

# IMPROVING QUALITY BY ADDRESSING SOCIAL DETERMINANTS AND REDUCING ACUTE CARE UTILIZATION

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Social Work and Health Convening 2017:  
State of our Knowledge, State of our Training

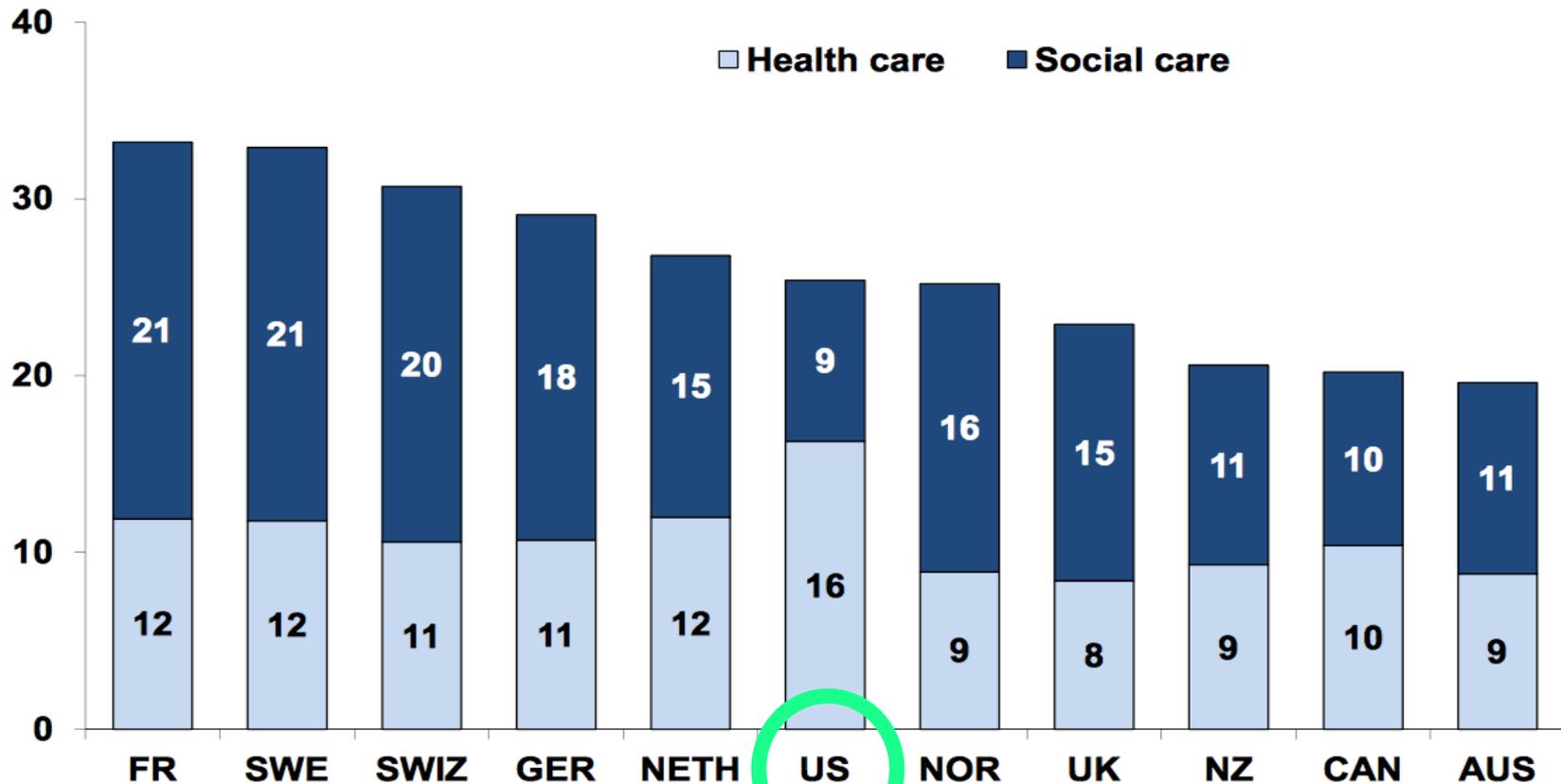
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Rush University Medical Center

**“More than 60 million Americans experience devastating one-two punches to their health— they have inadequate access to basic health care while also enduring the effects of discrimination, poverty, and dangerous environments that accelerate higher rates of illness.”**

- *Grand Challenges for Social Work*

# Health and Social Spending (% of GDP)

Percent



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.



