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Center for Health and Social Care Integration @ Rush

Excellence is just the beginning.

Paying for Social Care: Investing in What Matters

September 27, 2023

Robyn Golden, MA, LCSW
Bonnie Ewald, MA

Robyn Golden, MA, LCSW

Associate Vice President of Social Work and Community Health,
RUSH University Medical Center

Bonnie Ewald, MA

Managing Director, Center for Health and Social Care Integration,
Social Work and Community Health @ RUSH

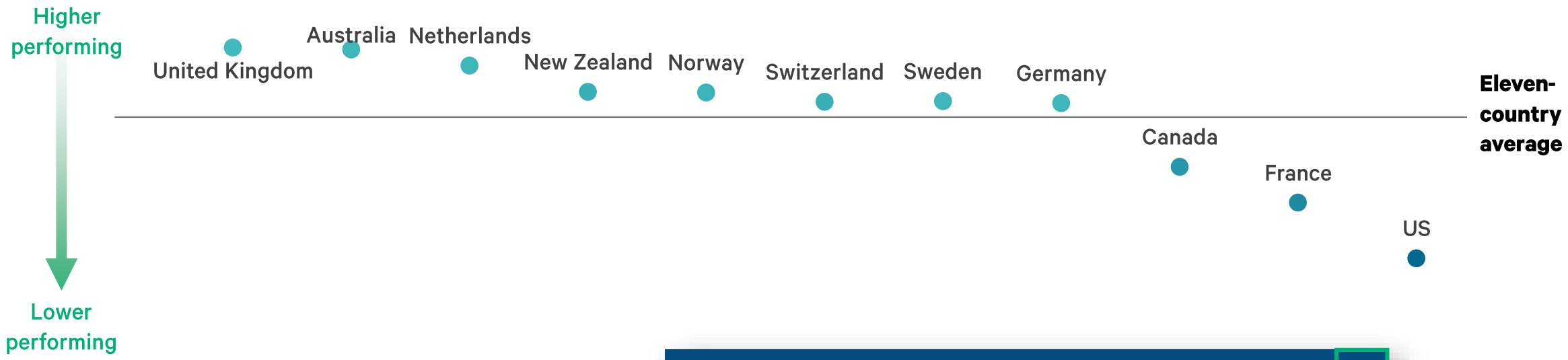
THE IMPERATIVE

“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*

(AASWSW, 2016)

US health care performs worse than other industrialized countries



Scores based on:

- Care process
- Access
- Administrative efficiency
- Equity
- Health care outcomes

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and

The US spends more on healthcare and less on social care

Health spending and non-health social spending as percent of GDP, 2019

Country	Health spending	Non-health social spending	Health spending and non-health social spending
France	11.1%	24.2%	35.3%
Belgium	10.7%	22.3%	33.0%
Sweden	10.8%	22.0%	32.8%
Austria	10.5%	22.0%	32.5%
United States	**16.7%**	**15.6%**	**32.3%**
Germany	11.7%	19.8%	31.5%
Switzerland	11.3%	19.3%	30.6%
Netherlands	10.1%	20.4%	30.5%
Comparable country average	**10.7%**	**19.8%**	**30.5%**
Australia	10.2%	17.8%	28.0%
Canada	11.0%	16.5%	27.4%
United Kingdom	9.9%	17.3%	27.2%
Japan	11.0%	15.8%	26.8%

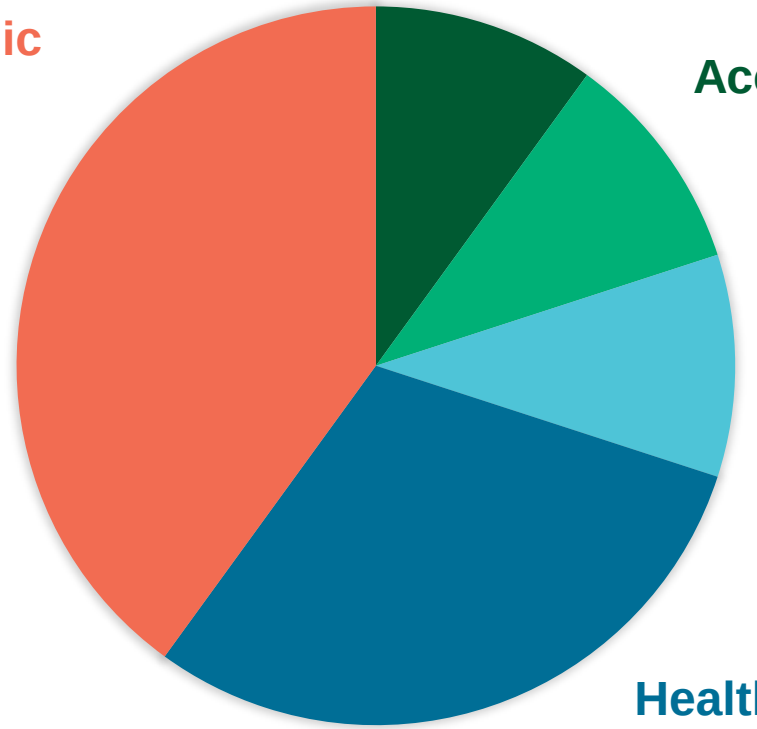
Note: Health spending shown here is health consumption, which does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD data • Get the data • PNG

