

Association of Social Risks With Avoiding or Delaying Health Care and With Emergency Department Visits: Evidence From 2017 Ohio Medicaid Assessment Survey

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The Affordable Care Act expanded access to insurance coverage and health care services.¹⁻⁴ However, many patients still report avoiding or delaying health care because of multiple reasons, including cost,⁵⁻⁷ lack of adequate insurance coverage,^{5,8} and low health literacy.^{7,9} In a report from the National Center for Health Statistics, approximately 31% of individuals aged 18 to 64 years reported avoiding/delaying health care for any reason.⁶ Avoiding/delaying health care is associated with poor health outcomes. Previous studies have associated avoiding/delaying health care with decreased rates of cancer screening,¹⁰ increased mortality among those with HIV,¹¹ and increased health care costs that are avoidable.¹² Avoiding/delaying health care may lead to the diagnosis of disease at a later stage, reduce survival rate, and result in health complications that could have been avoided.¹⁰⁻¹⁴

Health insurance, health care costs, patient-provider communication, and health literacy are health care system-related factors that are associated with health services utilization; however, factors referred to as social risks (also referred to as social determinants of health) have shown to be significant as well. Social risks include housing instability, food insecurity, transportation concerns, unemployment, financial instability, limited social resources, and lack of social networks. Social risks often present an additional challenge among individuals belonging to vulnerable population groups like those of lower socioeconomic class, racial or ethnic minorities, uninsured individuals, or older age cohorts. Currently, the full effect of the coronavirus disease 2019 (COVID-19) pandemic on health is still emerging; however, racial/ethnic minority groups are experiencing a disproportionate burden of worse health outcomes.¹⁵ Recent research results on health outcomes and COVID-19 highlight widening health disparities among racial/ethnic minorities due to exposure to poorer economic, social, and physical conditions that have contributed to increased infection rates and higher associated morbidity and mortality.^{15,16} This complex matrix of factors within the health care system, along with high social risks experienced by these vulnerable groups, are crucial factors that affect the decision-making process of seeking health care services by patients.⁷⁻⁹ Previous studies on social risks have shown

ABSTRACT

OBJECTIVES: The primary aim was to examine the association of social risks with avoiding/delaying health care after controlling for sociodemographic covariates, and the secondary aim was to examine the association of social risks with emergency department (ED) visits after controlling for avoiding/delaying health care and sociodemographic covariates.

STUDY DESIGN: 2017 Ohio Medicaid Assessment Survey data were analyzed.

METHODS: Descriptive, bivariate analysis and multiple weighted logistic regressions were conducted. First, weighted logistic regression assessed the association of aggregated social risk (food insecurity, housing instability, financial strain) and health insurance type with avoiding/delaying health care after controlling for sociodemographic covariates. Next, weighted logistic regression assessed the association of social risks with ED visits after controlling for avoiding/delaying health care and sociodemographic covariates.

RESULTS: Among 39,711 respondents, 21.7% reported avoiding/delaying health care and 27.2% reported having at least 1 ED visit in the past year. Individuals with higher vs lower aggregated social risk had higher odds of avoiding/delaying health care (odds ratio [OR], 1.30; 95% CI, 1.26-1.34) and were more likely to have any ED visits (OR, 1.10; 95% CI, 1.07-1.13). Uninsured individuals compared with those with private insurance were more likely to avoid/delay health care (OR, 1.98; 95% CI, 1.73-2.26) and have higher likelihood of any ED visits (OR, 1.23; 95% CI, 1.06-1.42). Finally, individuals who reported avoiding/delaying getting health care were more likely to have higher odds of any ED visits (OR, 1.33; 95% CI, 1.23-1.45).

CONCLUSIONS: Social risks are important factors in patients' decisions to avoid/delay health care and are associated with increased odds of any ED visits. To reduce ED visits, policy-level efforts need to be made to address these social challenges.