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# Inefficient and Ineffective Care

## Acute, episode-based care

- More expensive settings
  - Emergency department, hospital inpatient
- Less predictability with care team
- More stressful setting
- Less opportunity to provide education
- Follow-up is often “lost in translation”



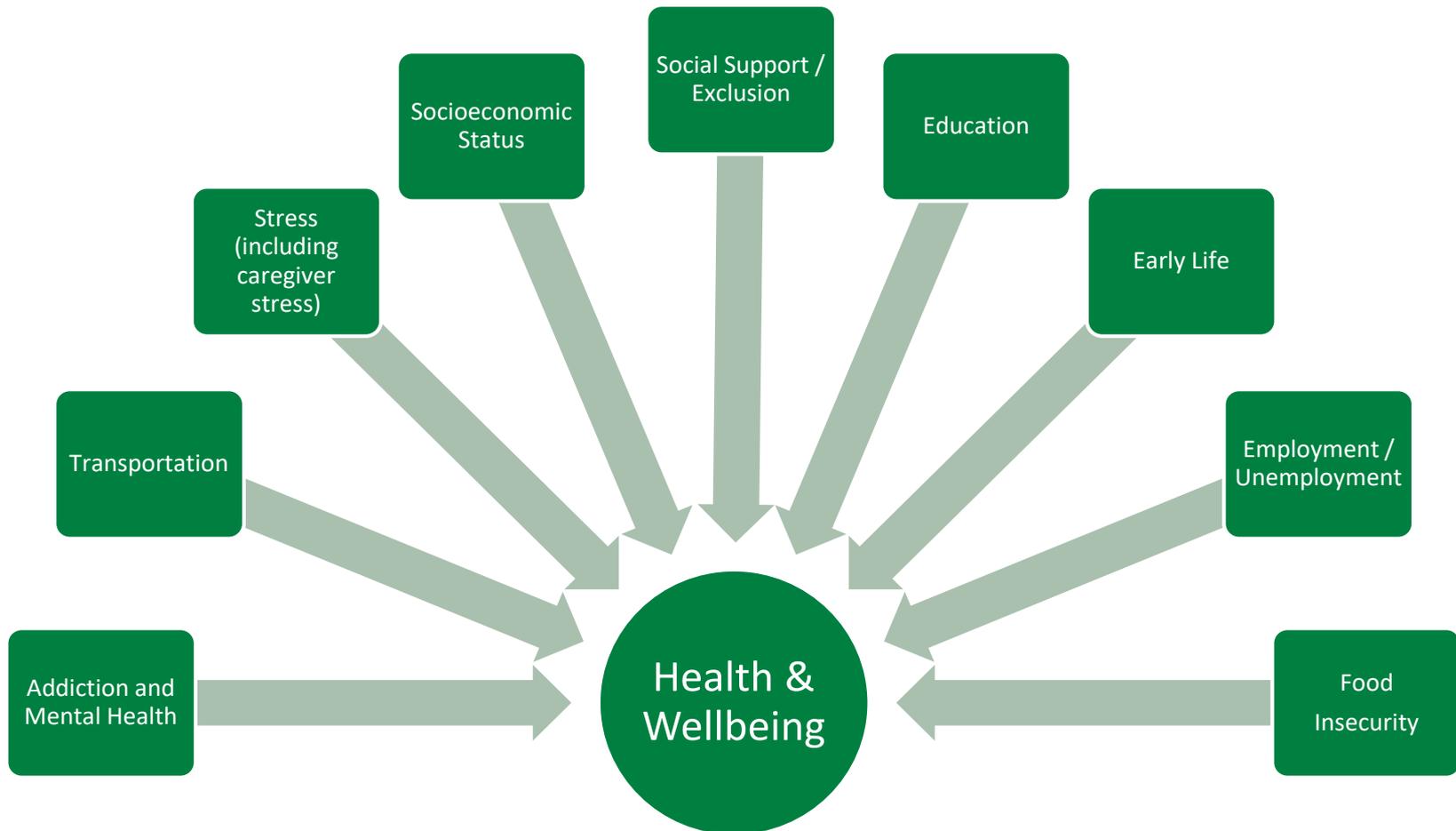
## “The 15-Minute Visit”

- Short, time-pressured visits in primary care setting
- Clinical inertia, MD-centered communication
- Diminished quality
  - Little time to address functional, cognitive abilities and changes
- Provider biases and less time for discussion to correct them