Peterson-KFF Health System Tracker

https://www.healthsystemtracker.org/indicator/health-well-being/poverty-status/

Social and economic factors are the biggest contributors to life expectancy and quality of life, and to inequitable outcomes



Quality of care
10%

Access to care
10%

Social & economic factors
40%

- Education
- Employment
- Income
- Family / Social support
- Community safety

Physical environment
10%

- Air & water quality
- Housing & transit

Health behaviors
30%

County Health Rankings. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model?componentType=health-factor&componentId=25

Social factors significantly influence health

Issues	Outcomes
Lack of social support and social isolation	Poor self-management and reduced care plan adherence
Housing and transportation issues	Increased health care costs and utilization
Low income and low educational attainment	Lower life expectancy, higher rates of chronic conditions

(WHO, 2003), (Gallant, 2003), (DiMatteo, 2004), (Krieger et al, 2002), (RWJF, 2008), (APHA, 2010), (CDC, 2011), (Shi, 2011), (Woolf, 2015), (Leigh-Hunt et al., 2017), (O'Neill Hayes & Delk, 2018), (Swope & Hernandez, 2019), (WHO, 2023

“**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.**”

Taylor LA, Tan AX, Coyle CE, Ndumele C, Rogan E, Canavan M, Curry LA, Bradley EH. Leveraging the social determinants of health: what works?. PloS one. 2016 Aug 17;11(8):e0160217.

Investments in social care are associated with positive outcomes and reduced costs

In one analysis of 39 studies in recent literature: 82% reported significant positive effects on health outcomes (n = 20), health care costs (n = 5), or both (n = 7)

Findings	Housing Support N (%)	Nutrition Support N (%)	Income Support N (%)	Care coordination and community outreach N (%)	Other* N (%)	Total N (%)
Positive, significant findings						
Positive health outcomes	5 (42%)	7 (64%)	3 (75%)	2 (22%)	3 (100%)	20 (51%)
Reduced costs	1 (8%)	0 (0%)	0 (0%)	4 (44%)	0 (0%)	5 (13%)
Both health outcomes and reduced costs	4 (33%)	0 (0%)	1 (25%)	2 (22%)	0 (0%)	7 (18%)
Other findings						
Mixed results	0 (0%)	1 (9%)	0 (0%)	1 (9%)	0 (0%)	2 (5%)
Non-significant effects	1 (8%)	2 (18%)	0 (0%)	0 (0%)	0 (0%)	3 (8%)
Negative health outcomes	1 (8%)	1 (9%)	0 (0%)	0 (0%)	0 (0%)	2 (5%)
Total	12 (100%)	11 (100%)	4 (100%)	9 (100%)	3 (100%)	39 (100%)

*Other studies contained interventions that had major educational components that were associated with improved health outcomes, especially among children.

doi:10.1371/journal.pone.0160217.t001

Taylor, L. A., Tan, A. X., Coyle, C. E., Ndumele, C., Rogan, E., Canavan, M., Curry, L. A., & Bradley, E. H. (2016). Leveraging the social determinants of health: What works? PloS One, 11(8), e1060217. https://doi.org/10.1371/journal.pone.0160217

What matters most to patients?

"There are often common themes in answers about what matters most...

- **We want to be comfortable.**
- **We don't want to be in pain.**
- **We want to be, by and large, close to family.**
- **We want to spend time on things that give us joy.**
- **We want the benefits of medical treatment, but we want to avoid the burdens, if possible.**

But it's also important to remember that we shouldn't assume that what matters to us is the same for our patients."

https://www.ihi.org/communities/blogs/why-asking-what-matters-to-you-matters-kedar-mate