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TAKEAWAY POINTS

- ▶ Avoiding or delaying health care is associated with poor health outcomes and increased health care costs.
- ▶ This study finds that social risks (food insecurity, housing instability, financial strain, and health insurance type) are associated with patients' decisions to avoid or delay health care and increased utilization of the emergency department.
- ▶ Policy makers should consider integrating health care and social resources to ensure the holistic health and well-being of individuals in the community.
- ▶ Payers and providers have an opportunity to measure, assess, and intervene strategically to improve the experience of the patients inside and outside the realms of the health care matrix.

the association of housing instability with increased emergency department (ED) utilization¹⁷⁻¹⁹ and decreased likelihood of using preventive services.^{20,21} Also, patients reporting food insecurity show increased needs for health services and often have to make the difficult decision of choosing between health care and basic survival requisites.^{22,23}

Previous research has focused on avoiding or delaying health care from the lenses of patient motivation and health care system factors. There is limited research examining the relationship of avoiding/delaying care and ED visits with social risks (eg, food insecurity, housing instability, financial strain). Exploring these associations may provide important information on the challenges and missed opportunities that are presented outside the realm of the health care system. Thus, the objectives of this study are (1) to examine the association of social risks with avoiding/delaying health care after controlling for sociodemographic covariates, and (2) to examine the association of social risks with ED visits after controlling for avoiding/delaying health care and sociodemographic covariates.

METHODS

Participants

A retrospective, cross-sectional study using the 2017 Ohio Medicaid Assessment Survey (OMAS) response data set was conducted. OMAS is a state-level representative survey of noninstitutionalized Ohioans. OMAS surveys changes in Ohio's Medicaid, Medicaid-eligible, and non-Medicaid populations to assess health care access, health status, and health care use for Ohio's current and potential Medicaid beneficiaries.²⁴ OMAS adopts a complex design (multiple strata) and stratified random digit dual-frame (cell and landline) telephonic survey and uses validated questions from existing state and federal health surveys.²⁴ Data are collected on health insurance type, health status (physical, mental, dental), diagnosis of selected health conditions, health utilization, health needs, perceptions of health care quality, access to health care, and health-related socioeconomic variables.

Measures

Social risks included in this study were aggregated social risk and health insurance type. Aggregated social risk was created by summing

responses to questions in these 3 areas: (1) food insecurity (assessed by "In the past 12 months, has it gotten easier, harder, or stayed the same to buy food for family or household?"); (2) housing instability (assessed by "In the past 12 months, has it gotten easier, harder, or stayed the same to pay rent or mortgage?"); and (3) financial strain (assessed by "In the past 12 months, has it gotten easier, harder, or stayed the same to pay off any debt you had?").²⁴ Item responses for each question were coded as easier, stayed the same, and harder. Polychoric correlation

was conducted to assess multicollinearity among the variables. Next, principal component analysis was done, and only 1 domain emerged with an Eigenvalue more than 1. Therefore, the questions assessing food insecurity, housing instability, and financial strain were combined to calculate the aggregated social risk. The second social risk measured health insurance type and had the following response options: dual (Medicare and Medicaid), Medicare only, Medicaid only, private, and uninsured.

Health care utilization was assessed by ED visits and avoiding/delaying health care. ED visits were assessed by the question "During the past 12 months, how many times were you a patient in a hospital emergency room?"²⁴ Item responses ranged from 0 to 20, which were dichotomized as yes (1 or more visits) and no (0 visits). Avoiding/delaying of health care was assessed by the question "During the past 12 months, did you delay/avoid getting health care that you felt you needed?"²⁴ The response category was categorical and coded as yes and no.

Covariates included in the study were age (19-34, 35-64, and > 64 years), gender (male and female), race (White, African American or Black, Asian American, and other), ethnicity (Hispanic and non-Hispanic), marital status (married, single, and widowed/separated/divorced), and patient-reported perception of health status (excellent, very good, good, fair, and poor). These variables were collected as categorical responses.²⁴

Data Analysis

Descriptive analyses were carried out comparing distributions of social risk factors and other covariates between male and female respondents using the χ^2 test. Data analysis included survey weights to adjust for unequal probability of sample selection, and standard errors were adjusted for the complex design of the survey sample.²⁴ Next, 2 separate weighted multiple logistic regressions were conducted. The first series of weighted logistic regression tested for the direct association of social risks (aggregated social risk and health insurance type) with avoiding/delaying health care. Next, association of social risks (aggregated social risk and health insurance type) with avoiding/delaying health care was done after controlling for sociodemographic factors (age, gender, race and ethnicity, marital status) and health status. The second series of weighted logistic regressions tested the direct association of social

risks (aggregated social risk and health insurance type) with ED visits. Next, association of social risks (aggregated social risk and health insurance type) with ED visits was done after controlling for sociodemographic factors (age, gender, race, ethnicity, marital status) and health status. The final logistic regression model evaluated the association of social risks with ED visits after adjusting for avoiding/delaying health care, sociodemographic factors, and health status. All statistical analyses were performed using SAS version 9.3 (SAS Institute), and a *P* value of less than .05 was used to determine significance.

