Making the *(Business)* Case for Health Social Work

Community Networks – Delivery Systems – National Work

June Simmons, *BA, MSW*
President & CEO
Partners in Care Foundation

SSWLHC Webinar
1/18/2022

PARTNERS IN CARE FOUNDATION

A Mission-Driven Organization

Our Mission

Partners aligns social care and health care to address the social determinants of health and equity disparities affecting diverse, under-served and vulnerable populations.

PARTNERS IN CARE FOUNDATION

A Mission-Driven Organization

What We Do

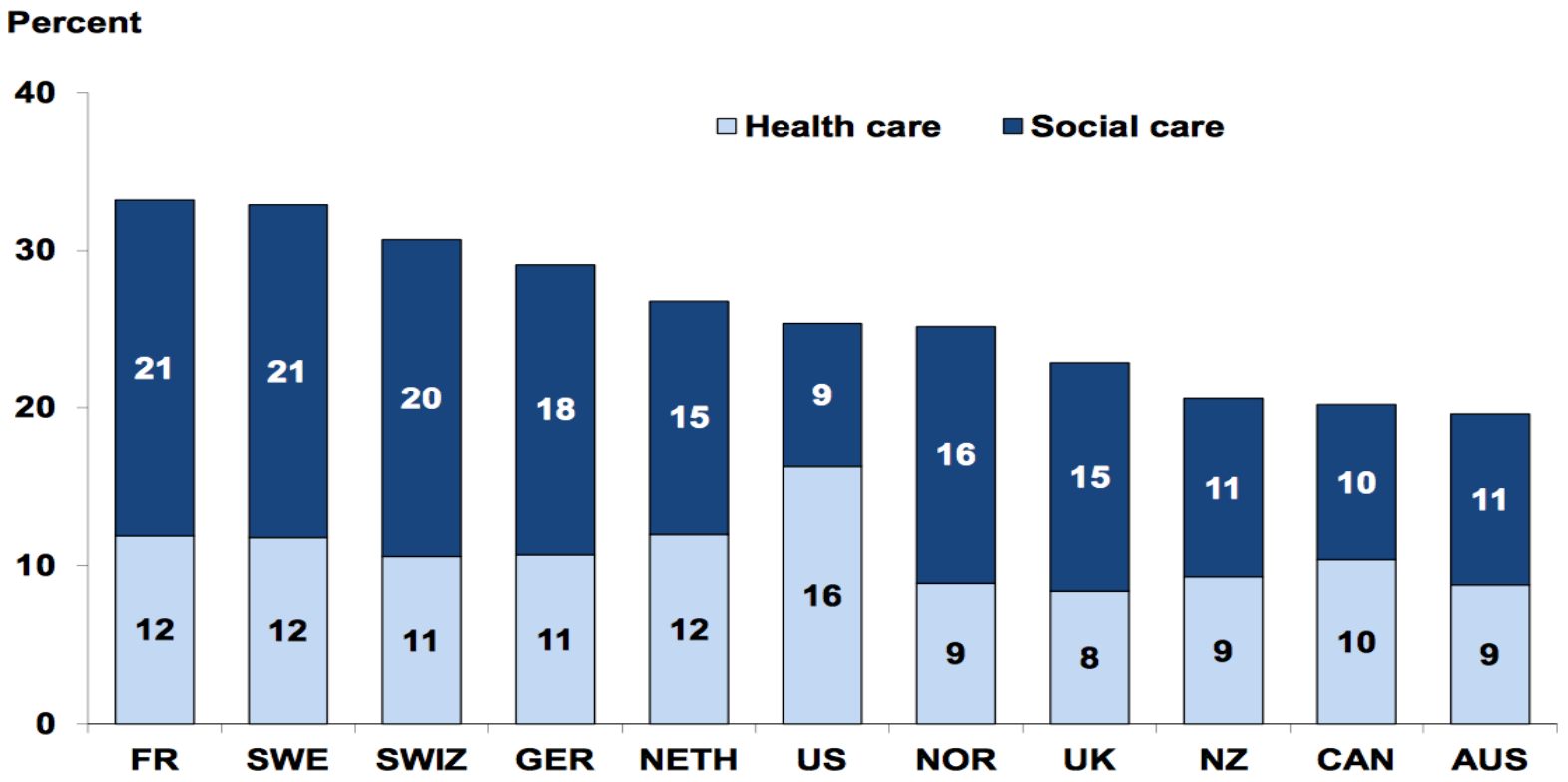
- Create, test, adapt, and disseminate evidence-based models of care applied to care management for community living and aging well.
- Deliver programs to improve chronic disease self-management, identify and resolve dangerous medication errors, thus preventing falls, averting costly ER use or hospitalizations, and preventing homelessness or nursing home placement through in-home care coordination.
- Provide social care management, both brief and long term, as well as consumer empowerment through evidence-based workshops to enhance health self-management skills and behavior changes.

The Current State of Health Care

Mismatch Between Patient Needs and Provider Knowledge and Skills

- History of delivering medical care with two professions: doctors and nurses
- Social problems remain unidentified and unaddressed given limits of these professions
- Separation between what is perceived as “social care” and “health care”
- Lack of time in medical system to examine patient’s social environment – even where social workers exist, referrals are avoided if possible
- Assumption that provision of referral information creates change

