SCIENTIFIC LETTERS

Addressing social emergencies from a hospital emergency department: interim analysis of an intersectoral coordination model

Atención a la urgencia social desde un servicio de urgencias hospitalario: análisis intermedio de un modelo de coordinación intersectorial

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Social emergency represents a growing phenomenon in emergency departments (EDs), where situations of extreme vulnerability converge that go beyond immediate clinical problems.[1-3] Factors such as poverty, homelessness, and deterioration of family networks generate crises requiring an integrated response; however, available services remain insufficient and fragmented. In this context, addressing social emergencies requires an intersectoral coordination model capable of integrating health, social, and community resources. Although experiences exist in different regions, the scientific literature is scarce, and current proposals lack systematization.[4] This work describes the experience developed in a tertiary hospital, where a specific pathway was implemented for the joint management of social vulnerability in the ED.

Hospital Universitario Arnau de Vilanova (HUAV) in Lleida (Spain), along with the Municipal Social Services (SSM), designed and implemented an intersectoral coordination model to improve care for patients in situations of high social vulnerability. The experience is based on the institutionalization of two complementary structures: a clinical commission for vulnerable patients—comprising professionals from emergency medicine, geriatrics, gynecology, pediatrics, mental health, legal medicine, primary care, and hospital management—and an operational social commission, integrated by ED physicians, hospital social workers, municipal social workers, and community resources, including the mental health network. These commissions meet regularly to share cases, define intervention plans, and ensure coordinated follow-up. Their bidirectional functioning allows both the detection of vulnerable patients who attend the hospital and the identification, from social services, of individuals who may have serious health problems without active medical care. This synergy promotes a shared vision and a more agile response, adapted to the complex realities of these patients. As a sign of institutional commitment, a specific clinical lead has been appointed for this group, equating their care to that of other prevalent ED conditions.

We designed a retrospective observational study in the ED to analyze the implementation of a social-emergency care circuit. All patients seen in the ED between September 2023 and September 2024 who required urgent social assessment and coordination between hospital and mental health social work teams were included. Cases in which social referral was deferred were excluded.

Variables collected included sociodemographic characteristics (age and gender), medical and social diagnoses, substance use, comorbidity (Charlson Index), use of health and social resources, and final situation after intervention. Two periods were defined for analysis: "before" (12 months prior to inclusion) and "after" (12 months following inclusion). Data were compared according to origin (SSM vs HUAV) and, globally, changes in the number of coordinations with primary care and with social services between "before" and "after"—key variables for the program's objectives. The division by origin (SSM vs. HUAV) reflects the hypothesis that clinical and social profiles, as well as patterns of resource utilization, differ between patients identified in the community and those identified at the hospital, potentially conditioning the response to the program.

Statistical analysis included a descriptive assessment of variables. For bivariate comparison, chi-square or Fisher's exact test was used for qualitative variables, and Mann–Whitney or Student's t-test depending on distribution. Significance was set at $P < .05$. The study was approved by the Research Ethics Committee (CEIC-3252).

During the first 12 months of implementation (September 2023–September 2024), a total of 29 patients were included in coordinated follow-up. Of these, 19 (65.5%) were referred from SSM and the rest from HUAV (Table 1). The mean age was 53 ± 12 years, with 10.3% > 65 years. The main clinical characteristics were untreated chronic multimorbidity, malnutrition, severe mental disorders, and active addictions. No significant differences were found between groups (SSM vs HUAV) either in clinical characteristics or in resource use during the 12 months prior to program entry.

Regarding the global care impact after program inclusion, an increase in coordination between the hospital and SSM was observed ($P < .005$), rising from a median of 2 consultations (IQR, 0–4) to 6 (3–8), and with primary care ($P = .02$) from a median of 0 consultations (0–1) to 2 (0–3). Furthermore, an increase in ED visits and diagnostic tests was observed (Table 2). A total of 18 patients (62.1%) accessed at least one social resource after intervention, 9 (31%) remained homeless at the end of follow-up, and 2 died during the process. No significant differences were found in resource use between groups (SSM vs HUAV) after entering the program.

The emergence of social emergency in the hospital challenges the traditional role of EDs as purely biomedical spaces. In addition to treating acute conditions, they become points of contact with social realities that are invisible in other settings. This "gateway" function confers a responsibility that cannot be addressed solely with clinical resources. Medicalizing social problems without coordination structures may lead to professional frustration, excessive diagnostic intervention, and inefficiency. Intersectoral models, therefore, allow sharing responsibilities and dignifying care for individuals in exclusion. The experience presented fits within this context and represents a pioneering initiative in the Catalan health care system.

