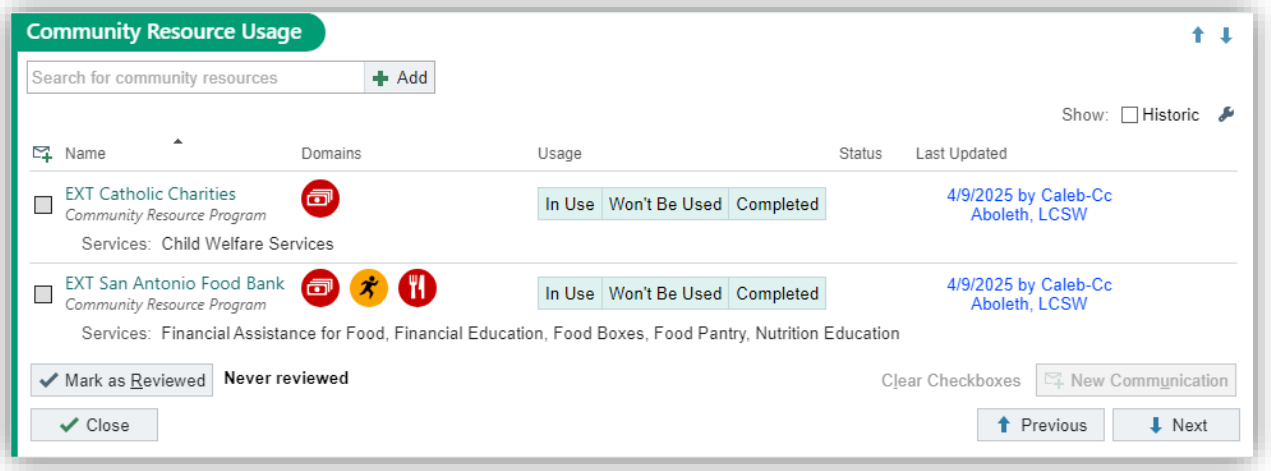
Pathways to Address NMDOH

- Each pathway consists of time bound
  - Targets – high-level milestones meant to be completed for a program
  - Checklist Tasks – Track day-to-day activities.
  - Ability to track Community Resources patients were referred to.







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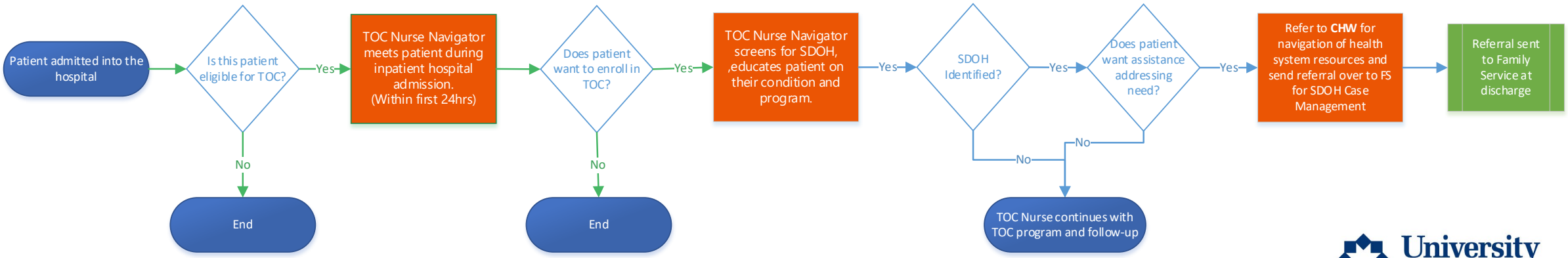
Program Cohorts – Transitions of Care

- Transitions of Care (TOC) is an internal navigation program focused on identification, education and post-acute follow-up.
- Target Population
  - Hospital patients who are admitted for an exacerbation of Congestive Heart Failure (CHF) or new onset of heart failure and qualify for the Transitions of Care Program.
  - Hospital patients who have a LACE+ Readmission score between 50-70 and qualify for the Transitions of Care Program.
- Cohorts Launched October 2023 and March 2024