Spending on Social Care vs. Health Care

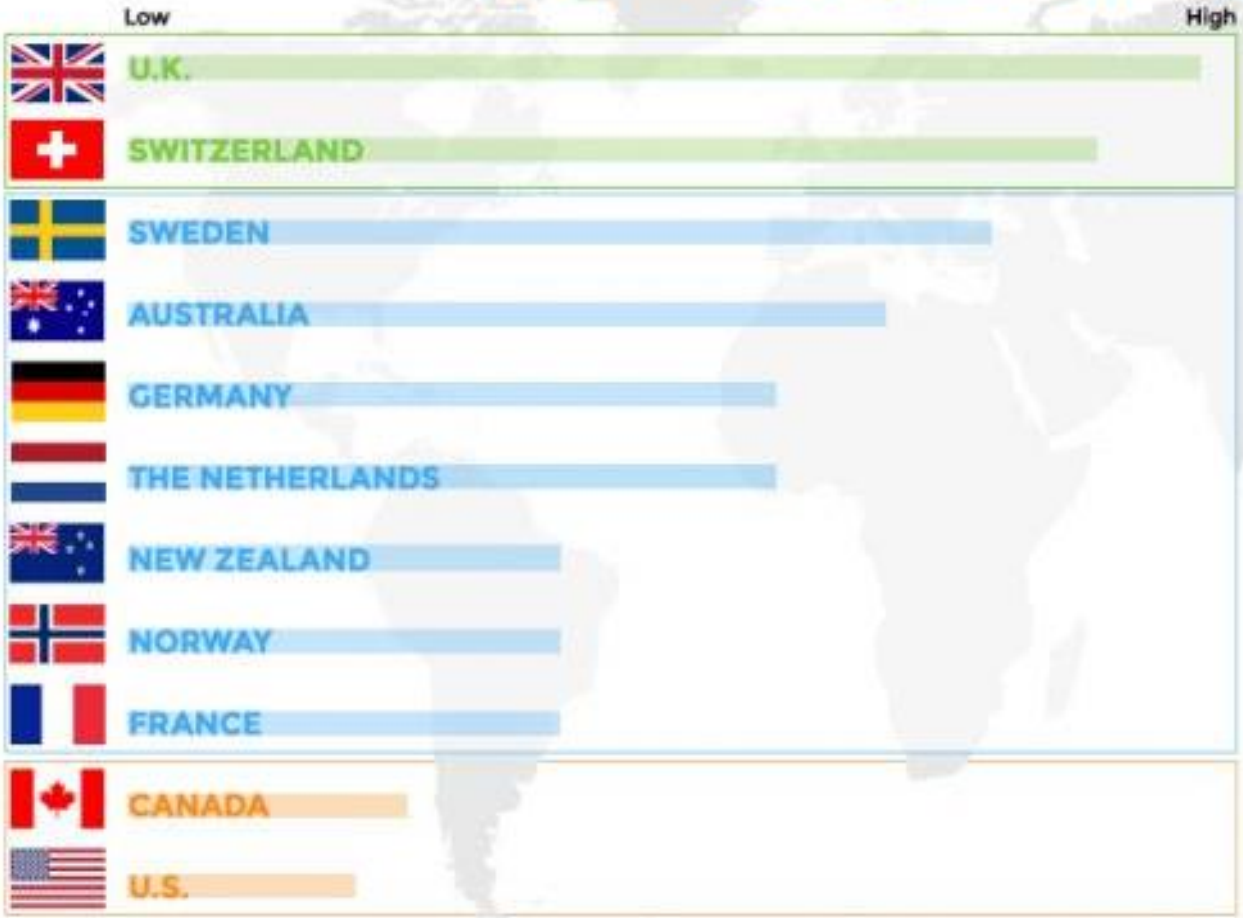


Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

The COMMONWEALTH FUND

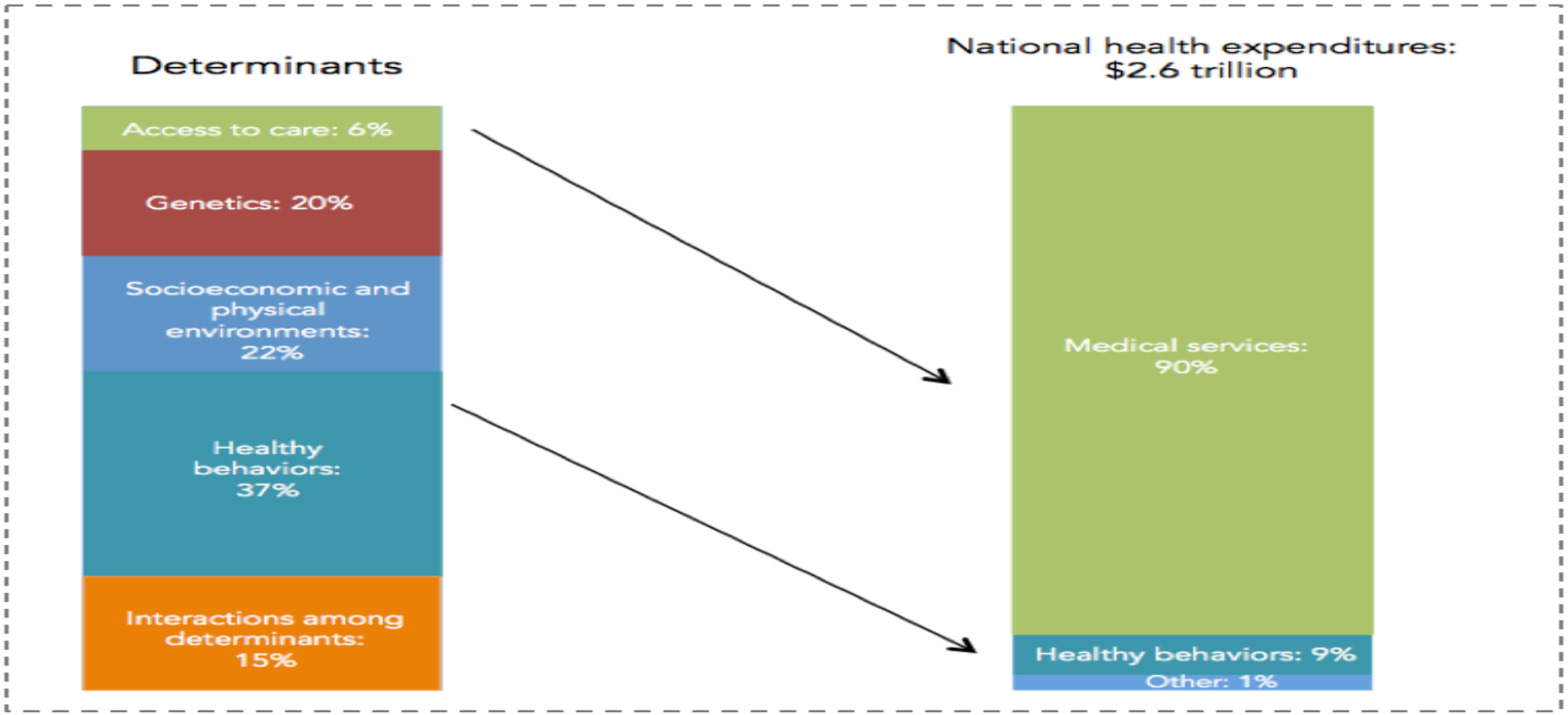
A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Overall Health Care Ranking



Health Care Outcomes: Life Expectancy

How Were We Spending Our Money?