Internationally, experiences exist integrating community resources and collecting social indicators to prevent exclusion.[1-5] A study conducted in Canada showed improvement in housing conditions for 42–65% of patients, and another one conducted in Boston showed a 50% reduction in hospital readmission.[6,7] In our case, although the most frequent resource was emergency accommoda-

Table 1. Baseline characteristics and resources used in the 12 months prior to program inclusion

	SSM N = 19 n (%)	HUAV N = 10 n (%)	*P*
Sociodemographic data			
Age [mean (SD)]	55 (11)	48 (14)	.168
Female gender	3 (15)	1 (10)	1.000
Comorbidities			
Mental illness	12 (63.1)	8 (80)	.430
Alcohol use	17 (89.5)	9 (90)	1.000
Tobacco use	19 (100)	8 (80)	.110
Charlson Index [mean (SD)]	2.5 (0.7)	2.3 (0.5)	.318
Resources used [median (P25–P75)]			
ED visits	3.0 (1.0-12.5)	5.5 (3.25-7.0)	.818
Social assessments	1.0 (0.0-2.5)	0.0 (0.0-1.0)	.321
Primary care visits	0.0 (0.0-1.0)	1.5 (0.0-5.75)	.185
Radiologic tests	1.0 (0.0-3.0)	5.0 (0.25-5.0)	.215
Laboratory tests	2.0 (0.0-7.0)	7.5 (0.25-17.2)	.153
HUAV–SSM coordinations	0.0 (0.0-1.5)	0.0 (0.0-0.75)	.384
Mental Health coordinations	0.0 (0.0-0.0)	0.0 (0.0-0.0)	.638
Primary Care coordinations	0.0 (0.0-1.0)	0.0 (0.0-0.0)	.413

HUAV: *Hospital Universitario Arnau de Vilanova;* SSM: Municipal Social Services; SD: standard deviation; P25–P75:25th–75th percentile; ED: emergency department.

Table 2. Resources used in the 12 months after program inclusion and social status at end of follow-up

	SSM N = 19 n (%)	HUAV N = 10 n (%)	*P*
Resources used [median (P25–P75)]			
ED visits	6.0 (3.0-18.5)	16.5 (7.0-27.8)	.175
Social assessments	4.0 (0.0-7.5)	2.5 (2.0-4.0)	.834
Primary care visits	1.0 (0.0-3.5)	2.0 (0.5-16.0)	.215
Radiologic tests	3.0 (1.0-4.5)	5.5 (4.25-8.5)	.133
Laboratory tests	6.0 (2.5-7.0)	9.5 (5.0-20.5)	.198
HUAV–SSM coordinations	3.0 (0.0-8.0)	4.5 (0.0-5.75)	.888
Mental Health coordinations	0.0 (0.0-1.5)	0.0 (0.0-0.0)	.159
Primary Care coordinations	0.0 (0.0-1.0)	0.0 (0.0-0.0)	.413
Social status			.372
Deceased	2 (10.5)	0 (0)	
Homeless	7 (36.8)	2 (20)	
Institutionalized	4 (21)	2 (20)	
Emergency accommodation	5 (26.3)	4 (40)	
Inclusion program	1 (5.3)	2 (20)	

HUAV: *Hospital Universitario Arnau de Vilanova;* SSM: Municipal Social Services; P25–P75: 25th–75th percentile; ED: emergency department.

tion, it constitutes a first step toward inclusion. With 62.1% of patients accessing a social resource, the present results fall within the upper range of these experiences. Long-term monitoring will be necessary. In Spain, however, experiences remain incipient and local, lacking a structural policy that promotes sociosanitary integration.[8]

Moreover, patients with social problems pose clinical and organizational dilemmas. Labels such as "difficult patient" may conceal serious diseases. It has been described that individuals with lower socioeconomic status have greater disease burden and hospitalization, although persistent inequalities in care remain.[9] The increase in ED visits and diagnostic tests after inclusion in our program may reflect both accumulated clinical needs and greater linkage to the system. In this sense, an initial increase in consultations may reflect improved access, even if it does not immediately resolve underlying problems. Initiatives such as Housing First or home hospitalization in social accommodations could represent new pathways for intervention.[10]

Among the study limitations we find its single-center nature, small sample size, and absence of a control group should be noted. Impact on morbidity and mortality and long-term sustainability were not evaluated, and hospital admissions were not systematically recorded.

To advance toward replicable models, validated social screening tools and outcome indicators—both clinical and social—are required. Sustainability will depend on integration into strategic planning, specific training, and political commitment. Our experience shows that even with limited resources, organizational changes can be achieved when institutional will and shared vision exist.

In conclusion, addressing social emergency requires models that recognize vulnerability as a clinical priority. The experience presented demonstrates that a coordinated response between hospital and social services is possible, with organizational impact and potential benefits. Although preliminary, these results may inspire similar strategies in other centers and open debate on the effective integration of social care into emergency medicine.

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