The Super Utilizer: what you don’t know and what you can do to help

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What is the Southwest Texas Crisis Collaborative?

The Southwest Texas Crisis Collaborative (STCC) is a division of STRAC, focused on ending ineffective utilization of services for the safety net population at the intersection of chronic illness, mental illness, and homelessness in San Antonio, Texas and Bexar County.

STCC is committed to improvement by developing a comprehensive, integrated crisis system across all major public payors, hospital providers, philanthropy, public safety (Fire/EMS and Law Enforcement) and behavioral health providers.

This initiative hopes to provide an unprecedented opportunity to create impact in the larger SA/Bexar County community, and be a part of systems change that will hopefully serve as a model to be replicated across Texas and the country.
Why is the Southwest Texas Crisis Collaborative?
What is a Super Utilizer?

**Safety Net Population**
- 313,985 Safety Net
- 1,121,629 Encounters
- $1.1 Billion

**Mental Health Population**
- 33,810 Mental Health
- 320,350 Encounters
- $200 Million

**Homeless Population**
- 14,614 Homeless
- 109,432 Encounters
- $80 Million

**High Utilizer Target Population**
- 500 Target Group
- 11,589 Encounters
- $19 Million

**Super Utilizers**
- 3,507 Super Utilizers
- 62,504 Encounters
- $175 Million

Source: CHP Study
What is a Super Utilizer?

The Robert Woods Johnson Foundation defines Super-Utilizers as individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system.

In Capital Healthcare Planning’s initial analysis, “Super-utilizers” are defined as Safety Net patients who had:

- Inpatient - 3+ discharges or had both a serious mental health diagnosis and 2+ discharges
- ER utilization – 9+ visits
- Exclusions – Pediatric Cancer Care, Neonatal
Who is a Super Utilizer?

- Jim
  - Schizoaffective disorder, past drug use, epilepsy/seizures, limited family support, low SES, unfunded, no access to medications
  - Came from out of town 6 months ago to live in a half-way house
  - 3 months ago, moved into LMHA supported housing after being in and out of the hospital
  - Transferred to my case load as part of the ACT team and immediately needed to move out of the LMHA supported housing because of 3 month limit. One of my first clients on my own
  - Took him to Haven for Hope and he was intimidated by the size and scope. Could not get a bed as a member because he was not a resident of Bexar county, did not feel comfortable in the shelter side.
  - Started feeling overwhelmed, paranoid, and suicidal
  - Went to the closest ER, they held him for a few hours and then were discharging him
  - Felt like there was no place for him to go and felt overwhelmed, cut arm in ER.
  - Got admitted to inpatient, was given an additional diagnosis of malingering
  - When discharged, went to Salvation Army. Was able to stay at Salvation Army for many weeks, around 3 months, started working and contributing. Had a massive seizure while cooking in the kitchen, woke up in ER, and was not allowed back into the program.
  - All the while we were working on his medications, benefits applications, family relations, coping skills, etc...
mental health diagnosis

limited social support

housing issues

no money

Why is a Super Utilizer found in the Emergency Department?
Maslow’s Hierarchy of Needs

- **Physiological needs**: air, water, food, shelter, sleep, clothing, reproduction
- **Safety needs**: personal security, employment, resources, health, property
- **Love and belonging**: friendship, intimacy, family, sense of connection
- **Esteem**: respect, self-esteem, status, recognition, strength, freedom
- **Self-actualization**: desire to become the most that one can be
Maslow’s Hierarchy of Needs in a hospital

Physiological needs
air, water, food, shelter, sleep, clothing, reproduction

breathing, circulation, temperature, intake of food and fluids, elimination of wastes, movement
Maslow’s Hierarchy of Needs in a hospital

- Safety needs: personal security, employment, resources, health, property
- Physiological needs: air, water, food, shelter, sleep, clothing, reproduction

housing, community, climate, family
maslow's hierarchy of needs in a hospital

relationships with others, communications with others, support systems, being part of community, feeling loved by others
Maslow’s Hierarchy of Needs in a hospital