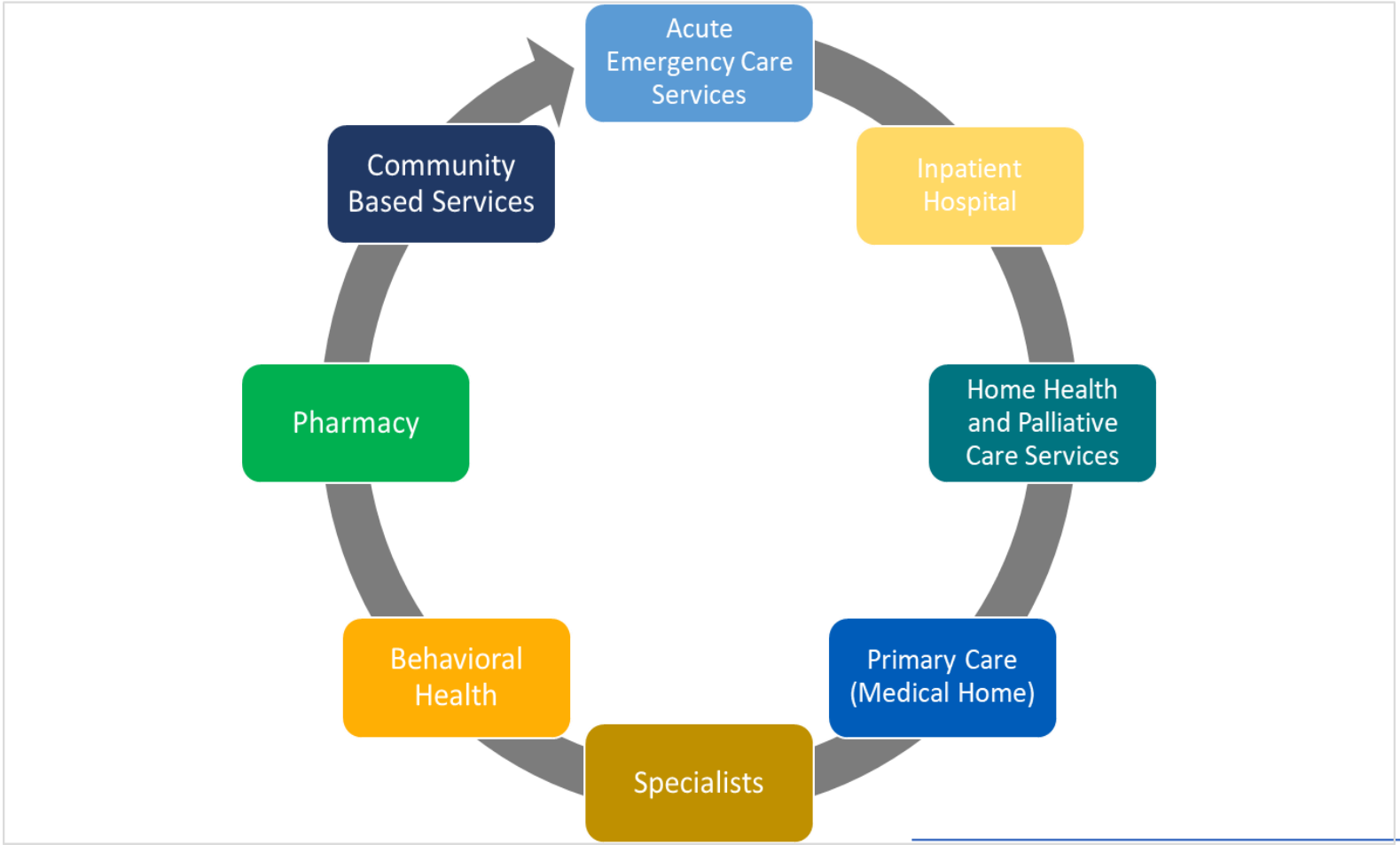


The Evolution of the U.S Health Care Delivery System –From Volume to Value

Improving Alignment Between Social Care and Medical Care

- New ability to measure outcomes – new insights into population health outcomes
- Changing reimbursement models VS Incentives to continue seeing patients for medical reasons when real reason is related to SDOH
- Lack of training for physicians and nurses in understanding issues affecting patients' abilities to follow treatment recommendations and skills in asking the right questions
- Current systems are parallel – how can financing transform to align these different sectors?

Social Care Across the Health Care Continuum



Health Happens at Home

The impact of what you don't see.

PARTNERS IN CARE FOUNDATION

The Case for Social Work Services & Leadership

Critical Timing For Fundamental Change and for Social Work Leadership

- Hospitals no longer the center of the universe
- Payment reforms and current Congressional proposals to redesign to improve impact of Medicare and Medicaid
- Many State Medicaid Reforms-
  - The Cal-AIM model
- Mental and behavioral health parity and awareness
- COVID-19 and impacts to the workforce
- NASEM Studies: Integrating Social Needs Care Into the Delivery of Health to Improve the Nation's Health (2019) and The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity Consensus

Social Work's Ability to Address Social Care

"Social workers are specialists in providing social care…

With expertise in patient and family engagement, assessment, care planning, behavioral health, and systems navigation, social workers identify and address multiple factors that contribute to health and well-being."

The National Academies of | SCIENCES ENGINEERING MEDICINE

Social Workers and Other Social Care Providers Play a Key Role in Promoting Better Health for All

Findings from *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*

Decades of research demonstrate that improving social conditions — such as access to stable income and housing, nutritious and sufficient food, appropriate health care, and reliable transportation — is critical to improving overall health across the United States and reducing disparities in health outcomes. Integrating social care into health care delivery can help achieve this goal.

Taking social risk factors into account is critical to improving the prevention and treatment of acute and chronic illness, which requires effective interprofessional teams that include experts in social care, such as social workers. Social care providers understand that the conditions in which people live, work, and play influence their mental and physical health, their ability to access health care, and individuals' health-related behaviors. They provide interventions to address social needs and maximize the success of health care plans.

Social workers are specialists in providing social care who have a long history of working within health care delivery, and in-depth training and credentialing. With expertise in patient and family engagement, assessment, care planning, behavioral health, and systems navigation, social workers identify and address multiple factors that contribute to health and well-being.