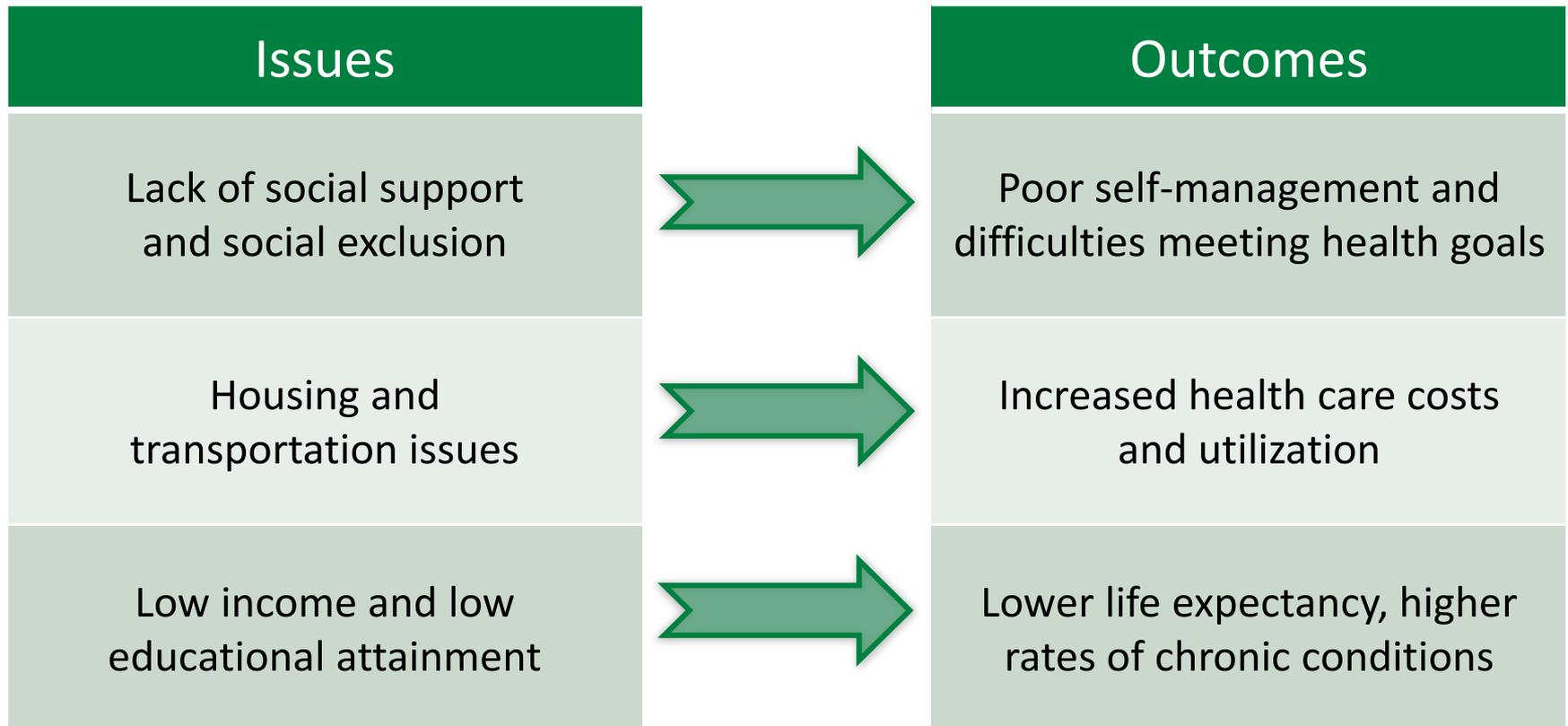
(Edvardsson, 2010)

(Fiscella, K. & Epstein, R.M., 2008)

***Social determinants of health*** are the conditions in which people are born, grow, live, work and age.



# Social Factors Often “Determine” Health



**“Social determinants of health have taken center stage in recent health policy discussions because of the growing focus on global payment, accountable care organizations, and other initiatives focusing on improving population health.”**

**-- Yale Global Health Leadership Institute**

# Payment & Delivery System Reforms

- **Growth of care and payment models that:**
  - 1) try to reduce acute care utilization
  - 2) emphasize social determinants
  - 3) integrate physical and mental health care
- **Significant culture shift**
  - Food, housing, and transportation as medicine
  - Growing focus on interprofessional education and training
  - Focus on coordination of services and value over volume
- **Driven by federal policies**
  - Affordable Care Act
  - IMPACT Act of 2014
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Hospital Community Health Needs Assessments
  - New regulations for Medicare and Medicaid skilled nursing facilities
  - HHS goal: By 2018, 90% Medicare payment tied to quality, 50% via alternative payment models
- **Uncertain future with new administration**

# Medicare Payment Innovation

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## Medicare: a growing focus on value

**Medicare CPT codes** to bill for chronic care management, transitional care management, behavioral health integration

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**Pay for performance:** Reimbursement adjustment for quality outcomes (e.g., hospital readmissions, hospital-acquired conditions, value-based purchasing)

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**Bundled payments** for an entire care episode (e.g., joint replacement)

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**Risk-based Alternative Payment Models** (e.g., Accountable Care Organizations, Oncology Care Model, Comprehensive Primary Care Plus)

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## Accountable Health Communities

Universal, **comprehensive screening for health-related social needs** in Medicare and Medicaid beneficiaries at participating clinical sites

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Payment is tied to addressing identified needs

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# MACRA: Here to Stay?

- **New Part B provider payment system to incentivize primary care improvements**
  - Passed with strong bipartisan support in 2015, impacts payment in 2019
- **Reimbursement based on composite score:**
  1. **Quality** – A number of **SW-related measures** (e.g., care plan, functional status assessment, evaluation for risk of opioid misuse, falls risk)
  2. **Resource use** – Risk-adjusted score comparing resources used to treat similar conditions
  3. **Clinical practice improvement activities** – e.g., **care coordination**, shared decision-making, safety checklists, PCMH designation
  4. **Advancing care information** – e.g., patient access to EMR, reporting to public health and clinical data registry
- **Additional incentives for practices taking on risk**

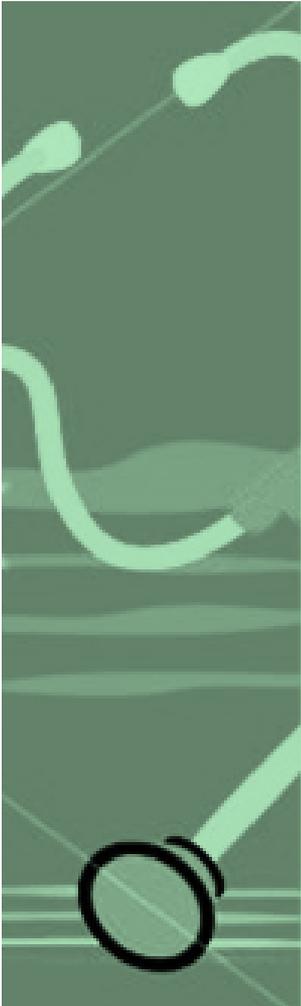
# Strategies for Reducing Hospitalizations