- **Physiological needs**: air, water, food, shelter, sleep, clothing, reproduction
- **Safety needs**: personal security, employment, resources, health, property
- **Love and belonging**: friendship, intimacy, family, sense of connection
- **Esteem**: respect, self-esteem, status, recognition, strength, freedom

hope, joy, curiosity, happiness, accepting Self
Maslow’s Hierarchy of Needs in a hospital

- **Physiological needs**: air, water, food, shelter, sleep, clothing, reproduction
- **Safety needs**: personal security, employment, resources, health, property
- **Love and belonging**: friendship, intimacy, family, sense of connection
- **Esteem**: respect, self-esteem, status, recognition, strength, freedom
- **Self-actualization**: desire to become the most that one can be

thinking, learning, decision making, values, beliefs, fulfillment, helping others
Maslow’s Hierarchy of Needs updated?
Maslow’s Hierarchy of Needs updated

What has changed?
Perhaps the most obvious change is that “self-actualization” has been rolled into “status/esteem” as it is not exactly a distinct human need.

We see the evolutionary need of reproductive goals at the top of the pyramid. For us in healthcare, we know that people have to be as healthy as possible in order to achieve these goals.

Even with these developments at the interface of evolutionary biology, anthropology, and psychology, we can see how the Emergency Department can meet several needs of the Super Utilizer.
Even though the emergency department provides excellent care, *should* it strive to meet *all* the needs of the patient?

What is best for the system?

What is ED’s responsibility to patient?

How can the ED determine the most appropriate care plan for a patient?
A study out of the Yale Global Health Leadership Institute found that a patient’s overall health is determined by

- 20% genetics
- 20% healthcare
- 60% social determinants of health
What are the Social Determinants of Health?

**ID/Documents**
1. Do you have a valid government issued ID?

**Food**
2. Do you eat less than you feel you should because there’s not enough food?

**Housing**
3. Are you worried that in the next few months, you may not have safe housing that you own, rent or share?

**Utilities**
4. In the past year, have you had a hard time paying your utility company bills?

**Clothing**
5. Are you in need of clothing to meet your daily needs?

**Finances**
6. Are your finances covering your living costs?

**Transportation**
7. Do you have a dependable way to get to work or school and your appointments?

**Education**
8. Do you think completing more education or training would be helpful to you?

**Employment**
9. Do you have a job or other steady source of income?

**Medical Home**
10. Do you have a usual source of medical care?

**Insurance**
11. Do you have medical insurance?

**Childcare**
12. Does getting childcare make it hard for you to work, go to school or study?

**Social Support**
13. Do you have people in your life that you feel supported by?

**Prescription Access**
14. Have you experienced a time when finances got in the way of being able to cover your costs for your prescriptions?

**Consent to Help**
15. Would you like to receive assistance with any of these needs?

**General**
16. Are any of your needs urgent? For example, I don’t have food tonight or I don’t have a place to sleep tonight?
What can you do?

- Integrating social determinates of health can help you to better assess and understand your patients.
- Example: Insulin that must be kept cold
- What could the physician have done differently?
What are others doing?

The Patient Care Intervention Center, Harris County, Houston, Texas

Provides care coordination for “High-Needs, High Cost” patients with 2+ chronic conditions who frequent the emergency room using a patient driven goals based model.

The multidisciplinary team (social workers, community health workers, medical assistants, RNs, and MDs) coordinates care in relation to the patient’s PCP and specialist appointments, pharmacy (medication reconciliation), as well as transportation, social security benefits, housing, and food insecurities.

The intervention period ranges from 2-6 months and is concluded with a warm handoff back to the primary care home or referral source.
Conclusions

- Although the social needs of a Super Utilizer have been traditionally viewed as a social problem, it has become a healthcare problem.

- Looking at treatment through a different lens can lead to more effective outcomes in a more efficient manner.
References


- https://pcictx.org/


- TAVHealth. Social Determinates of Health Assessment.