Others who provide social care include:

Community health workers, who are often recruited from the communities they serve, and provide linkages among health care, social services, and the community.

Social service navigators, aides, and assistants, who assist patients and families on a wide range of activities and often help them find and access services in the community.

Nurses, who may serve within acute care settings, as care managers, as home care nurses, in community health centers, or in in-home visitation programs, and may address social needs directly or make referrals.

Home health aides and personal care aides, who provide extensive in-home support services to older adults, individuals with disabilities, and patients after a hospitalization.

Case managers, who coordinate the health and social care of patients and often focus on benefit enrollment.

Gerontologists, who are trained to support the aging process and aging populations.

Lawyers, who may assist patientsand families with legal matters that can compromise health, such as inadequate housing.

Family caregivers, who often provide social care and have a valuable perspective on the social needs of patients.

The Model Process

REFERRAL &
PRE-INTERVENTION PLANNING

Examples of Screening Approaches

PUBLIC HEALTH DIVISION
HIV Community Services Program

Oregon Health Authority

Psychosocial Screening Acuity — Regional

Client name: Client number:

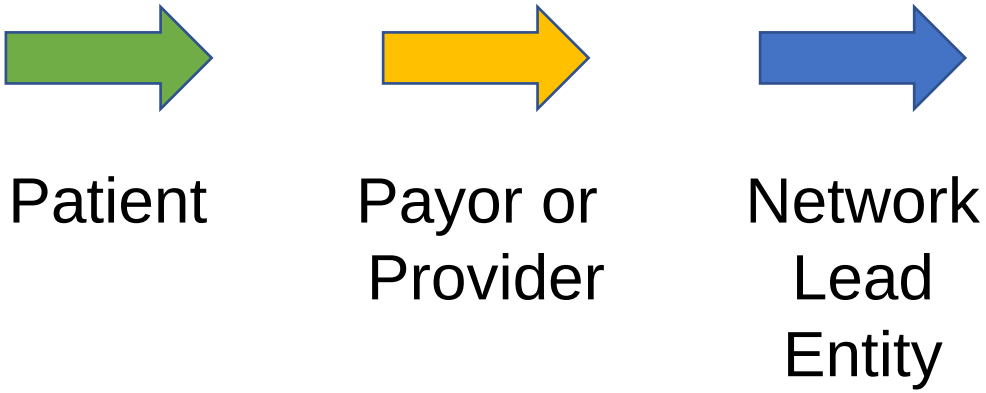
(Check the appropriate level in each life area. Multiply the number of "checks" in each column by the number of "points" for a total.)
If any of the following conditions apply, the psychosocial acuity level is automatically 4 and the acuity must be reassessed in 60 days:
☐ Incarcerated within the last 90 days. ☐ Diagnosed with HIV in the last 180 days. ☐ Currently homeless.

Life area	1 *(1 point)*	2 *(2 points)*	3 *(3 points)*	4 *(4 points)*
Basic needs/EFA	☐ Client is able to meet own basic needs. Client is able to access community assistance on their own as needed.	☐ Occasional help to access assistance. Needs occasional EFA < 2 times per year.	☐ Difficulty accessing assistance. Often w/o basics. Accesses EFA 3-6 times per year.	☐ Has limited access to food. Without most basic needs. Accesses EFA > 7 times.
Transportation	☐ Has reliable transportation. Is able to cover costs of transportation.	☐ Needs occasional assistance < 2 times per year.	☐ No means. Under or un-served area. Needs assistance 3-6 times per year.	☐ Serious impact on medical care. Needs assistance > 7 times per ye
Risk reduction	☐ Understand risks and practices harm reduction behavior.	☐ Poor understanding of risk and no exposure to high risk situations or behaviors.	☐ Has poor knowledge and/or occasionally engages in risky behaviors.	☐ Lacks knowledge and/or engages in significant risky behaviors.
Health insurance/medical care coverage	☐ Has own medical insurance and payer. Able to access medical care.	☐ Enrolled in CAREAssist. Needs occasional assistance accessing medical care < 2 times per year.	☐ Needs CM assistance or referral to access insurance or CAREAssist. No medical crisis. Needs assistance accessing medical care 3-6 times per year.	☐ Needs immediate assistance to access insurance or CAREAssist. Medical crisis. Does not have acce to medical care.
Self sufficiency	☐ Independent. F/U on referrals and access services.	☐ Sometimes requires assistance in F/U and completing forms.	☐ Difficulty w/ F/U; completing forms; accessing services.	☐ Never F/U; unable to complete forn burns bridges.
Housing/living arrangement	☐ Living in clean, habitable, stable housing. Does not need assistance.	☐ Stable housing subsidized or not. Occasionally needs assistance with housing < 2 times per year.	☐ Unstable housing subsidized or not. OHOP violation or eviction imminent. Frequently accesses assistance 3-6 times per year or pays rent late. Not safe housing.	☐ Unable to live independently. Recently evicted. Homeless. Temporary housing. Accesses assistance > 7 times per year.
Mental health	☐ No history of mental health problems. No need for referral.	☐ History and/or reports current difficulties/stress — is functioning. Engaged in mental health care.	☐ Experiencing severe difficulty in day-to-day functioning. Requires significant support. Needs referral to mental health care.	☐ Danger to self/others, needs immediate intervention. Needs but not accessing therapy.
Addictions	☐ No difficulties with addictions. No need for referral.	☐ Past problems and/or less than 1 year recovery. Not impacting ability to pay bills or health.	☐ Current addiction — willing to seek help. Impacts ability to pay bills and access to medical care.	☐ Current addiction — not willing to seek help. Unable to pay bills or se medical care because of addiction.
Points per level				

Total points: 0 ☐ **Points reported on care plan** **Date:**

Client name: Page 1 of 1 OHA 8496R (07/1

From Silos to Integration:
Regional Delivery Systems and Partnerships



- Coaching Provider
- Transportation Provider
- Handyman Provider
- Food/Meals Provider
- Social Benefits Provider
- Financial Counseling
- Consumer Empowerment