- **Access to accessible and comprehensive primary care and community-based supports**
  - Proactive outreach to high risk patients
- **Reducing ED-initiated hospitalizations as appropriate**
- **Systematic interventions during hospitalization**
  - Interprofessional rounding
  - Personalized care plan development, based on social & community factors
  - Patient and caregiver education re: care plan
  - Medication reconciliation
- **Supporting the transition home from hospital or rehab**
  - Post-discharge follow-up with patient/caregiver to support meeting health goals, by addressing psychosocial issues and other influences
  - Communication with PCP and PCP follow-up appointment

**“Amidst the press  
of acutely ill patients,  
it is difficult for even the  
most motivated and elegantly trained  
providers to assure that  
patients receive the  
systematic assessments,  
preventive interventions, education,  
psychosocial support,  
and follow-up that they need.”**

- Wagner, Austin, and Von Korff

# Health Care's Blind Side – It takes a team!



- **2011 Robert Wood Johnson Foundation survey of 1,000 primary care physicians**
  - 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care
  - 85% feel social needs directly contribute to poor health
  - R<sub>x</sub> for social needs, if they existed, would be 1 in 7 R<sub>x</sub>s written
  - Psychosocial issues often treated as physical concerns
- **Evidence of outcomes for interprofessional teams in inpatient and outpatient medical systems**
  - Reduction in health service utilization
  - Improvements in patient satisfaction and communication with care team
  - Increased provider satisfaction

(Boult, et al, 2009)

(Fenton, 2011)

# Moving Toward Comprehensive Care

- **Interprofessional primary-care-based initiatives gaining prominence**
  - Long-term relationship between care team and patient/family
  - Shared decision making
  - Health education
  - Improved patient experience
  - Integrating mental health into primary care – reduces stigma
  - Clinics innovating by creating networks of community partners (“medical neighborhood”), partnering more with hospitals
- **Various certifications and reimbursement opportunities** (e.g. PCMH, MACRA, CCM)



# The Case for SW Involvement

- **SW brings a unique perspective, skillset to health care**
  - One foot in hospitals, other in community
  - Person- and family- centered approach
  - History of advocating for marginalized populations
- **Role for social workers in augmenting the patients' and families' healthcare encounters**
  - Address gaps in care resulting from insufficient time, staff, resources
  - Assess patients' psychosocial and long-term services and supports needs
  - Educate patients and providers on patient self-management practices
- **Opportunities for partnership between community-based organizations and healthcare entities**
  - Contracts with hospitals and payers for transitional care
  - Embedding staff into primary care clinics



# Defining Social Work Contributions

- **Social workers use evidence-based clinical skills and best practices**
  - Person in environment perspective (Ecological Systems Theory)
  - Stages of change
  - Cultural humility
  - Psychotherapeutic techniques
    - Client-centered interviewing: OARS, Motivational Interviewing
    - Acceptance and Commitment Therapy
    - Cognitive Behavioral Therapy
- **However, value of SW to healthcare delivery system undefined**
  - Hard to define the art of relationship-based care and systems navigation
  - Often leads to lack of provider and payer buy-in
- **Operationalizing SW integration and demonstrating value a key step in growing SW impact**