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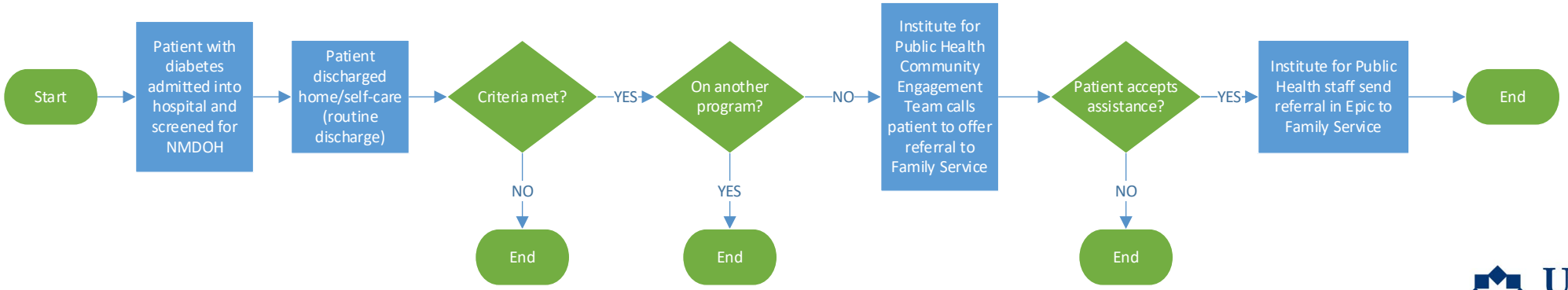
Program Cohorts - Diabetes

- Target Population – Hospital patients with Diabetes who live in a zip code with a high social vulnerability index (≥75%) and had a routine discharge
- Social Vulnerability - Systemic socioeconomic inequities like poverty, poor housing conditions, and lack of access to quality health care lead to worse health outcomes
- Exclusion Criteria
  - Listed on any of the following registries: Transplant, Congestive Heart Failure, and Cancer
  - Enrolled in any Transition of Care case management program
  - Not screened for NMDOH within last year



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Screening & Referral: Process Overview and Program Expectations

- Patients screened for NMDOH within 24-48hrs of hospital admission
- Patients receive warm handoff to Family Service staff from University Health staff
- Family Service expected to
  - Make initial outreach to patient within 72 hours of receiving referral
  - Schedule an intake appointment within 10 days of receiving referral
  - Connect patients to resources and follow-up to ensure resources were received and needs are met.
  - Document all patient encounters within Epic.

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Family Service Assessment Tools and Process

In addition to the UH screening and referrals:

- **Getting To Know You Tool**
  - The CMS Accountable Health Communities Health-Related Social Needs Screening Tool
  - ACES Screening Tool
  - Other demographics
- **Checking on You Tool**
- **Algorithm** to assess entire family, not just the patient

Once referral is received in the EHR (Epic):

- Contact patient
- Assess the patient and family to include home environment
- Provide supports/services, link to internal and/or external services
- Document in Epic (referring provider can see what is happening with their patient)