Building Social Care Networks

- This is a disruptive transformation
  - Who do we target? What services are key? How much, how long? What results?
- Where should funding come from? Wrong wallet problem
- High rate of return visits to hospitals and providers is based on inadequate access to social care
- Carter et al., (2017) Those reporting a barrier related to at least 2 measures of social determinants of health were more likely to have preventable readmissions. Targeting criteria key

Advantages When Health Care & Social Care Work Together

1. Health care provides a medical response to an individual's condition
2. Typically, medical care is resource intensive requiring wise application
3. Circumstances in that individual's home can undermine or negate medical interventions
4. Social care agencies can identify and address those threatening circumstances:
    - *Medication adherence problems*
    - *Food insecurity*
    - *Environmental issues (rugs, mold, stairs, heat, cold, etc.)*
    - *Income/poverty related*
5. The benefits for health care AND individual:
    - *Improved medical condition and health*
    - *Decreased overall expense*
    - *Admission and ER utilization reductions*
    - *Ability to remain in community setting with social network*

Bold New Partnerships

- Health Systems
- Hospitals
- Medical Groups/IPAs & Health Plans

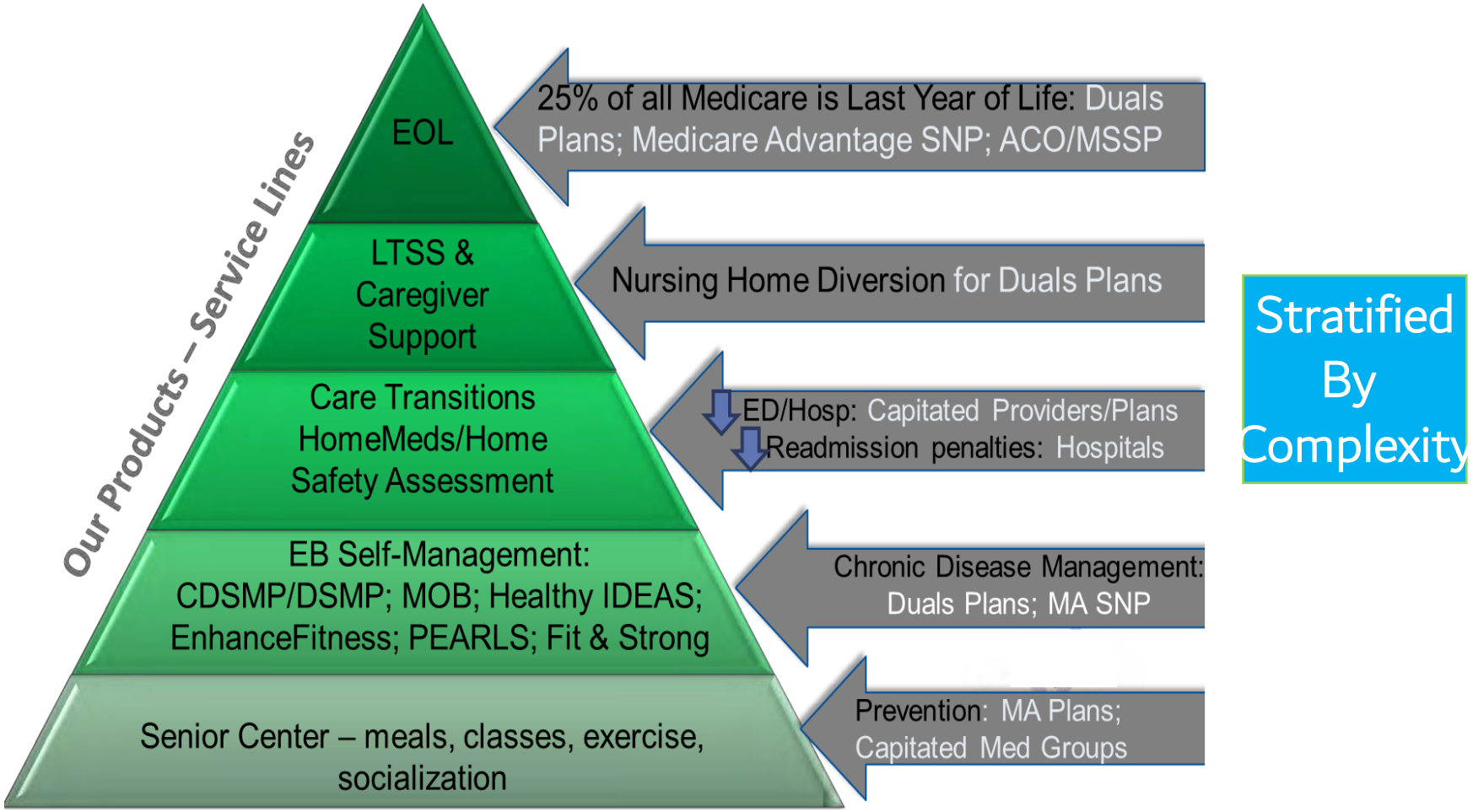
- New home and community-based specialty models of care, a critical component across the care continuum
- Depth of experience, with deep local knowledge and connections
- Full regional coverage with consistent tools, IT and results
- Evidence-based programs for chronic conditions, caregivers, medication safety and post-acute coaching and support
- Careful targeting

Powerful Value Proposition

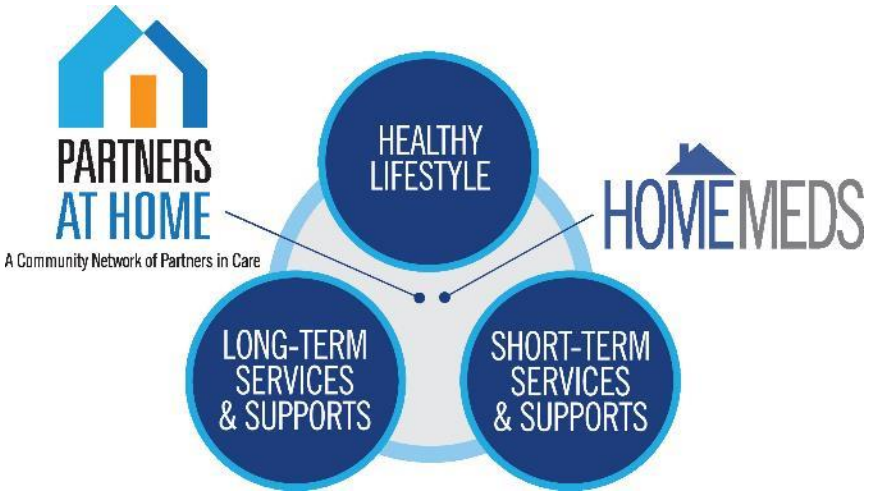
1. Reduce hospital readmissions
2. Achieve Nursing Home diversion
3. Contribute to improving Quality Measures (HEDIS, Medicare Star, MACRA)
4. Improve clinical outcomes
5. Enhance the patient experience influencing Net Promoter Score
6. Keep people in their homes and communities, reducing costly institutionalized care

Together, we achieve the Triple Aim!