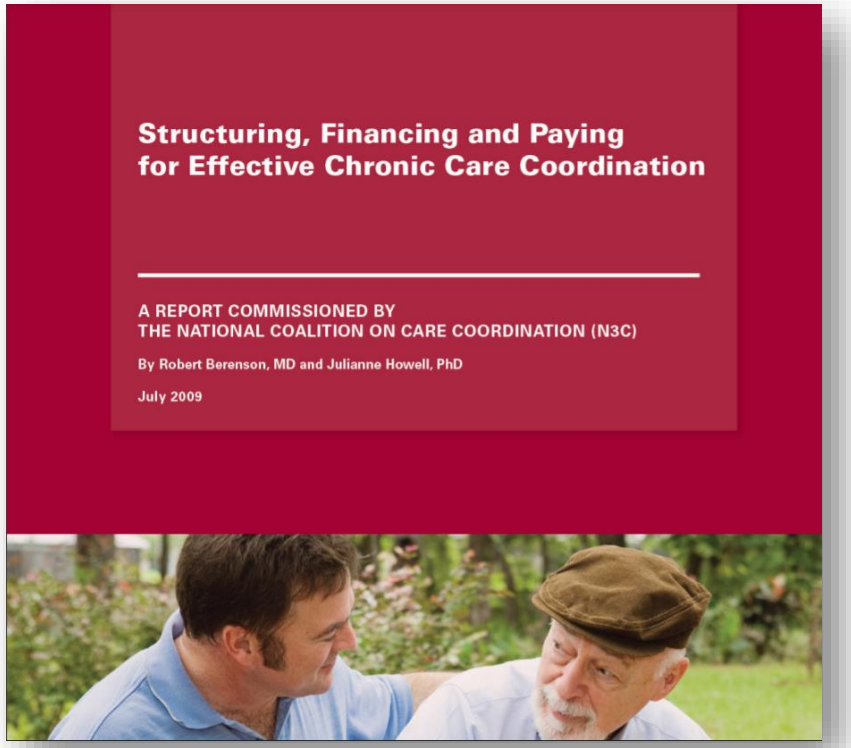
LOOKING BACK AND MOVING FORWARD

2000s: Medicare pilots a case management payment

> *Large firms quickly developed with nurses calling assigned individuals to provide case management. By 2007, Medicare determined that the vast majority of these firms failed to deliver on either quality or cost parameters, and the program was essentially discontinued.*
>
> *Follow-up analysis has shown that* ***the few that did succeed… had one key element in common: first-name, caring, personal relationships in which the case manager was an advisory friend*** *who got to know the individual and connected with him or her at a personal level.*
>
> *However, the majority of systems used nurses who had no personal connection to the individual, and the* ***calls were often characterized by those receiving them as "harassment" rather than friendly coaching and facilitation****.*

Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

2009 report calls for interprofessional teams



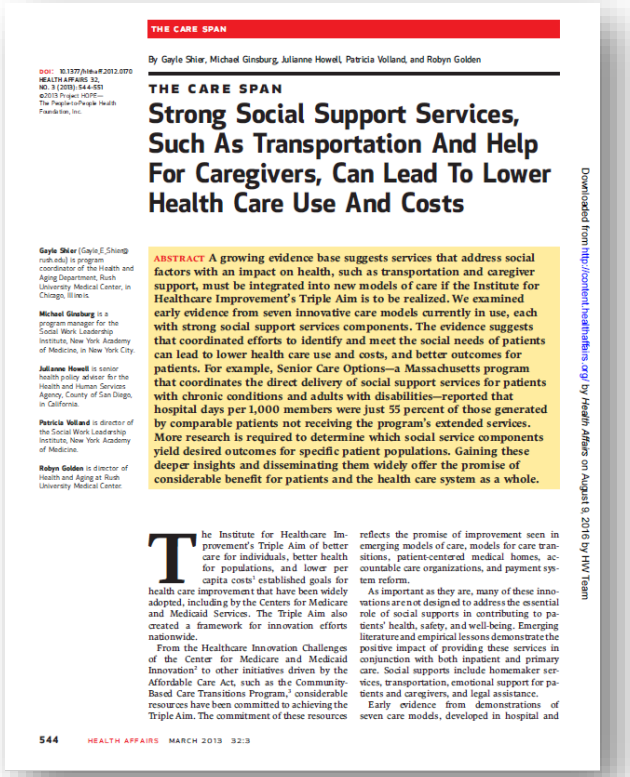
"Effective care coordination for people with multiple chronic conditions and/or functional limitations requires linkages between medical care and support services.

The availability of an interdisciplinary team of professionals, including nurses, social workers, pharmacists, and others, is therefore important to providing needed support."

- "Structuring, Financing, and Paying for Effective Chronic Care Coordination"

https://www.urban.org/sites/default/files/publication/29916/1001316-Structuring-Financing-and-Paying-for-Effective-Chronic-Care-Coordination.PDF

2013 study finds impact of social support services and calls for researching “who?” and “when?”



THE CARE SPAN

By Gayle Shier, Michael Ginsburg, Julianne Howell, Patricia Volland, and Robyn Golden

DOI: 10.1377/hlthaff.2012.0170
HEALTH AFFAIRS 32,
NO. 3 (2013): 544–551

THE CARE SPAN

Strong Social Support Services, Such As Transportation And Help For Caregivers, Can Lead To Lower Health Care Use And Costs

Gayle Shier (Gayle_E_Shier@rush.edu) is program coordinator of the Health and Aging Department, Rush University Medical Center, in Chicago, Illinois.

Michael Ginsburg is a program manager for the Social Work Leadership Institute, New York Academy of Medicine, in New York City.

Julianne Howell is senior health policy adviser for the Health and Human Services Agency, County of San Diego, in California.

Patricia Volland is director of the Social Work Leadership Institute, New York Academy of Medicine.

Robyn Golden is director of Health and Aging at Rush University Medical Center.

ABSTRACT **A growing evidence base suggests services that address social factors with an impact on health, such as transportation and caregiver support, must be integrated into new models of care if the Institute for Healthcare Improvement's Triple Aim is to be realized. We examined early evidence from seven innovative care models currently in use, each with strong social support services components. The evidence suggests that coordinated efforts to identify and meet the social needs of patients can lead to lower health care use and costs, and better outcomes for patients. For example, Senior Care Options—a Massachusetts program that coordinates the direct delivery of social support services for patients with chronic conditions and adults with disabilities—reported that hospital days per 1,000 members were just 55 percent of those generated by comparable patients not receiving the program's extended services. More research is required to determine which social service components yield desired outcomes for specific patient populations. Gaining these deeper insights and disseminating them widely offer the promise of considerable benefit for patients and the health care system as a whole.**

The Institute for Healthcare Improvement's Triple Aim of better care for individuals, better health for populations, and lower per capita costs[1] established goals for health care improvement that have been widely adopted, including by the Centers for Medicare and Medicaid Services. The Triple Aim also created a framework for innovation efforts nationwide.

From the Healthcare Innovation Challenges of the Center for Medicare and Medicaid Innovation[2] to other initiatives driven by the Affordable Care Act, such as the Community-Based Care Transitions Program,[3] considerable resources have been committed to achieving the Triple Aim. The commitment of these resources reflects the promise of improvement seen in emerging models of care, models for care transitions, patient-centered medical homes, accountable care organizations, and payment system reform.

