OVERVIEW

Many patients with complex chronic illnesses and/or functional impairments face not only managing the medical care necessitated by their conditions, but also finding ways to access supportive services that help them live independently in their homes and communities. Access to supportive services can be difficult for anyone with complex conditions, and social and economic patient characteristics can complicate the task. The absence or insufficiency of home care support; assistance in hospital-to-home transitions; follow-up medical coaching; and access to transportation for medical appointments, adequate nutrition, and mental or behavioral health services act as barriers to positive health care outcomes. Theoretically, models of care, such as health homes, that aim to improve outcomes for people with complex chronic conditions may help fill these gaps. But how far these initiatives will go beyond the traditional medical model of care remains to be determined. This Forum session, a continuation of the Forum’s programming on serving populations with complex conditions, explored barriers to effective coordination of social support and health care services and discussed opportunities for service integration.

SESSION

Many patients have impairments that span the medical, social, and long-term services and supports (LTSS) systems, and for these patients accessing supportive services can be especially difficult. Unlike medical care that has a highly visible infrastructure
and substantial financial support through insurance, social services and LTSS are less well-defined and accessing them involves uncertainties about what services may be needed or available, unfamiliar provider types, limited information on the competence and reliability of providers, and often out-of-pocket payments. These issues are compounded for patients who have low incomes, live in poor housing, have limited family or social networks, suffer from mental or cognitive impairments, and/or lack family involvement in health care regimens. For many of these vulnerable people, compliance with physicians’ orders may take a back seat to the stresses of day-to-day survival.¹

Many physicians are aware that some patients have social services needs that are barriers to positive health outcomes. For instance, a survey of physicians for the Robert Wood Johnson Foundation found that a majority surveyed believed that unmet social needs directly contribute to poor health and that addressing these needs is as important as providing medical care. But even within this survey, about half of the physicians surveyed were not aware of social services available to meet social needs of patients.²

**BARRIERS THAT REINFORCE SILOS OF CARE**

For decades, experts in medical sociology, public health, and social work practice have recognized the important role of patients’ social and economic characteristics in positive health care outcomes. These characteristics include a person’s family support, income and economic status, education, living arrangements, housing quality, attitudes toward health, and social networks, among other things.³ When treating a patient, health care providers often are not aware that these characteristics can affect a patient’s adherence to treatment plans and that even the socially or economically “advantaged” may have difficulty accessing needed support services. Practitioners often refer to the “silos” of care that exist among the professions of medicine, social work, LTSS, and behavioral health. For many patients with complex chronic conditions, experts say that sole reliance on a medical model of care will not result in improved health outcomes, and that a more holistic approach to care should be pursued.

Some of the barriers to a coordinated and holistic approach include:

- lack of knowledge among health care providers about available community services, or confusion about which community service agencies to engage,
• lack of methods to target patients who would most benefit from social support interventions,

• poor understanding by physicians and other health care providers about the socioeconomic characteristics of their patients, such as their home environments, family care arrangements, and health literacy,

• loose ties among hospital, nursing home, and community services providers,

• weak or non-existent hospital discharge planning, including patient instruction about medication reconciliation and physician follow up,

• absence of payment models to reimburse for comprehensive care management activities,

• fragmented and undercapitalized provider systems for LTSS and community services,

• inability of community-based home care providers to take responsibility for 24-hour care for high-risk patients upon hospital or nursing facility discharge,

• lack of patient referral to, or availability of, behavioral health providers,

• weak or non-existent involvement of family caregivers in the patient’s care plan, and

• lack of health care literacy.

In recent years, some experts have stressed the importance of using an interdisciplinary and coordinated approach to dismantle some of the silos of care. In the field of LTSS, for example, care management teams (often comprised of social workers and nurses) assess consumers’ functional, economic, and social needs; living arrangements; caregiver support availability; and self-management skills, among others. They develop plans of care, seek to arrange services, and provide continuous monitoring of consumer status. Such care management has become a hallmark of most state LTSS programs, including Medicaid home- and community-based services (HCBS) waiver programs.

In contrast, it has been difficult for the medical profession to adopt a patient-centered, interdisciplinary approach to care that would bridge multiple dimensions of patient need. Many experts believe that patients with complex chronic conditions will have better health
care outcomes with approaches that adhere to principles of team-based care, patient self-management, and appropriate patient support from community resources.