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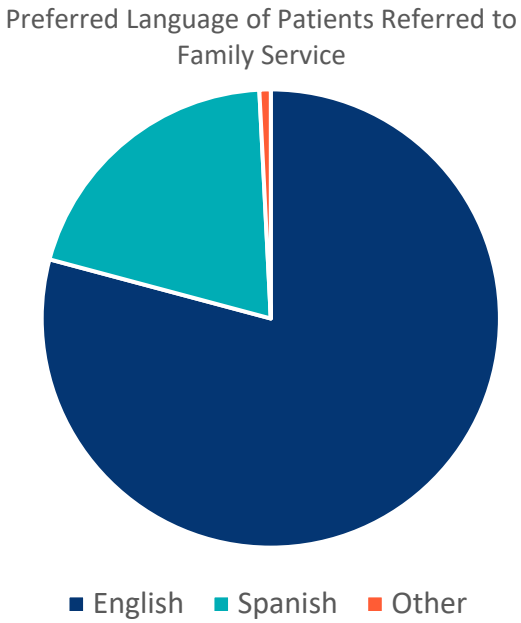
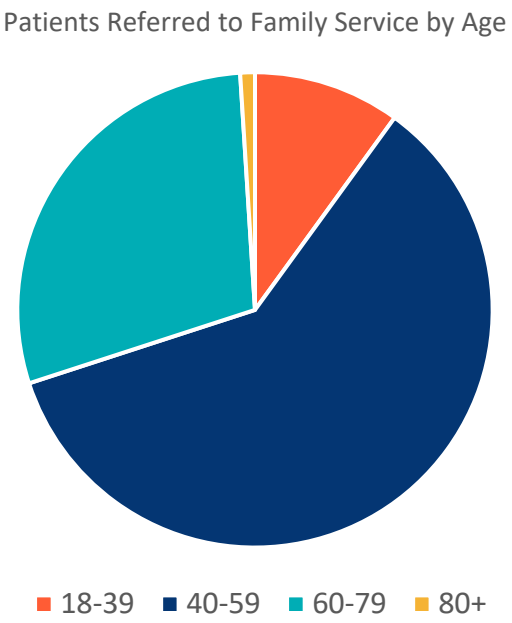
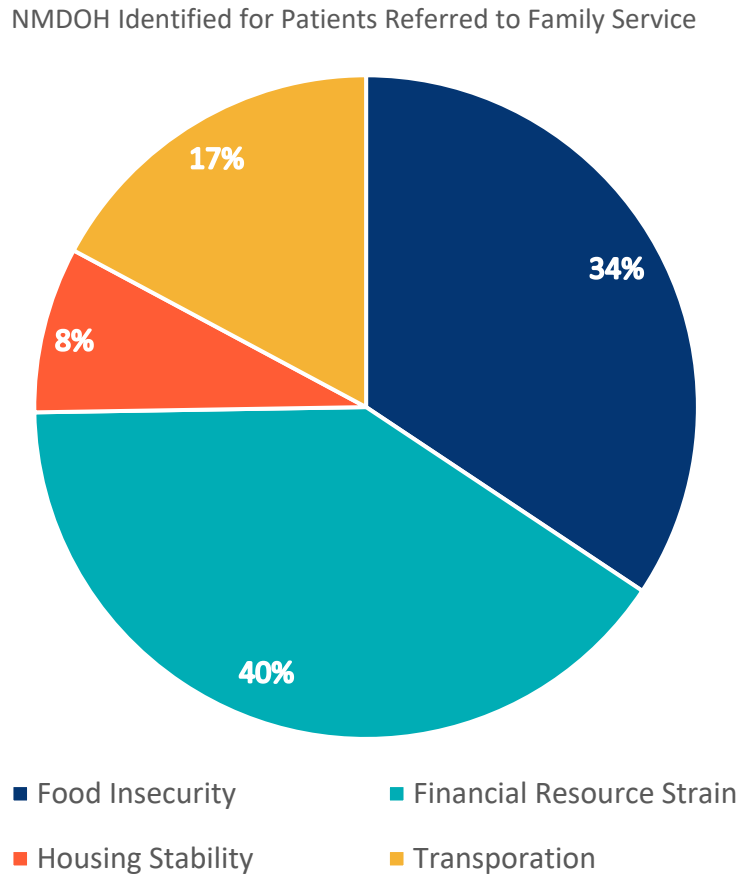
Program Outcomes

- October 2023 – December 2024
  - Individuals Referred – 401
    - Received Family Serve case management - 220
  - Pathways Created – 435