RESULTS

Sociodemographic characteristics of the sample by gender are provided in **Table 1**. There were 21,564 (54.3%) female and 18,147 (45.7%) male respondents. Of the total 39,711 respondents, 21.7% respondents reported delaying/avoiding health care, and 27.2% of the respondents reported having at least 1 visit to the ED in the past year. A higher proportion of women reported having government-sponsored insurance (Medicare, Medicaid, dual) vs men, who were more likely to report being uninsured or having private insurance. A significantly higher proportion of women compared with men reported finding it harder to buy food (21.9% vs 16.0%), pay for housing (19.0% vs 15.7%), and pay off debt (30.4% vs 23.6%). A higher proportion of women compared with men also reported avoiding/delaying health care (25.5% vs 20.4%) and having at least 1 ED visit in the past 12 months (30.5% vs 26.6%). Chi-square tests showed that these observed differences between men and women were highly significant (*P* < .0001). In addition, among individuals who reported avoiding/delaying health care, about 33.5% reported more difficulty paying for food, about 30.6% reported more difficulty paying for rent or mortgage, and about 45.2% reported more difficulty paying off their debt.

Results from the multiple logistic regression exploring the association of social risks with avoiding/delaying health care are shown in **Table 2**. Individuals with higher aggregated social risk had higher odds of avoiding/delaying health care (odds ratio [OR], 1.30; 95% CI, 1.26-1.34) and this association continued to be significant after controlling for all sociodemographic covariates. Individuals with Medicaid (OR, 1.27; 95% CI, 1.15-1.40) and who were uninsured (OR, 2.27; 95% CI, 2.00-2.58) were more likely to avoid/delay health care, and those who had Medicare were less likely (OR, 0.60; 95% CI, 0.54-0.67) to avoid/delay health care compared with individuals with private insurance. However, after controlling for sociodemographic covariates, only uninsured individuals (OR, 1.98; 95% CI, 1.73-2.26) continued to be more likely to avoid/delay health care compared with individuals with private insurance. Being female, single, and widowed/separated/divorced were associated with significantly higher odds of avoiding/delaying health care. Being older than 34 years and being African American or Asian American were associated with significantly lower odds of avoiding/delaying health care.

TABLE 1. Sociodemographic Description of the Study Participants by Gender, 2017 Ohio Medicaid Assessment Survey

Variables	Male	Female
Total n	18,147	21,564
Social risks		
Aggregated social risk		
Food insecurity		
Easier	1822 (10.95%)	1562 (7.83%)
Same	12,157 (73.07%)	14,028 (70.32%)
Harder	2659 (15.98%)	4359 (21.85%)
Missing	1509	1615
Housing instability		
Easier	1670 (10.97%)	1474 (8.15%)
Same	11,167 (73.33%)	13,184 (72.93%)
Harder	2391 (15.70%)	3420 (18.92%)
Missing	2919	3486
Financial strain		
Easier	1865 (11.84%)	1678 (8.85%)
Same	10,161 (64.51%)	11,518 (60.73%)
Harder	3724 (23.64%)	5771 (30.43%)
Missing	2397	2597
Health insurance type		
Dual Medicare/Medicaid	1149 (6.33%)	1581 (7.33%)
Medicaid	1960 (10.80%)	3413 (15.83%)
Medicare	4429 (24.41%)	6245 (28.96%)
Private	9254 (50.99%)	9359 (43.40%)
Uninsured	1355 (7.47%)	966 (4.48%)
Age in years		
19-34	4253 (23.44%)	3810 (17.67%)
35-64	9084 (50.06%)	10,976 (50.90%)
> 64	4810 (26.51%)	6778 (31.43%)
Race		
White	13,638 (83.32%)	15,973 (81.10%)
African American or Black	1860 (11.36%)	3002 (15.24%)
Asian American	275 (1.68%)	179 (0.91%)
Other	595 (3.64%)	542 (2.75%)
Missing	1779	1868
Ethnicity		
Hispanic	539 (3.24%)	542 (2.71%)
Non-Hispanic	16,105 (96.76%)	19,433 (97.29%)
Missing	1503	1589
Marital status		
Married	8433 (50.50%)	8946 (44.78%)
Single	3752 (22.47%)	3303 (16.53%)
Widowed/separated/divorced	4513 (27.03%)	7729 (38.69%)
Missing	1449	1586