Demonstrations conducted by the Centers for Medicare & Medicaid Services (CMS) in the late 1990s and early 2000s focused on ways to improve care for people with chronic conditions and to take a more interdisciplinary approach to patient care. (See “Coordinating Care for Adults with Multiple Chronic Conditions: Searching for the Holy Grail” at www.nhpf.org/library/details.cfm/2727.) While the interventions were not conceived to address the full range of patient needs, and only some showed promise, others began to shed light on some specific methods to improve care and control costs. These included frequent in-person contact with patients by a care coordinator, targeted care coordination activities for high-risk patients, appropriate social supports for patients to assist them in their health regimens, appropriate transition of patients among care providers, strong patient education, and guidance to patients on medication management.

TESTING NEW MODELS OF CARE TO DISMANTLE THE SILOS

Building on the CMS demonstrations and state experiences in managing LTSS, the Patient Protection and Affordable Care Act of 2010 (PPACA) included a number of provisions to continue testing and implementing models that take a patient-centered, interdisciplinary approach to care and focus on coordination of services among providers. Various care models offer health care providers opportunities for better connections among health, social support, LTSS, and behavioral services. These include the Community Care Transition Program (CCTP) to reduce hospital readmissions, demonstration programs for Medicare and Medicaid dual eligibles, Medicaid health homes, and the Independence at Home (IAH) demonstration, among others. These care models are in various stages of development and implementation across states and providers. Whether they will actually make the delivery of care more patient-centered, interdisciplinary, and coordinated will depend on the commitment of providers to access the range of health and social supportive services that patients need, the extent of cooperation among multiple providers to integrate services, and adequate financial incentives to make integration successful.
KEY QUESTIONS

- What makes accessing social and supportive services so much more challenging than accessing medical care?
- What patient characteristics interfere with management and adherence to health care regimens?
- What social support services are important in helping health care providers and patients achieve good health care outcomes?
- What barriers exist between health care professionals and social service providers?
- How extensive is the use of interdisciplinary teams in various health care settings? What will it take to move the health, social services, and LTSS systems to a more integrated approach?
- How could the various models of care enabled by PPACA improve coordination of health care, social services, LTSS, and behavioral health services? What is needed for success?

SPEAKERS

Robyn L. Golden, LCSW, director of health and aging, Rush University Medical Center, discussed the importance of health care providers’ recognition of the social and economic characteristics of patients, barriers that current health care and social service providers face in coordinating care, and opportunities offered by implementation of various health care delivery models included in PPACA to address these issues. Jane Brock, MD, chief medical officer for the Colorado Foundation for Medical Care, discussed how health care delivery systems can reach out to social service providers to improve health care outcomes for patients, especially as they transition among sites of care. She also discussed the role of Medicare Quality Improvement Organizations in working with community-based organizations and the implementation of the Community Care Transition Program (CCTP). Betty Shephard, MBA, lead vice president, Care Management, HealthCare Partners, discussed the genesis and status of HealthCare Partners’ approach to case management for patients with chronic conditions, including how its staffing model is designed to make the most efficient use of personnel to better meet patient needs.
ENDNOTES


5. For example, see the Chronic Care Model, www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.


8. Section 3026 of PPACA established the CCTP grant program to help hospitals work with community-based providers to improve care transitions. Eligible entities are hospitals with high readmission rates that partner with community-based organizations. CMS is required to give funding preference to Administration on Aging (AoA) grantees that provide care transition interventions in cooperation with multiple hospitals and practitioners serving medically underserved populations. More information available at www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html?itemID=CMS1239313.
9. Section 2602 of PPACA established the CMS Medicare-Medicaid Coordination Office which is responsible for coordinating services for dually eligible Medicare and Medicaid beneficiaries and helping states integrate primary, acute, behavioral health services and LTSS. More information available at http://innovations.cms.gov/initiatives/State-Demonstrations/index.html.

10. Section 2703 of PPACA added a new Medicaid state plan option to help states integrate and coordinate primary, acute, and behavioral health services and LTSS for people with chronic conditions. PPACA identified health home services that must be provided by designated providers or health teams: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow up; individual and family support; referral to community and social support services; and use of health information technology to link services. More information available at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html.

11. Section 3204 of PPACA authorized CMS to test a payment incentive and service delivery model known as Independence at Home (IAH). The demonstration will test the feasibility of treating patients through home-based interdisciplinary teams. IAH demonstration practices must use physician- or nurse practitioner–led home-based primary care teams, including physician assistants, pharmacists, and other health and social services staff who are available 24 hours a day, seven days a week to carry out home-based care plans. More information available at https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1240082.html.