As important as they are, many of these innovations are not designed to address the essential role of social supports in contributing to patients' health, safety, and well-being. Emerging literature and empirical lessons demonstrate the positive impact of providing these services in conjunction with both inpatient and primary care. Social supports include homemaker services, transportation, emotional support for patients and caregivers, and legal assistance.

Early evidence from demonstrations of seven care models, developed in hospital and

“Future work must develop an evidence base about:

1) the professional skills and knowledge that are required to address social needs successfully within health care settings,
2) the activities, tasks, and services addressing social needs that directly result in improved outcomes, and
3) the patient risk factors that are most susceptible to social support.

This level of specificity is required to support the development and refinement of models that are credible, replicable, and sustainable.”

— Shier, Gayle, et al. Health Affairs 32.3 (2013): 544-551.

https://pubmed.ncbi.nlm.nih.gov/23459734/

2019: National Academies consensus study calls for attention to social care integration

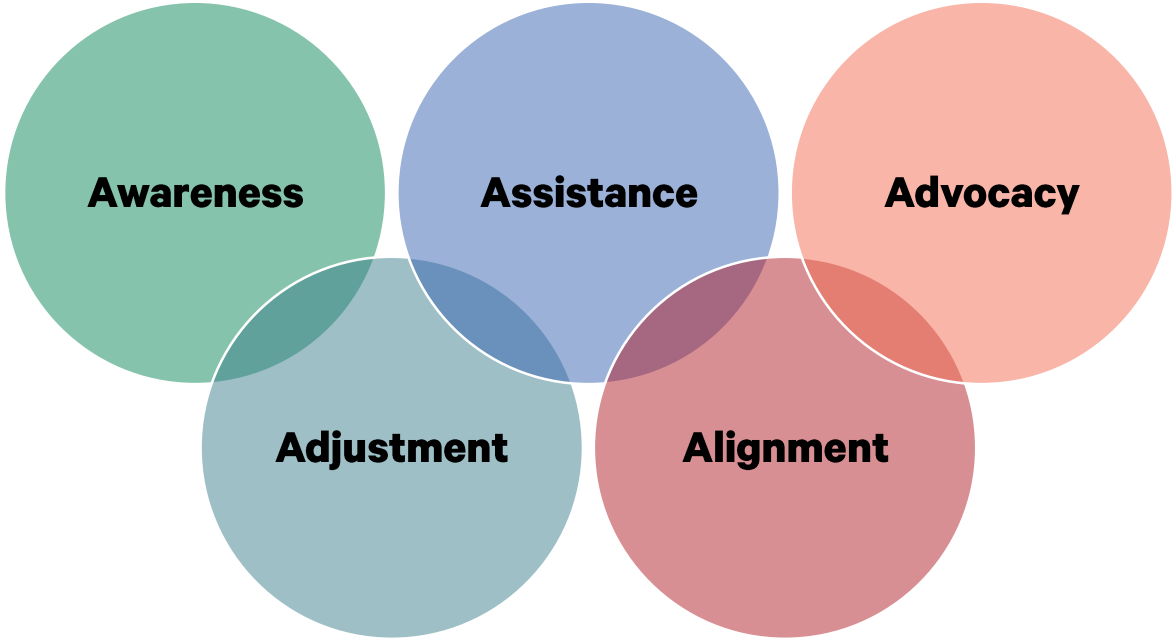
"Health care systems are paying increased attention to social factors, such as access to stable housing, reliable transportation, and nutritious food.

These upstream social conditions help shape people's health because they affect both the delivery and the outcomes of health care. It is therefore critical to take them into account to improve both primary prevention and the treatment of acute and chronic illness.

How can services that address social needs be integrated into clinical care? What kind of infrastructure will be needed to facilitate that integration?"