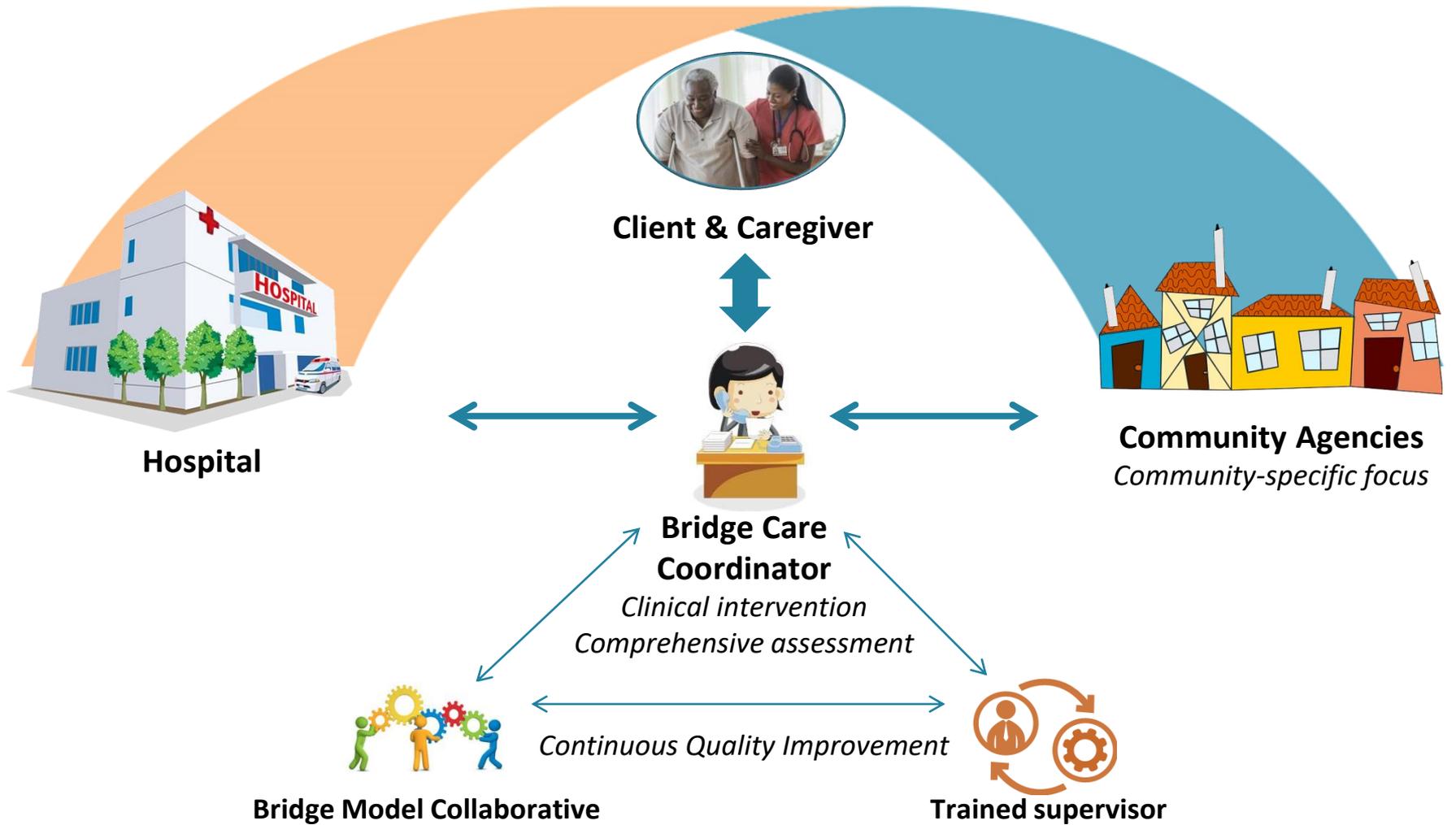
# INTEGRATING SOCIAL WORK INTO HEALTH CARE

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# Bridge: A Transitional Care Program

- **Developed with partners from across IL**
  - 50+ replication sites around country
  - Works with adults with complex medical or social needs
- **Pre-discharge**
  - Review electronic medical record for medical, social history
  - Interprofessional connections, led by social worker
  - Bedside visit
- **Post-discharge**
  - Repeated contacts for 30 days
  - Facilitate discharge plan, connections to CBOs
  - Coordinate home health, primary care, hospital providers
  - Patient engagement and activation

