Breaking Down the Silos of Patient Care: Integration of Social Support Services into Health Care Delivery

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• Started the day with a 36-year-old brother of a 50-year-old man with dementia
  – Limited English speaking
  – Low socioeconomic status
• Ended the day with a 99-year-old woman proud to not be using a walker
  – High financial means, but lonely
• Both very different scenarios with implications on health outcomes
• Social determinants influence health outcomes\textsuperscript{1}
  – Social gradient (SES, education, culture)
  – Stress
  – Early life
  – Social exclusion
  – Work
  – Unemployment
  – Social support
  – Addiction
  – Food
  – Transportation
Societal-level social determinants have individual-level impact

<table>
<thead>
<tr>
<th>Issue</th>
<th>Outcome</th>
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<tr>
<td>Low education, lack of social support, and social exclusion</td>
<td>Poor self-management and reduced care plan adherence³</td>
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<td>Housing⁵ and transportation⁶ issues</td>
<td>Increased health care costs and utilization</td>
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<tr>
<td>Health disparities and psychosocial issues</td>
<td>Preventable hospitalizations⁷ and mortality⁸</td>
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• 2011 Robert Wood Johnson Foundation survey of 1,000 primary care physicians
  – 85% feel social needs directly contribute to poor health
  – 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care
  – Rx for social needs, if they existed, would be 1 in 7 Rx’s written

• Psychosocial issues treated as physical concerns

Health Care’s Blind Side
What Happens to Consumers?

• 2012 John A. Hartford Foundation survey shows consumers feel the impact of “health care’s blind side”\textsuperscript{12}
  – Not treated as a whole person
  – Rarely asked about issues impacting well-being
    • Activities of daily living
    • Falls
    • Mental health
  – Lack of communication and coordination
• No one asks the caregiver how they are doing
• Community-based services and supports system could be addressing psychosocial issues
  – Community-based organizations (CBOs)
  – Aging and disability network
  – Long term services and supports (LTSS)
  – Mental health services

• Institute of Medicine recommendation: “community links”\textsuperscript{13}
  – Assessing psychosocial issues
  – Delivering services in the community
  – Communicating these issues with medical team
Fragmentation as a Major Obstacle

• “Siloed” health and social service systems
  – Separate and distinct funding streams
  – Different delivery systems and eligibility rules
  – Different training programs
  – Distinct terminology

• Looking at diagnosis and episodic care
  – Provider-driven
  – Mental health forgotten
  – Not “bilingual” or “bicultural” to bridge medical and social systems
• Financing barriers to integrated care
  – Social services not reimbursed
  – Undercapitalization of social safety net
  – No investment in team-based care and workforce development

• Value of social services, social workers to health care delivery system undefined
  – Need to valuate services, negotiate fees, determine costs, and explain ROI
  – Business case not clear
What’s Needed for Chronic Care

• Opportunities for improving care for people with chronic care needs (Georgetown Public Policy Institute)\(^1\)
  – Comprehensive primary care
  – Assessment of person and caregiver LTSS needs
  – Coordination of LTSS and medical care
  – Collaboration between care coordinators, PCPs, patients, families
  – Supportive care transitions
  – Commitment to person- and family-centered care
• Solid outcomes for interprofessional teams in inpatient and outpatient medical systems\textsuperscript{15}
  – Reduction in health service utilization\textsuperscript{16}
  – Improvements in patient satisfaction and communication with provider team\textsuperscript{17}
• Rothman and Wagner: “Most successful chronic illness interventions include major roles for non-physicians. The appropriate deployment and use of practice teams seems to be far more important to improving chronic illness than physician specialty.”\textsuperscript{18}
“Care coordination” is a person- and family-centered, assessment-based, interdisciplinary, multicultural approach to integrating health care and social support services in a cost-effective manner in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator.

(National Coalition on Care Coordination)
Financing the Ideal Model

• Routes to financing effective care coordination:
  – Current fee-for-service structure limited due to episodic focus
  – Need incentives for effective performance: quality of care, patient experience, and health spending
• FFS system payment options (Medicare):
  – Modify codes or levels of payment within Physician Fee schedule
  – Risk-adjusted monthly fee per eligible beneficiary tied to performance
  – “Shared savings” model rewarding efficient, quality service delivery
• Within managed care systems (Medicare Advantage and Medicaid) combine financing sources to meet needs
Financing the Ideal Model

• Improved medical and social service funding sources
  – Social service investment
  – Encourage and incentivize collaboration and team
  – Share responsibility and align goals

• Demonstration projects through CMS and ACL
  – Include integrated models
  – Show cost savings across funding streams
  – Improve quality of life
The Healthcare Neighborhood

- Integrated model with the medical and social components of equal value
- Team-based care with the person and family on the team
- Service connection, coordination, and communication
  - “Boundary spanning” and “spanners”
  - Partnerships across sites and settings
- Community engagement and activation
  - Where people live
  - Where service providers are located
  - Where social determinants of health begin and can be influenced
The Opportunities of PPACA

• Opportunities to address the social in health care through PPACA
  – Enhanced primary care/Patient Centered Medical Homes
  – Accountable care organizations
  – Transitional care and hospital readmission reduction
  – Medicare and Medicaid dual eligible demonstrations
  – Medicaid Health Homes
  – Independence at Home demonstration
  – Bundled payment
To learn more, visit:

• Accountable Care Organizations: http://innovations.cms.gov/initiatives/aco/index.html

• Dual Eligible Demonstrations: http://innovations.cms.gov/initiatives/State-Demonstrations/index.html

• Medicaid Health Homes: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html

Thank You

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