Diverse social care activities make a difference

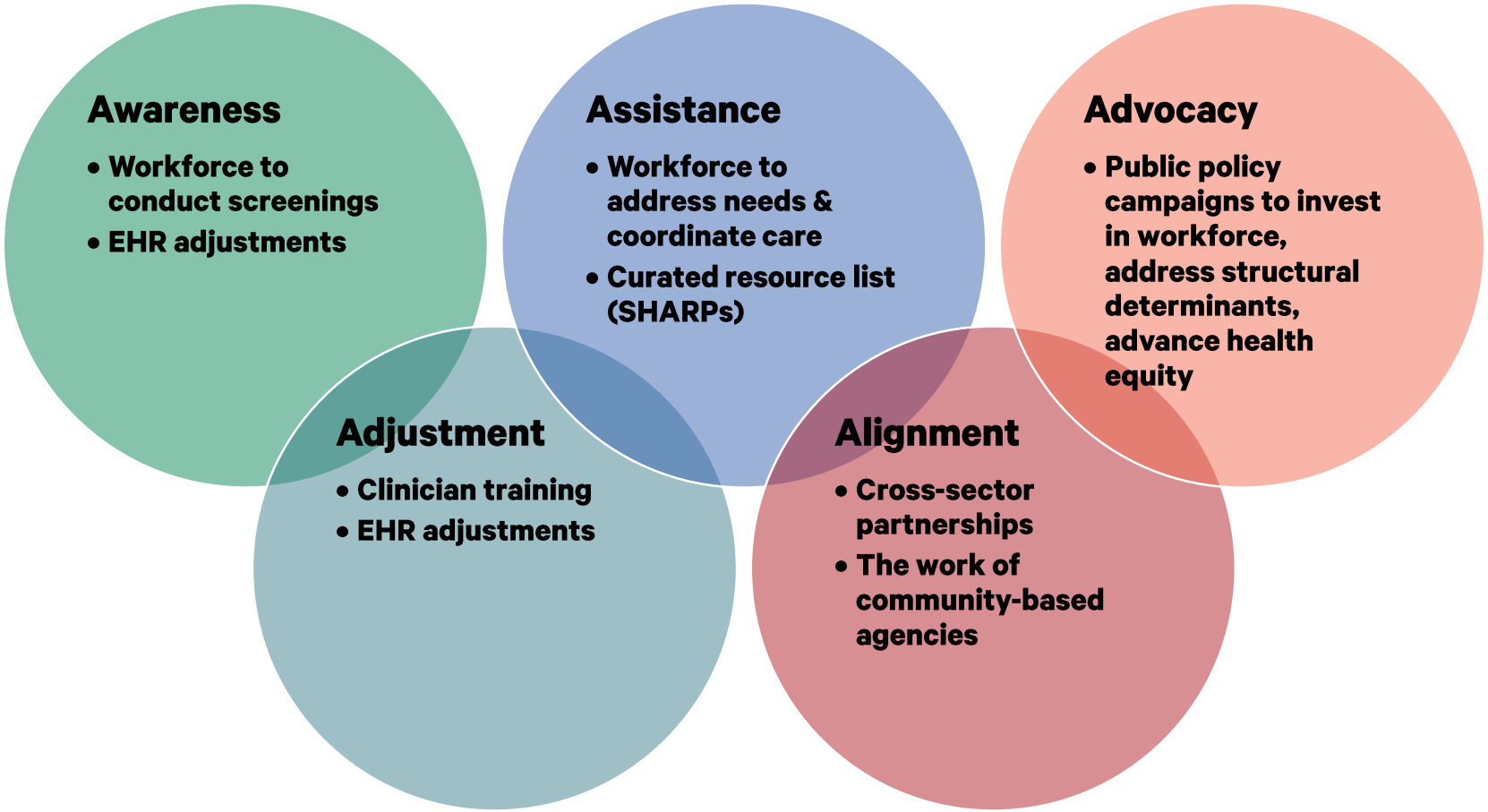
"Social care integration activities include awareness of social risks and social needs, adjustment of clinical care, assistance to address needs, alignment with community partners, and advocacy to minimize social risks and increase social care resources."



https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health

Diverse social care activities make a difference – and each takes investment by and in different stakeholders

Examples of investments needed:



https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health

NASEM: Effective interprofessional teams include experts in social care

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.

https://nap.nationalacademies.org/resource/25467/Social_Care_Social%20Workers%20and%20Social%20Care%20Providers%20FINAL_06092020.pdf

Areas of need as we move forward

Administrative complexities present challenges to and opportunities for more sustained and effective health care transformation

Medical model not designed around social care provision

- *Need for care models that enable integration of health care and social care*
- *Need for cross-sector partnerships between healthcare and social services*

Workforce needs

- *Recruitment & retention in social work and other roles*
- *Lack of role clarity*

Financing challenges

- *Lack of financing for social care integration activities*
- *“Wrong pockets” problem of investing in community improvements*

“The past several years have ushered in a new regulatory and quality paradigm around social care accountability in the health care sector…

The collective aspiration is that social care standards and incentives will help advance the “quadruple aim” through more robust engagement by plans, delivery systems, and individual providers—and perhaps enable more dollars to flow to community-based and government social services to enable population-level change.

Our best next step is to use the new policies as a national learning laboratory, leveraging the increased engagement from health care payers and delivery systems catalyzed by the new initiatives to rigorously evaluate social care activities.”

https://www.healthaffairs.org/content/forefront/developing-national-social-care-standards

SECURING THE INVESTMENTS WE NEED

Typical funding sources for social care activities

Governmental initiatives

- E.g., SNAP, home-delivered meals, or state funds like Illinois' Choices for Care program, public health initiatives, demonstration projects (e.g., HUD's Integrated Wellness in Senior Housing program)

Grant funding

- Philanthropic
- Individual donors

Healthcare funding

- Payers
  - *Billing "fee for service" directly*
  - *Contracts with managed care*
- Health systems and provider groups (e.g., Accountable Care Organizations)
  - *Operational funds*
  - *Alignment with value-based care and/or community benefit reporting*

Gaps in coverage limit access

“Good intentions by clinicians and systems are stymied by payment restrictions and the outright lack of payment for social interventions.”