(continued)

TABLE 1. (Continued) Sociodemographic Description of the Study Participants by Gender, 2017 Ohio Medicaid Assessment Survey

Variables	Male	Female
Social risks		
Overall health		
Excellent	3347 (18.44%)	3639 (16.88%)
Very good	5691 (31.36%)	6506 (30.17%)
Good	5277 (29.08%)	6282 (29.13%)
Fair	2666 (14.69%)	3622 (16.80%)
Poor	1166 (6.43%)	1515 (7.03%)
Avoiding/delaying health care		
Yes	3450 (20.42%)	5156 (25.53%)
No	13,449 (79.58%)	15,041 (74.47%)
Missing	1248	1367
Emergency department visits		
Yes	4561 (26.61%)	6241 (30.52%)
No	12,579 (73.39%)	14,208 (69.48%)
Missing	1007	1115

Results of the multiple logistic regression to explore the association of social risks with ED visits after controlling for avoiding/delaying health care and other covariates are shown in **Table 3**. Individuals with higher aggregated social risk reported greater odds of having at least 1 ED visit in the past 12 months (OR, 1.21; 95% CI, 1.17-1.24), and this association was consistently significant after controlling for other covariates. Individuals with health insurance types of Medicare (OR, 1.70; 95% CI, 1.55-1.87), Medicaid (OR, 3.79; 95% CI, 3.45-4.16), dual Medicare/Medicaid (OR, 3.35; 95% CI, 2.91-3.86), or who were uninsured (OR, 1.67; 95% CI, 1.46-1.91) were reported greater odds of any ED visits compared with individuals with private insurance. This association continued to be significant even after controlling for all the covariates. Individuals identifying as African American or “other” race group, or as being widowed/separated/divorced, reported greater odds of any ED visits. Finally, individuals who reported avoiding/delaying health care had greater odds of any ED visits (OR, 1.33; 95% CI, 1.23-1.45) compared with those who did not report avoiding/delaying health care.

DISCUSSION

The disproportionately worse health outcomes reported among racial/ethnic minorities in the current COVID-19 pandemic have made it increasingly apparent that research should look beyond biological and genetic factors as the major predictors of diseases. It is critical to examine social risk factors and their contribution to health disparities in studying societal patterns of illness and health. This investigation examined the association of social risks (health insurance type and aggregated social risk) with avoiding/delaying health care and its downstream association with ED utilization.

First, the primary hypothesis investigating the positive association of health insurance type and avoiding/delaying health care

TABLE 2. Logistic Regression of Social Risks on Avoiding/Delaying Health Care Among 2017 Ohio Medicaid Assessment Survey Participants

	Model 1		Model 2	
	OR	95% CI	OR	95% CI
Aggregated social risk	1.30***	1.26-1.34	1.22***	1.18-1.26
Health insurance type				
Private	Reference	Reference	Reference	Reference
Dual Medicare/Medicaid	0.93	0.79-1.10	0.86	0.71-1.03
Medicaid	1.27***	1.15-1.40	0.96	0.86-1.07
Medicare	0.60***	0.54-0.67	0.90	0.76-1.06
Uninsured	2.27***	2.00-2.58	1.98***	1.73-2.26
Age in years				
19-34	—	—	Reference	Reference
35-64	—	—	0.68***	0.62-0.75
> 64	—	—	0.29***	0.24-0.35
Gender				
Male	—	—	Reference	Reference
Female	—	—	1.37***	1.27-1.47
Race				
White	—	—	Reference	Reference
African American or Black	—	—	0.67***	0.60-0.75
Asian American	—	—	0.64**	0.44-0.92
Other	—	—	0.90	0.68-1.18
Ethnicity				
Non-Hispanic	—	—	Reference	Reference
Hispanic	—	—	0.89	0.70-1.13
Marital status				
Married	—	—	Reference	Reference
Single	—	—	1.16**	1.04-1.28
Widowed/separated/divorced	—	—	1.36***	1.25-1.49
Health status				
Excellent	—	—	Reference	Reference
Very good	—	—	1.46***	1.29-1.64
Good	—	—	2.17***	1.92-2.45
Fair	—	—	3.02***	2.64-3.47
Poor	—	—	3.46***	2.88-4.16