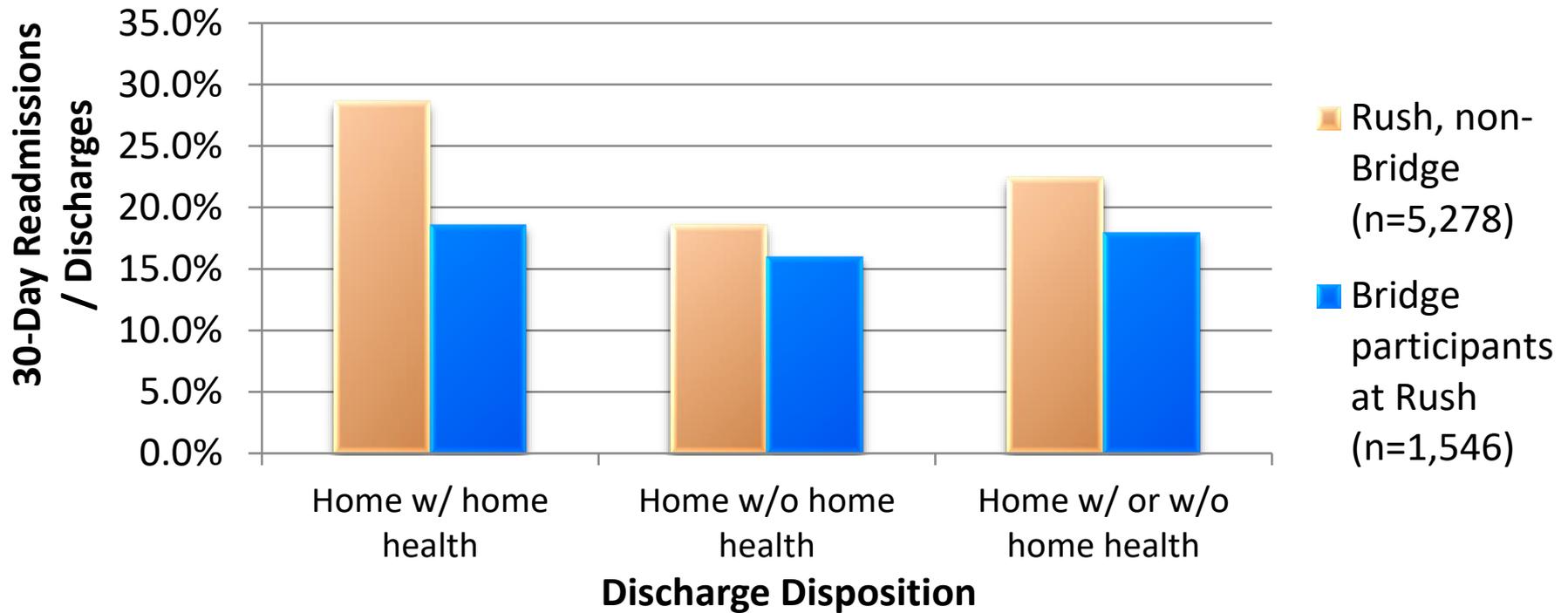




**Social Determinants of Health**

**Continuous Quality Improvement**

# JAGS: Bridge’s Impact on Readmissions



**“Well suited to assess and address the transitional care needs of adults with complex medical, behavioral, and social needs”**

# Bridge Impact on “Super-utilizers”

- Pre-post pilot (N=456)
- June 1<sup>st</sup> 2014 – May 31<sup>st</sup> 2015

<u>Variable</u>	<u>Pre-Intervention</u> n or Mean % or $\pm$ SD n = 456	<u>Post-Intervention</u> n or Mean % or $\pm$ SD n = 456	<u>Significance</u> (paired t-test)
# of Admissions	<b>2.52 <math>\pm</math> 1.79</b>	<b>1.25 <math>\pm</math> 1.67</b>	<b>.000</b>
30-day Readmission Rate	<b>29.1% <math>\pm</math> 34.3%</b>	<b>11.3% <math>\pm</math> 24.0%</b>	<b>.000</b>
# of ED visits	<b>2.39 <math>\pm</math> 2.64</b>	<b>1.52 <math>\pm</math> 2.15</b>	<b>.000</b>
# of no-shows	<b>4.05 <math>\pm</math> 5.35</b>	<b>3.25 <math>\pm</math> 5.11</b>	<b>.000</b>

# Bridge: Hospital-Community Partnerships

- **Bridge Model implemented by many community-based organizations (CBOs) in partnership with area hospitals**
  - 27 of 65 sites trained in Bridge are CBOs (mostly Aging Network)
- **Initiatives with healthcare sector significant opportunity for CBOs to innovate beyond traditional roles**
  - Contracts with hospitals and Medicaid MCOs
  - Contract with private SNF for the transition home after rehab
  - Some CBOs implementing mix of Bridge and other models (e.g. Eric Coleman's Care Transitions Intervention)
  - Statewide networks of CBOs contracting with payers to offer more consistency across region/state

# AIMS: An Outpatient Intervention

- **“Ambulatory Integration of the Medical and Social”**
- **Team of Master’s level clinical social workers**
  - Based out of primary and specialty care settings
  - Five-step guided protocol; telephonic with in-person components
- **Wraps around medical care by addressing psychosocial needs**
  - Increases primary/specialty care clinician and team awareness of psychosocial issues, person-in-environment perspective
  - Increases practice efficiency by best utilizing skills of each discipline
  - Connects patients to evidence-based disease management
  - Integrates evidence-based social work core competencies, patient-identified goals and care preferences
- **Replicated at community-based sites in IL and MD**

# AIMS: Promising Findings

- Compared utilization for AIMS participants vs. similar Rush population
  - Admissions, 30-day readmissions, and ED visits were significantly lower in AIMS participants in 6 month period