https://jamanetwork.com/journals/jama-health-forum/fullarticle/2787444

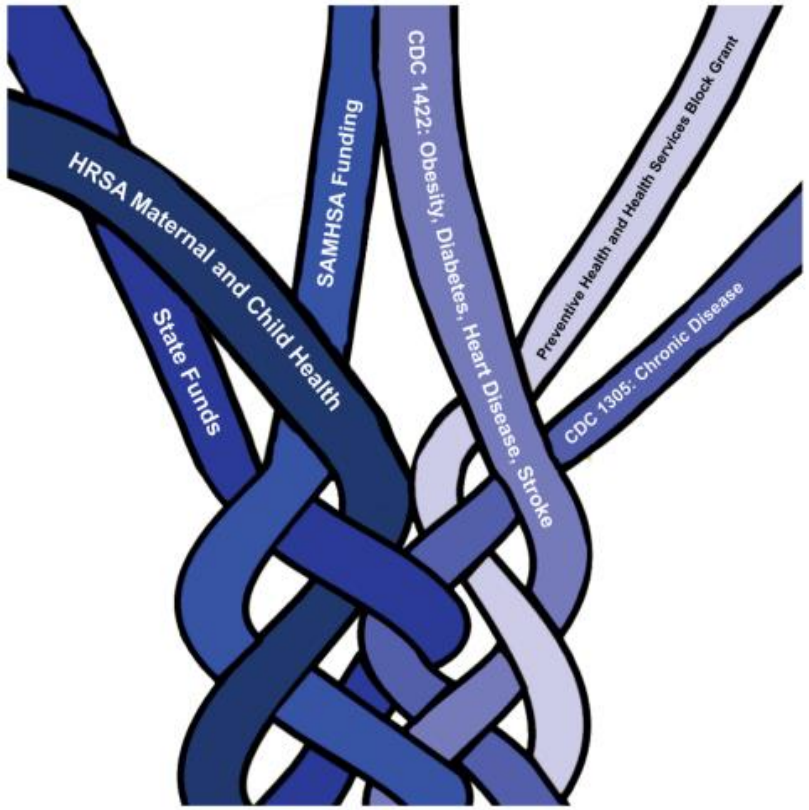
Making it work in the real world

Most initiatives require support from multiple funding streams

- Requires coordination of funds with different timelines and reliability, and tracking sources with specific deliverables
- “Braiding” and “blending” are two general approaches

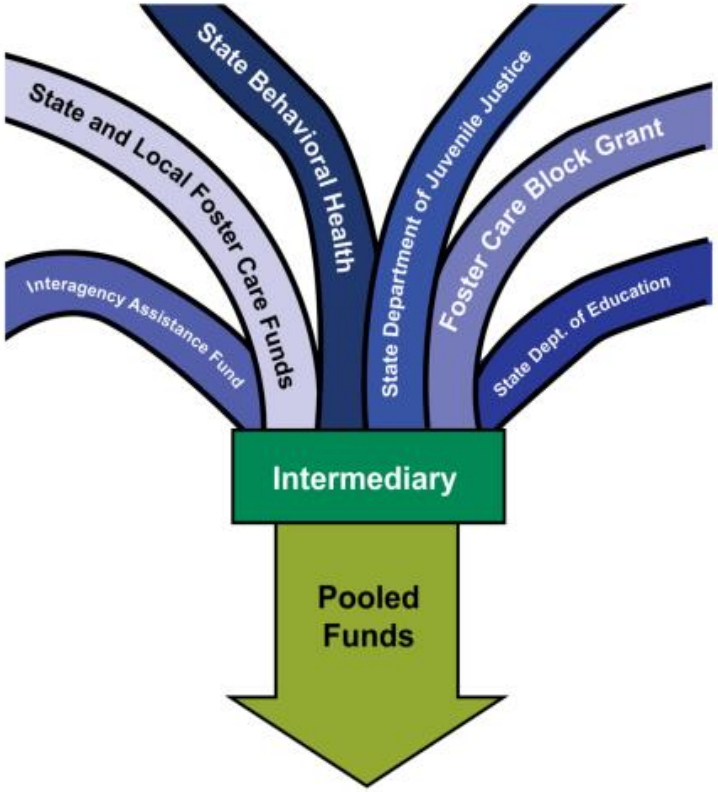
https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending

Braiding



Adapted from the National Academy for State Health Policy, December 2017.
https://nashp.org/wp-content/uploads/2017/12/deBeaumont.pdf

Blending



Adapted from the National Academy for State Health Policy, June 2016.
https://nashp.org/wp-content/uploads/2016/06/CSA-Virginia-Brief-1.pdf

https://www.brookings.edu/wp-content/uploads/2020/04/BraidingAndBlending20200403.pdf

Making it work in the real world

Most initiatives require support from multiple funding streams

- Requires coordination of funds with different timelines and reliability, and tracking sources with specific deliverables
- "Braiding" and "blending" are two general approaches

Based on research and input from the field, NASEM committee recommends additional attention to financing of health and social care integration

We also recognize that broader systemic and infrastructure investments are needed beyond integration activities highlighted here

- E.g., Transportation, affordable housing, environmental justice initiatives, digital access

https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending

Integrating social care into health care requires new financing approaches

Recommendations from 2019 NASEM report:

1. **Update legal definitions of health care.**
2. **Reform health care payment.**
3. **Boost accountability.**
4. **Streamline financing for dually eligible Medicare and Medicaid beneficiaries.**
5. **Increase administrative capacity of social service providers.**

https://nap.nationalacademies.org/resource/25467/Social_Care_Financing_FINAL_05192020.pdf

Integrating social care into health care requires new financing approaches

Recommendations from 2019 NASEM report:

1. **Update legal definitions of health care.**
   Optimize opportunities under Medicare and Medicaid by expanding view of health care

2. **Reform health care payment.**
3. **Boost accountability.**
4. **Streamline financing for dually eligible Medicare and Medicaid beneficiaries.**
5. **Increase administrative capacity of social service providers.**

https://nap.nationalacademies.org/resource/25467/Social_Care_Financing_FINAL_05192020.pdf