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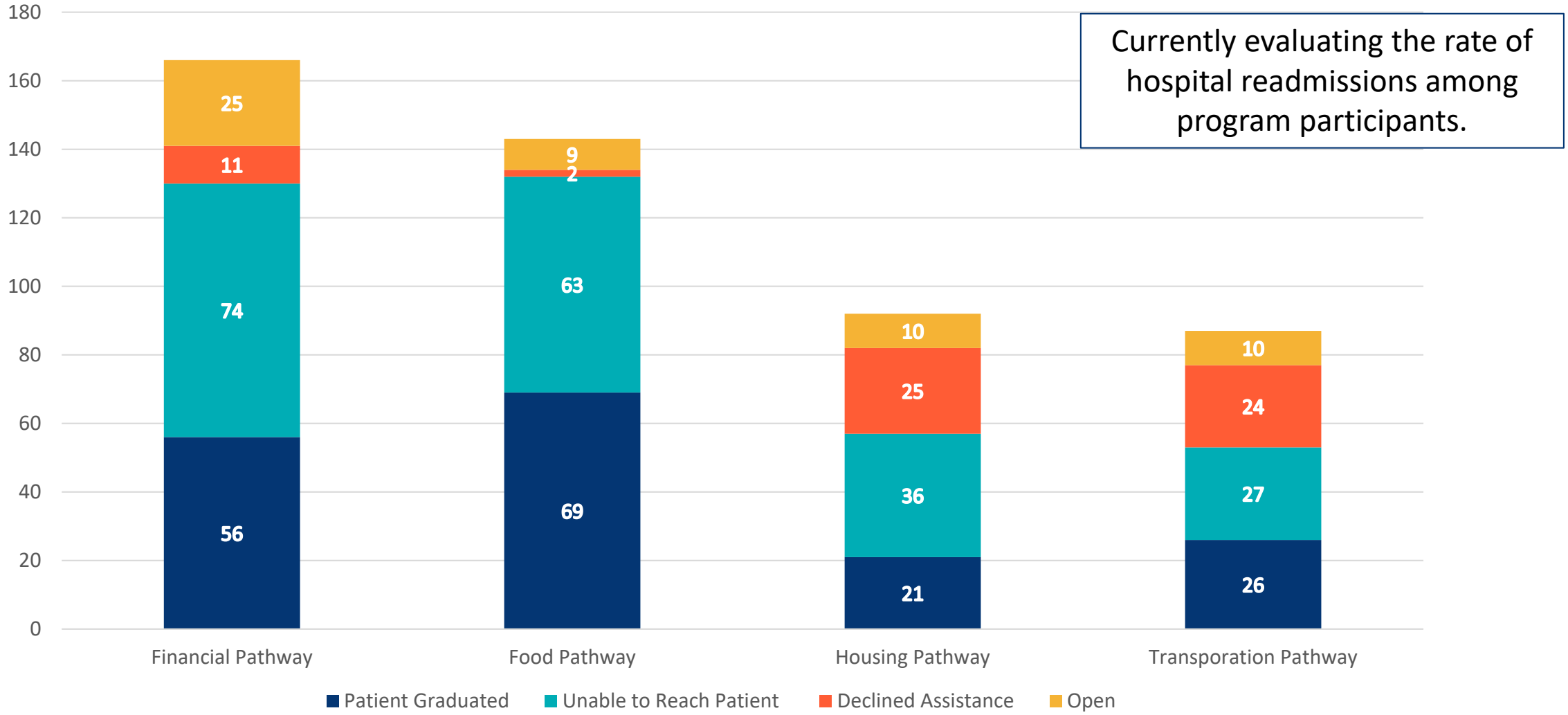
NMDOH Needs Addressed



Currently evaluating the rate of hospital readmissions among program participants.

Average number of days to close pathways - 144

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Challenges and Lessons Learned

Challenges

- Lengthy process to grant individuals access to Epic
- Continuous oversight and training necessary to maintain system proficiency
- High rate of attrition among patients referred to the program
- Staff turnover
- New program for both partners

Lessons Learned

- An NMDOH program like this takes time to build
- Key to have all stakeholders in the room during development
- Must be an investment and partnership not solely transactional

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Why partner with Community Based/Social Services Organizations?

- Trusted, grassroots organizations with deep community ties
- Experts in addressing NMDOH
- Advocate for vulnerable populations and navigate complex systems
- Operate efficiently to maximize limited funding
- Enhance care coordination, referrals, and outcome tracking
- Help reduce delays in care and prevent avoidable, high-cost utilization
- Offer insights into correlations between NMDOH and high-cost claims

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Future and Spread

- Leveraging EpicLink as a referral tool for community partners
- Optimizing the use of space at University Health Vida
- Creating Pathways to Partnership
  - Referral partner
  - Host events in our community spaces
  - Co-locate in University Health Vida

Questions

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