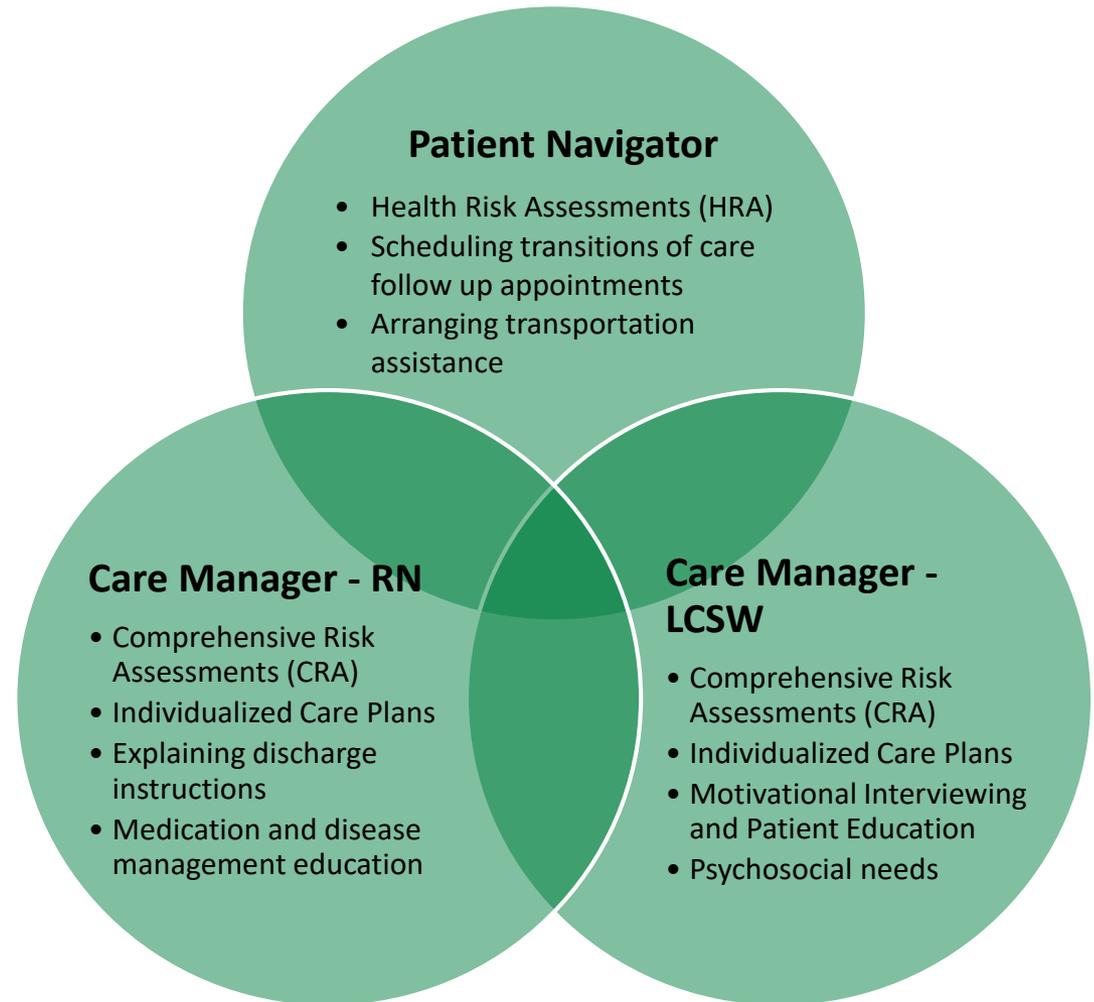
Utilization Metric	AIMS Mean (n=640)	Rush Comparison (n=5,987)
Hospital Admission	0.51*	1.0
30-day Readmissions	0.15*	0.35
ED Visits	0.10*	0.95

*\*Statistically significant using one-sample t-test*

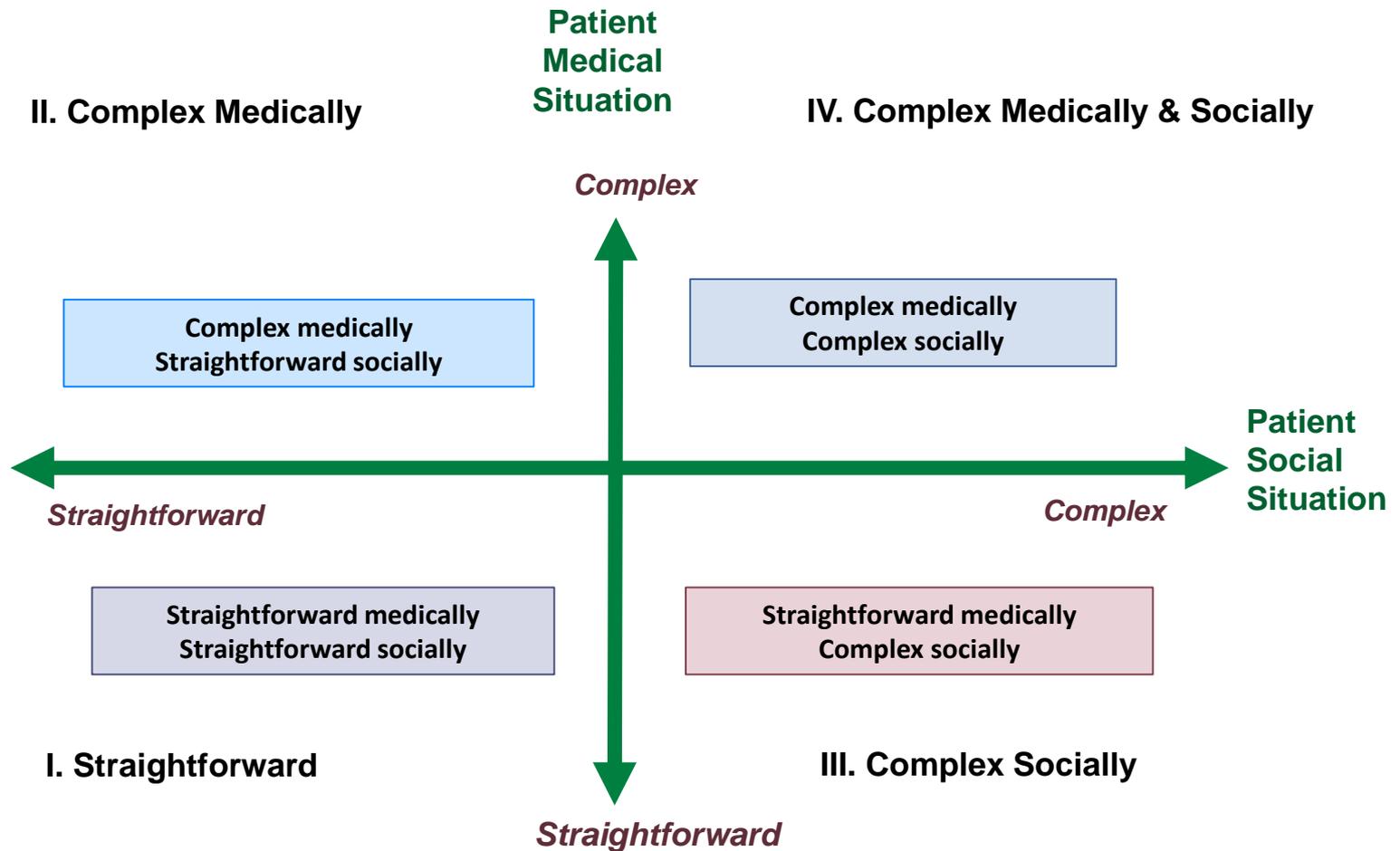
- Currently doing 2-year quasi-experimental study with Commonwealth Fund support (results expected spring 2018)