"As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Dr. LaShawn McIver, Director, CMS Office of Minority Health

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

“Fee for service”

Health care services traditionally have been reimbursed on a volume basis, often with adjustments based on complexity

- This called “fee for service” (FFS)

Financing social care assistance and care coordination via FFS reimbursement structures requires recognition of billing codes that describe the service

- Incentive with “medical loss ratio”

Several types of billing codes and approval processes

- CPT codes
- HCPCS (Levels I, II, III)
- LOINC, SNOMED

A spotlight on Medicare

Medicare statute says Medicare coverage is "limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury"

- Gradually pushing envelope on prevention

Clinic-based (Medicare Part B) code sets recognized by CMS in last decade include:

- Medicare Annual Wellness Visit
- Patient-focused health risk assessment
- Transitional Care Management
- Chronic Care Management
- Behavioral Health Integration
- Principal Care Management

These codes are billable by physicians or other "qualified health providers"

- Services by "auxiliary personnel" or "clinical staff" can contribute toward billable service on "incident to" basis

A spotlight on Medicare

CMS proposed significant changes in their proposed Medicare Part B policy for 2024 (“physician fee schedule”)

New proposed billing codes for:

- Social Determinants of Health (SDOH) Screening
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)
- Caregiver Training Services

Recognizing clinical social workers, marriage & family therapists (MFTs), and other mental health counselors as eligible to bill for:

- Health behavior assessment & intervention services

A spotlight on Medicaid

States have several options for incorporating social care:

- **State plan**
- **Health Homes**
- **Managed care**
  - "In lieu of" services (ILOS)
- **1115 waiver**
  - Housing, nutrition, HRSN case management
- **1915(b) waiver**
  - Home and community-based services (HCBS) – transportation, personal care services, adult daycare, supported employment

California example

- 2018: Health Homes
- 2020: "Medi-Cal 2020"
  - 25 "Whole Person Care" pilots for Medicaid beneficiaries with complex needs
  - Via 1115 waiver
- 2022: CalAIM
  - Transitioning pilots across state via Medicaid managed care system
  - Via 1115 waiver, 1915(b) waiver, and state plan amendments

https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/ ,
https://www.kff.org/policy-watch/a-look-at-recent-medicaid-guidance-to-address-social-determinants-of-health-and-health-related-social-needs/,
https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html

A spotlight on Medicaid

CMS building in guardrails

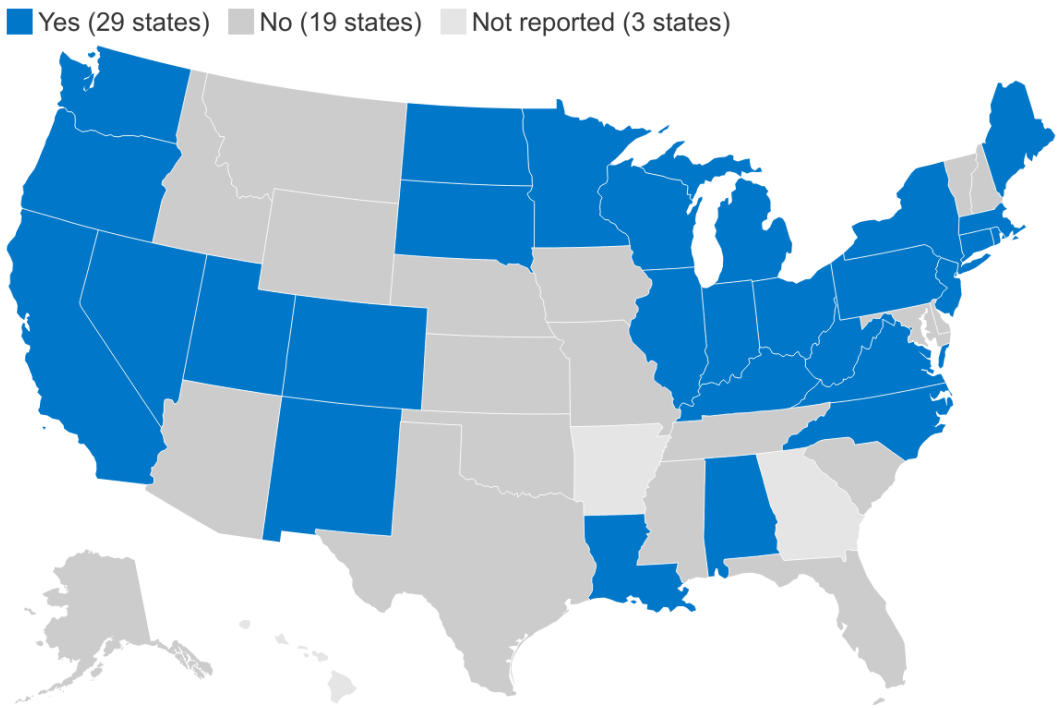
- Percent of funds that can be spent (e.g., 5%)
- State spending on related services must be maintained or increased
- Medicaid reimbursement rates 80% of Medicare rates
- Data collection from states

CHWs

- 29 states pay for community health worker (CHW) services via Medicaid
- Billing codes in use vary

Figure 1

States that Allow Medicaid Payment for Services Provided by Community Health Workers (CHWs) as of July 1, 2022



NOTE: Arkansas, Georgia and Hawaii did not provide responses to this question.
SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022.