Partners' Service Lines, Potential Purchasers, and Value Proposition



A Full Range of Evidence-Based Programs & Services Complementing the Clinical Model



Long-Term Services & Supports

Multipurpose Senior Services Program (MSSP):
Services to keep people at home (nursing home diversion)

CA Community Care Transitions:
Returns people home from nursing home ("repatriation")

Evidence-Based Healthy Lifestyle

Multi-session workshops such as: self-management programs, exercise programs, and fall prevention programs offered both in-person and remotely.

Short-Term In-Home Services

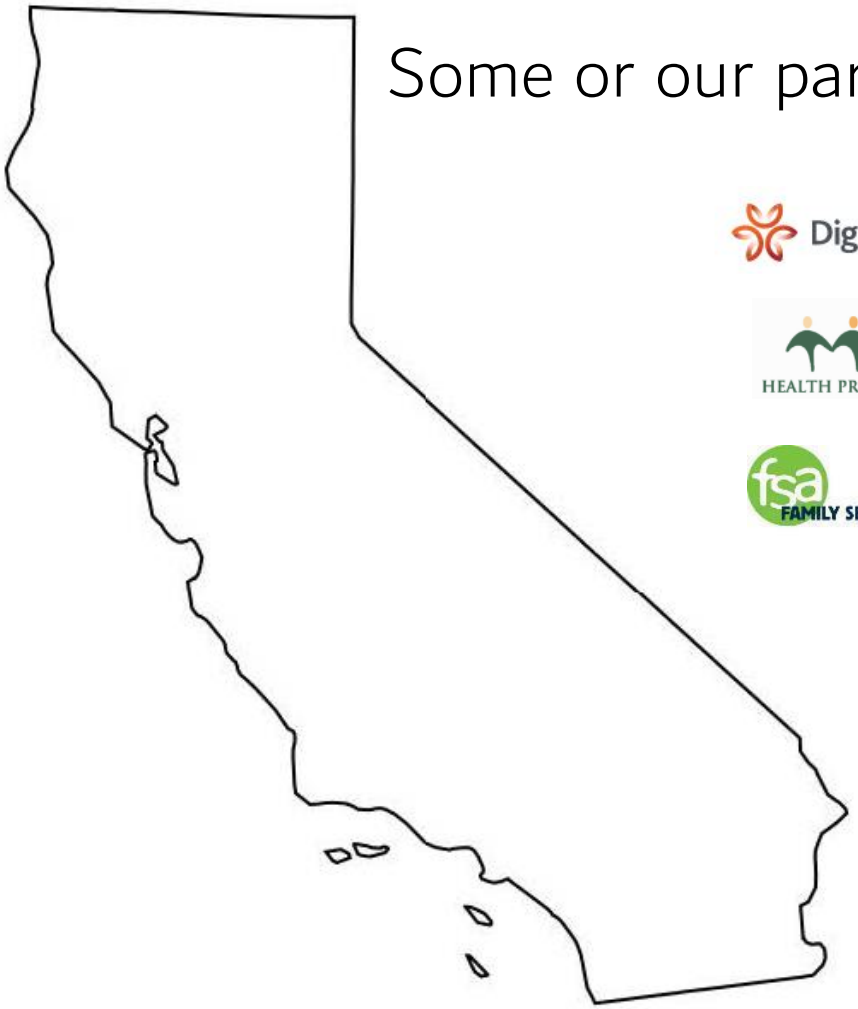
Care Transition Choices: Patient activation through coaching *or* telephonic social work support after discharge from hospital or SNF

HomeMedsPlus: Medication inventory/patient adherence/pharmacist review and recommendations, psychosocial, functional, cognitive & home safety assessment & care/service coordination for post-acute and high-risk individuals

TCM/CCM: Medicare fee-for-service physician billing codes for 30-day transitional care management & 12-month chronic care management.

Services delivered through **Partners At Home**, our statewide community-based network.

PARTNERS AT HOME
A Community Network of Partners in Care



Some or our partners…

Keiro

Vaaa
Ventura County Area Agency on Aging
"To Serve. To Guide. To Envision."

Dignity Health

Creative Housing & Services
The art of affordable housing
An affiliate of Episcopal Communities & Services

Saint Agnes Medical Center

HEALTH PROJECTS CENTER

Community Care

Camarillo Health Care District
For your health & wellness

fsa FAMILY SERVICE AGENCY Since 1899

ssg Special Service for Groups

WLCAC

PARTNERS IN CARE FOUNDATION

The Simplicity of One Partner,

with the resources of many!

Service Coordination

Comprehensive Assessments

HomeMeds/Med Reconciliation

Evidence-Based Healthy Lifestyle Workshops

LTSS: Meals, Transportation, Home Mods, etc.

Behavior Health Specialists

PARTNERS AT HOME

A Community Network of Partners in Care

The SHARPs – Referral = Services

- The technology revolution has brought favorable changes
- Measurement has brought tremendous insight
- SDOH is now a recognized concern – long under-valued, now there is "competition" to seize the new market"
- What are the boundaries?
  - Who gets the new investments?

Achieving Proven Results

The Social Determinants Specialists.

Partners in Care FOUNDATION

These are new practice partnerships – what target populations/which interventions?