# Medicaid managed care: A Triad Approach

- Network of 3 hospitals, 9 FQHCs providing care to Chicago-area Medicaid beneficiaries
- Triad approach to care management
  - SW, RN, and/or Patient Navigator
  - Based on client need



*Should RN, LCSW, or Patient Navigator be the lead care manager for a given patient?*



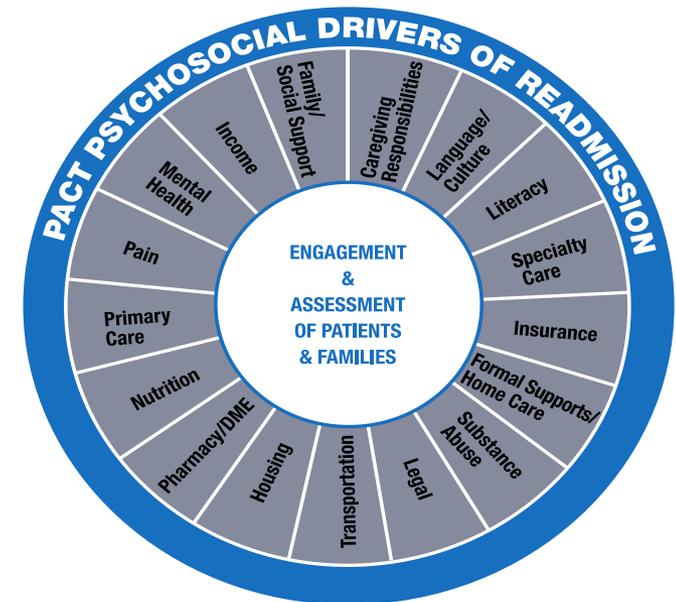
# Other Significant SW Efforts to Watch

- **Mt. Sinai, NY**

- Preventable Admissions Care Team (PACT)
  - 4-week SW intervention pre- and post-discharge to identify and address issues driving readmissions
  - 40% reduction in admissions and a 40% reduction in ED visits (across 7829 patients), increased PCP follow-up
- Mobile Acute Care Team (MACT)
  - Interprofessional team providing home-based acute care and follow-up supports

- **Veterans Health Administration**

- >12k MSWs employed, wide range of roles and settings
  - VA Care Management Program
  - SW as part of Patient Aligned Care Team (another PACT)
- SW plays leadership role in linking VA care with non-VA hospitals and services



# Challenges to Scaling Up Initiatives

- **Evidence for models that work, but hard to spread or scale them up**
  - Health systems and payers often opting to “build” services vs. buying from trusted community agencies
    - Historic fragmentation between healthcare and community providers
  - ROI for care coordination still not there
- **Other challenges to success and growth**
  - What to do when long-term resources just aren’t there?
  - How to prove impact amidst continuous quality improvement efforts?
  - Unpredictable future – Will Medicaid expansion be rolled back? Will CMS payments continue to be adjusted for the same quality measures?

# Noteworthy Developments

- **2017: Medicare Part B reimbursement** for Chronic Care Management and Behavioral Health Integration
- **Focus on family caregiving**
  - National Academies report: Families Caring for an Aging America
  - CARE Act law in 20 states
- **“Vital Directions for Health and Health Care”**
  - Dozens of policy recommendations for new administration from National Academy of Medicine
  - Emphasis on community partnerships, mental health, workforce development, care management initiatives
- **Exploration of payment adjustment for social risk factors**
  - National Academies (former IOM) report on Medicare payment
  - Minnesota considering adjusting for social risk in Medicaid payments
- **Advocacy to raise profile of integrating social work into healthcare**
  - National Academies consensus report

# How to continue the momentum?

- **Maintain consumer protections & coverage obtained in ACA**
  - Plus, expanding accessibility to care for uninsured
- **Advance innovations in care models and in targeting care**
  - Risk-stratification, hot spotting, Precision Medicine
- **Improve interprofessional education and training** to make healthcare interventions more effective and efficient
- **Strengthen value proposition of social work workforce**
  - Make clear business case of when SW is part of team and elevator speech
    - Impact on quadruple aim (better care experience, better health outcomes, lower costs, improved provider satisfaction)
- **Research to better understand what contributes to health outcomes (*and how*)**
  - And, to identify further opportunities for prevention and intervention

# QUESTIONS/COMMENTS?

# THANK YOU!

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*Contact me if interested in learning more about  
our initiatives or partnership/replication opportunities*

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