OR, odds ratio.
P* < .05; *P* < .01; ****P* < .001.

was confirmed in our study. Being uninsured led to avoiding or delaying health care, which is consistent with evidence from other studies.^{7,25-27} In addition, our secondary hypothesis investigating the positive association of health insurance type and ED visits was confirmed. Having government-sponsored health insurance, including Medicare, Medicaid, and dual, was associated with higher odds of any ED visits in this study, which is consistent with the evidence from previous studies.^{28,29} Being uninsured was also associated with having higher odds of any ED visits, albeit much lower than those

with government-sponsored insurance. This is contrary to conventional understanding that uninsured individuals tend to use the ED at a much higher rate but consistent with findings of multiple recent research studies.^{30,31} This finding validates the direct association of comprehensive coverage (government insurance) with increased ED utilization observed in previous studies.^{30,31} More importantly, it highlights that the relationships between different insurance types and ED visits are complex and may be influenced by multiple factors, including characteristics of the population covered, the insurance coverage features, and availability of different types of care for the uninsured.³² This further emphasizes the financial and nonfinancial access barriers encountered by the uninsured. Research results have shown that individuals with insurance have better access to and increased utilization of health care services.³³⁻³⁶ Efforts need to be made to nudge uninsured patients toward utilizing safety-net facilities and gaining access to health insurance. On the other hand, utilization among those with Medicaid needs to be explored through the lenses of quality, access to primary care, and misaligned incentives of using the ED.

Second, our study found that social risks of food insecurity, housing instability, and financial strain were associated with higher odds of avoiding/delaying health care and any ED visits, similar to previous research findings.^{7,18,20} Studies show that poverty, underemployment or unemployment, and high housing costs are strongly associated with food insecurity,³⁷⁻⁴⁰ and individuals experiencing these high social risks are usually making difficult trade-offs, such as choosing between buying food and buying or paying for other items or needs, such as prescription medication,^{41,42} housing rent,⁴³ and utilities.^{44,45} These competing priorities are significant and substantial barriers to access and utilization of necessary health care services.^{7,18,20,23} A report by JPMorgan Chase on financial strain shows that cash flow dynamics affect health care utilization.⁴⁶ In their analysis of out-of-pocket expenditures, the authors observed that patients increased their out-of-pocket expenditures by about 60% in the first week after receiving their tax refunds.⁴⁶ Considering these results, it may be worth exploring changes in the way flexible spending accounts and health savings accounts are replenished. Quarterly replenishment may nudge patients to use health care services in a

more timely manner than a lump-sum yearly contribution. Similar nudges should be explored for individuals with government-sponsored health insurance.

In addition to our main research findings, significant gender differences with respect to social risks were observed. Higher proportions of women, compared with men, reported having

TABLE 3. Logistic Regression of Social Risks and Avoiding/Delaying Health Care on ED Visits Among 2017 Ohio Medicaid Assessment Survey Participants

	Model 1		Model 2		Model 3	
	OR	95% CI	OR	95% CI	OR	95% CI
Aggregated social risk	1.21***	1.17-1.24	1.12***	1.09-1.15	1.10***	1.07-1.13
Health insurance type						
Private	Reference	Reference	Reference	Reference	Reference	Reference
Dual (Medicare/Medicaid)	3.35***	2.91-3.86	2.14***	1.80-2.54	2.16***	1.81-2.56
Medicaid	3.79***	3.45-4.16	2.57***	2.32-2.85	2.58***	2.32-2.86
Medicare	1.70***	1.55-1.87	1.71***	1.47-1.99	1.72***	1.48-2.00
Uninsured	1.67***	1.46-1.91	1.28**	1.11-1.47	1.23**	1.06-1.42
Age in years						
19-34	—	—	Reference	Reference	Reference	Reference
35-64	—	—	0.63***	0.57-0.69	0.64***	0.58-0.70
> 64	—	—	0.48***	0.40-0.56	0.51***	0.43-0.60
Gender						
Male	—	—	Reference	Reference	Reference	Reference
Female	—	—	1.05	0.98-1.13	1.03	0.96-1.11
Race						
White	—	—	Reference	Reference	Reference	Reference
African American or Black	—	—	1.31***	1.18-1.45	1.34***	1.21-1.48
Asian American	—	—	0.35***	0.23-0.54	0.36***	0.24-0.55
Other	—	—	1.34*	1.04-1.73	1.35*	1.05-1.74
Ethnicity						
Non-Hispanic	—	—	Reference	Reference	Reference	Reference
Hispanic	—	—	0.96	0.77-1.21	0.97	0.77-1.22
Marital status						
Married	—	—	Reference	Reference	Reference	Reference
Single	—	—	1.08	0.97-1.20	1.07	0.97-1.19
Widowed/separated/divorced	—	—	1.20***	1.10-1.30	1.18**	1.08-1.29
Health status						
Excellent	—	—	Reference	Reference	Reference	Reference
Very good	—	—	1.43***	1.27-1.62	1.41***	1.24-1.59
Good	—	—	2.46***	2.18-2.77	2.37***	2.10-2.68
Fair	—	—	4.18***	3.65-4.79	3.96***	3.45-4.54
Poor	—	—	6.46***	5.40-7.74	6.08***	5.07-7.29
Avoid/delay health care						
No	—	—	—	—	Reference	Reference
Yes	—	—	—	—	1.33***	1.23-1.45