- Value propositions are key – innovations must be sustainable
- Cost benefit - shift service dollars to better results
- Total cost of care vs. profit per procedure
- Multiple drivers of positive financial outcomes
- Evidence-based models/responsible measurement
- Some examples

New Partnerships/New Services

- Engagement
- Post acute Readmission Reduction
- Frequent ER users
- Long-stay inpatient or nursing home rescue
- Health self-management skills building
- New payers – All payer groups
  - Health plans
  - Hospital systems
  - Medical groups

A Common & Costly Problem

Medication Errors Are:

- **Serious:** Journal of Community Hospital Internal Medicine Perspectives reports that (2016):
  - Adverse Drug Events (ADEs) accounts for more than 3.5 million physician office visits and 1 million ED visits each year.
  - Preventable ADEs impact more than 7 million patients annually.
- **Causing suffering:** falls, dizziness, and confusion.
- **Costly:** Drug-related morbidity/mortality > $528.4 billion.
  Includes: ER, hospital/readmissions, SNF use, etc.
  From: Annals of Pharmacotherapy, 2018
- **Common:** 20-60% of community-dwelling elders have medication-related problems - varies by age, functional status and health.
- **Preventable:** At least 25% of all harmful ADEs are preventable.

HomeMeds℠

Complementing the clinical model of care.

- Inventory all meds being taken
- Assess for potential adverse effects including BP, pulse, falls, dizziness, confusion
- Document adherence issues and understanding
- Algorithm identifies targeted potential medication related problems (MRPs)
- Pharmacist reviews potential MRPs and makes recommendations for resolution, contacts provider and/or patient Medication list provided to patient with instruction to take to future appointments.
- Telepharmacy available in patient home

HomeMeds℠ Plus
Expanded In-Home Services

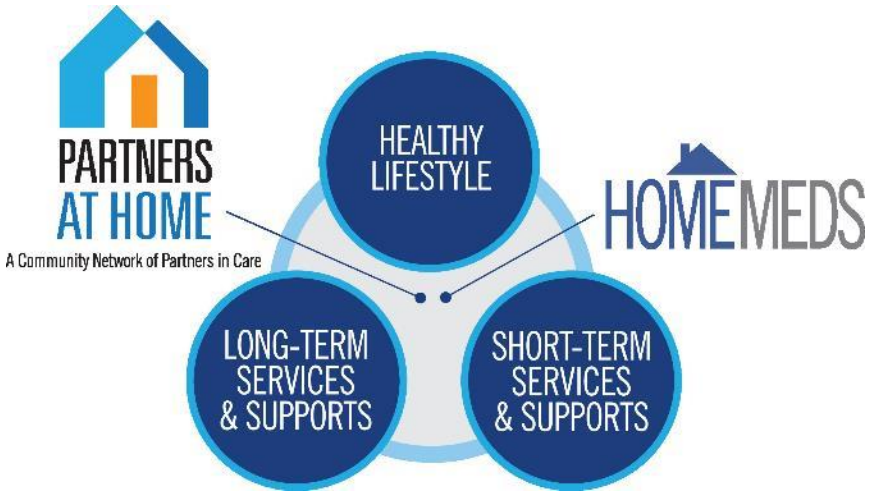
- HomeMeds PLUS:
- in-home evaluation and assessment with a 30-day follow-up to help the patient implement the care/service plan (provide referrals to patient)
- Enhanced care coordination:
  - Directly arrange for services requested by patient (ADD-ON)
  - Additional follow-up at 60 & 90 days (ADD-ON)
- Psychosocial assessment including:
  - Evaluate functional capacity (Activities of Daily Living) & coordinate access to DME
  - Screen for depression and cognitive impairment
  - Assess home safety, cleanliness, & maintenance, and observe for evidence of abuse, odors, inadequate food, caregiver issues, flag potential fall risks from medications, trip hazards or poor lighting

Measuring Social Work Value

- Cost:
  - 30-day readmission rates
  - visits to Emergency Departments
  - hospitalization costs /LOS
  - Nursing home costs

- Non-cost value terms:
  - Safety/Avoidable suffering
  - Quality Scores
  - Client and family satisfaction
  - Reduction in anxiety, depression, violence

A Full Range of Evidence-Based Programs & Services Complementing the Clinical Model



Long-Term Services & Supports

Multipurpose Senior Services Program (MSSP):
Services to keep people at home (nursing home diversion)

CA Community Care Transitions:
Returns people home from nursing home ("repatriation")

Evidence-Based Healthy Lifestyle

Multi-session workshops such as: self-management programs, exercise programs, and fall prevention programs offered both in-person and remotely.

Short-Term In-Home Services

Care Transition Choices: Patient activation through coaching *or* telephonic social work support after discharge from hospital or SNF

HomeMedsPlus: Medication inventory/patient adherence/pharmacist review and recommendations, psychosocial, functional, cognitive & home safety assessment & care/service coordination for post-acute and high-risk individuals

TCM/CCM: Medicare fee-for-service physician billing codes for 30-day transitional care management & 12-month chronic care management.

Medical Group Results

Post-acute high-risk Medicare Population

HOMEMEDS PLUS

Medical Group Results for 250 post-acute high-risk seniors.
Compared to patients who did not receive a home visit.

12.8%

Lower Rate ED Use

84%

Patients Accepted/Completed Home Visit

22%

Lower Rate of Readmissions

77%

Home Safety Issues Identified/Recommendations Made
(grab bars, bath chairs, emergency response systems)