ED, emergency department; OR, odds ratio.
*P < .05; **P < .01; ***P < .001.

government-sponsored health insurance (Medicare, Medicaid, dual) and reported hardships in paying for food, housing, and debt. Compared with their male counterparts, women also had higher odds of avoiding or delaying health care but no greater odds of ED visits. This observation is consistent with prior research, which indicated that after adjusting for health care needs and economic access, women had significantly fewer physician visits compared with men with similar health needs.⁴⁷ Women often face more barriers to health services utilization due to responsibilities of childcare, other caregiving responsibilities, and employment.

Additionally, this study reaffirmed racial disparities in access to and utilization of health care services. Consistent with previous research, African Americans and Asian Americans reported lower odds of avoiding/delaying health care, but African Americans reported higher odds of any ED visits and Asian Americans had lower odds of any ED visits compared with White individuals.^{48,49} This disconnect between health utilization and ED visits raises critical questions around access, quality of received health care, timeliness of care, and distrust of the health care system among racial and ethnic minorities. Legacies of past abuses and discrimination experiences, such as the Tuskegee syphilis study, contribute to the continued mistrust in the health care system among racial and ethnic minorities.⁵⁰ These observed disparities emphasize the need for interventions that create outpatient safety-net facilities in regions of need, especially to meet the needs of underserved racial and ethnic minorities. Furthermore, increasing awareness and engagement among minority communities can address issues pertaining to health utilization.

Finally, we found that individuals describing their health status as progressively worsening had higher odds of avoiding/delaying health care compared with those who reported excellent health status. In addition, individuals reporting progressively worsening health status also showed higher odds of any ED visits even after controlling for avoiding/delaying health care compared with those who reported excellent health status. This finding highlights that people who perceive themselves to be in excellent health promptly get health care when needed and subsequently utilize the ED less than those reporting their health status as less than excellent.

Limitations

OMAS is a cross-sectional survey that is associated with inherent limitations regarding interpretation of the findings, as no causality in relationships can be ascertained. Additionally, measurement of social risks including food insecurity, housing instability, and financial strain were available for only the past year, which may lead to underestimation or overestimation based on the most recent experiences. Additionally, social determinants of health (food insecurity, housing instability, financial strain) are assessed using standard questionnaires. Although the questions asked in OMAS are not the standard way to measure these domains, they have been adapted from previously validated items like previous OMAS surveys, the Behavioral Risk Factor Surveillance System, the

American Community Survey, the National Health and Nutrition Examination Survey, and the Medical Expenditures Panel Survey. Also, food insecurity, housing instability, and financial strain have been identified as “social risks” to account for the lack of consistency with respect to measurement of social determinants of health.

CONCLUSIONS

Social risks of health insurance type, food insecurity, housing instability, and financial strain are important factors in patients' decisions of seeking or delaying health care and in utilizing the ED as their usual source of care. Policy makers should consider integrating health care and social resources to ensure the holistic health and well-being of individuals in the community. Payers and providers have an opportunity to measure, assess, and intervene strategically to enhance patients' experiences inside and outside the realm of the health care matrix. This enhanced patient experience may generate improvements in health outcomes and reductions in health care costs. ■

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