53%

ROI Hospital Cost Avoidance

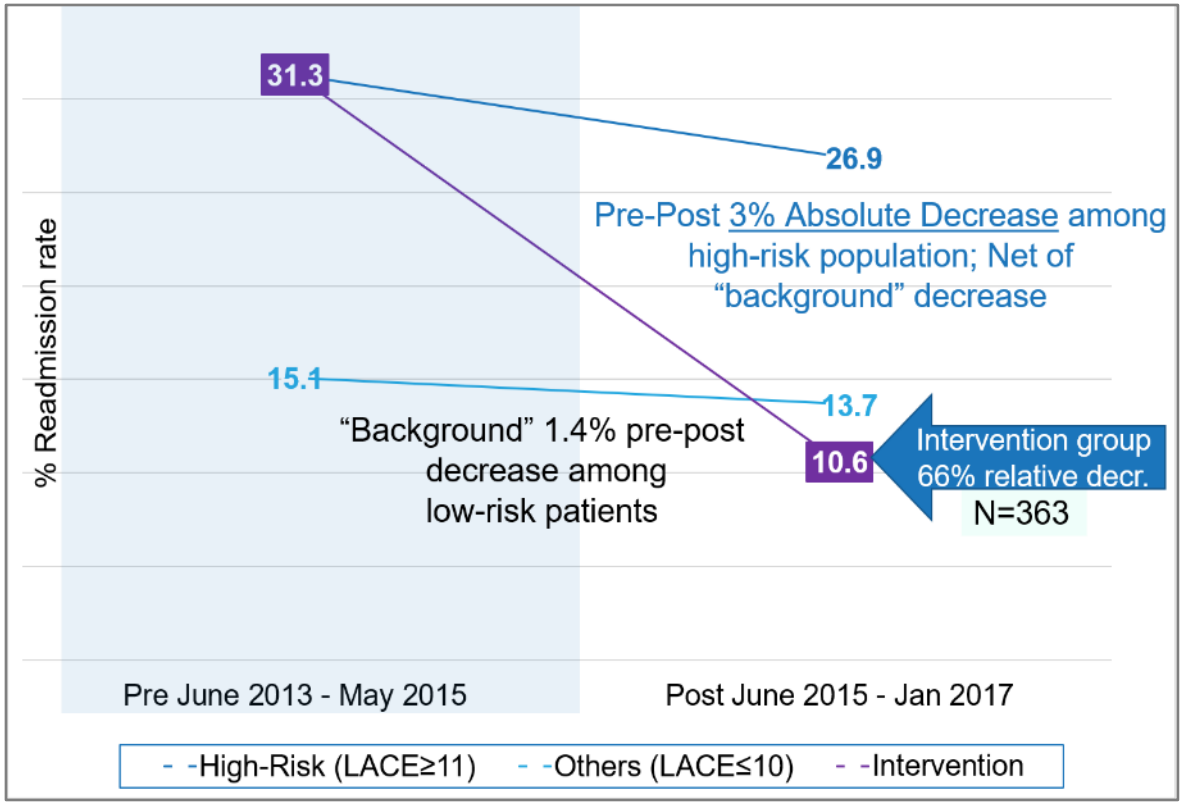
54%

Other Risk Factors Identified
(Depression, caregiving, finances)

UCLA Medical Group Results
Post-acute high-risk Medicare Advantage & Commercial Population

HOMEMEDS PLUS

Population Level Outcomes



With Recognition of SDOH as Drivers of Health, Care Evolving

- Lots of attention across the sectors and rapid change as pandemic and payment change lead
- SDOH solutions – a rush to address – many tech solutions, many commercial solutions proposed
- Serious evolution of Community Care Networks needs to scale faster
- Shift to SDOH driving administrative complexity
- Standards and systemic change needed

From Local to National
Leading the Way

A. The Partnership to Align Social Care - a National Learning and Action Coalition
   - 5 major health plans, major CBO networks, health systems, and ACL.

B. Define best pathways supporting the growth of resources enabling long-term sustainability of community-led SDOH delivery systems across the country.

C. Health plans and health systems co-designing with CBOs the strong and sustainable regional delivery systems needed:
   - establishing common expectations for contracting between payers and CBO networks;
   - facilitating multi-payer approaches to financing social care; supporting networks of CBOs that can meet community needs and address health inequities; Coding
   - setting standards for CBO-led Networks
   - enabling shared technology solutions across currently siloed referral networks.

A View to the Future –
A Bold Initiative!

- A vision of scaling and sustaining locally governed CBO **networks** organized as efficient, effective, and experienced SDOH service delivery systems.
- **New delivery systems will leverage best practices for blending and braiding of public, private, and philanthropic resources to ensure individual needs are addressed in a participant-directed approach, as well as to ensure the financial viability of each CBO network.**
- The planning phase identifies actionable steps for achieving the common goals of this new initiative.
- Next, will explore the feasibility of implementing each component and determine the probability of long-term sustainability of the defined options.
- Lastly, will determine the steps for adoption/implementation of the selected approach(es) to advance the common goals of the group.

Driving Social Work Leadership!

- There IS evidence that supports our work (though more is needed – add to the literature when able)
- Familiarize yourself with the academic literature and how to access if you don't have institutional access (Ok to send the author requests for copies)
- There are successful strategies for optimizing revenue (familiarize yourself with coding and billing options and best practices for reviewing and addressing denial management)
- Explore community solutions to address SDOH (partner with, and support community care networks)
- Join the battle for transforming health financing in USA

What Comes Next

- Explore impact of social work interventions
- Explore impact of social workers on teams
- Reframe value - include non-cost outcomes
- Inform others about what we do
- Involve clinical social workers in research

Additional Reading

Select Studies: Value of Social Work

Rizzo and Rowe (2016) Literature Review

- 42 studies examining impact of social work interventions in aging on quality of life (QOL) and cost.
- 71% percent reported significant QOL outcomes.
- Of the 21 studies including cost, 71.4% documented significant savings.

Reference: Rizzo, V. M., & Rowe, J. M. (2016). Cost-effectiveness of social work services in aging. *Research on Social Work Practice, 26*(6), 653-667. https://doi.org/10.1177/1049731514563578

Select Studies: Value of Social Work

Steketee, Ross, & Wachman (2017) Systematic Review

- 51 studies examining health outcomes and cost of social work led and social work as team member services.
- Most reported a positive effect on health and social service utilization.
- Research quality was higher when social workers were the leaders of the health services.

Reference: Steketee, G., Ross, A. M., & Wachman, M. K. (2017). Health outcomes and costs of social work services: A systematic review. *American Journal of Public Health, 107*(S3), S256-S266. https://doi.org/10.2105/AJPH.2017.304004

Select Studies: Value of Social Work

Fraser, Lombardi, Wu, de Saxe Zerden, Richman, & Fraher (2016) Systematic Review

- 32 studies examining functions and impact of social workers on interprofessional teams (integrated primary care).
- Mixed findings - integrated primary care provided by teams including social workers significantly improved patient care and behavioral health.

Reference: Fraser, M. W., Lombardi, B. M., Wu, S., de Saxe Zerden, L., Richman, E. L., & Fraher, E. P. (2018). Integrated primary care and social work: A systematic review. Journal of the Society for Social Work and Research, 9(2), 175-215. https://doi.org/10.1086/697567

The Time is Now

- Exciting to see this moment where systems are so open to change/have so much pressure to change
- There are champions in every sector – partner up
- Many voices to champion, with shared vision = powerful leverages for needed change
- What you do matters

Thank You!

Partners in Care FOUNDATION

For more information, please contact:

June Simmons
President and CEO
jsimmons@picf.org
818-837-3775 x101

The Social Determinants Innovators.