KFF

https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/ ,
https://www.kff.org/policy-watch/a-look-at-recent-medicaid-guidance-to-address-social-determinants-of-health-and-health-related-social-needs/

Integrating social care into health care requires new financing approaches

Recommendations from 2019 NASEM report:

1. **Update legal definitions of health care.**

2. **Reform health care payment.**
   Alternative payment models

3. **Boost accountability.**
4. **Streamline financing for dually eligible Medicare and Medicaid beneficiaries.**
5. **Increase administrative capacity of social service providers.**

https://nap.nationalacademies.org/resource/25467/Social_Care_Financing_FINAL_05192020.pdf

Value-based care: Opportunities and challenges

Social care aligns with value-based care incentives

We're seeing investments in limited areas

- Pilots focused on specific disease states and not often available across the board
- Medicare Advantage Special Supplemental Benefits for the Chronically Ill

Yet, "Return on investment" (ROI) hard to identify

- Complexities of people's lives mean that most change happens longitudinally
- Person-centered social care interventions typically don't address a single issue in isolation


Posted on: June 12, 2020

AFFORDABLE HOUSING FINANCE

UnitedHealth Group Invests $100 Million in Affordable Housing Fund

The health care company is teaming with NAHT and SAHF to help build homes and improve resident health.

https://jamanetwork.com/channels/health-forum/fullarticle/2760141

Center for Medicare & Medicaid Innovation (CMMI)

Innovation Center has implemented dozens of payment reform demonstrations since 2012 with goals around quality measure and cost of care outcomes

Table 2. Accountable Care Metrics

Aim: Increase the number of beneficiaries in a care relationship with accountability for quality and total cost of care.

Impact on Beneficiaries: Beneficiaries in accountable care relationships will experience more person-centered, seamless care that supports their health and care goals.

Metric 1: Percent of Traditional Medicare beneficiaries with Parts A & B that will be in a care relationship with accountability for quality and total cost of care	• **2021 Baseline**	• 44%
	• **2024 Target**	• 60%
	• **2025 Target**	• 65%
	• **2030 Target**	• 100%

https://www.cms.gov/priorities/innovation/data-and-reports/2022/cmmi-strategy-refresh-imp-report

Integrating social care into health care requires new financing approaches

Recommendations from 2019 NASEM report:

1. Update legal definitions of health care.
2. Reform health care payment.

3. **Boost accountability.**
   Use classification and procedure codes to describe services

4. Streamline financing for dually eligible Medicare and Medicaid beneficiaries.
5. Increase administrative capacity of social service providers.

https://nap.nationalacademies.org/resource/25467/Social_Care_Financing_FINAL_05192020.pdf

Healthcare requirements and incentives to screen for social needs

Payers and regulators increasingly requiring healthcare delivery systems to capture data on health-related social needs (awareness)

CMS

- Inpatient and outpatient
- Varying accountability for follow up

National Committee for Quality Assurance (NCQA)

- "Healthcare Effectiveness Data & Information Set (HEDIS)" measures
- New Social Need Screening and Intervention (SNS) HEDIS measure

Joint Commission

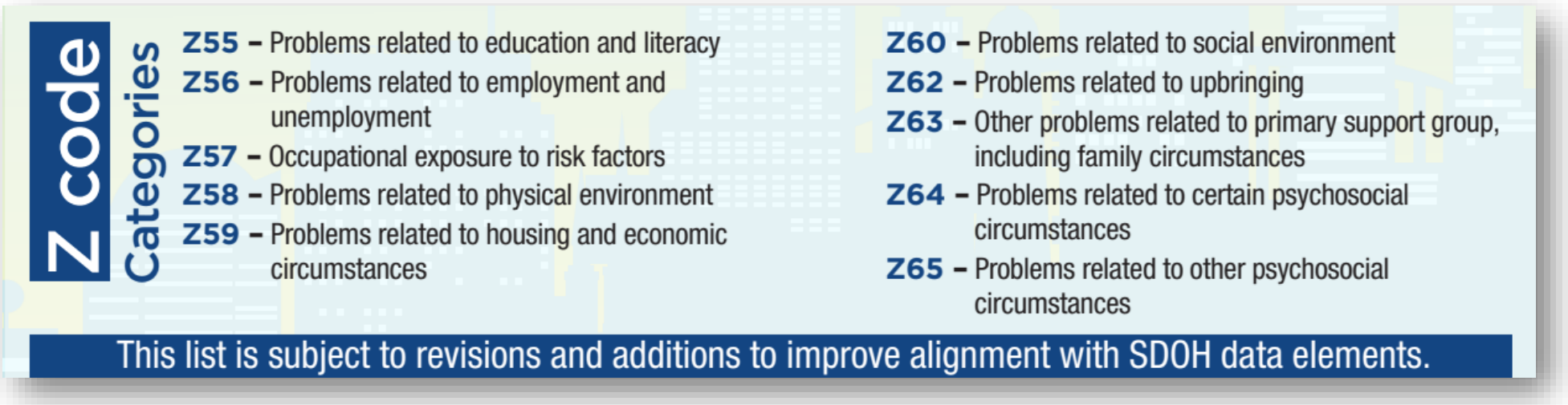
- Requires screening for representative sample of patients

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

Capturing social needs data

"Z codes"

- ICD Diagnostic Code family – factors influencing health status and contact with health services
- Use to capture complexity and inform incentives in Medicare Advantage and Medicare FFS inpatient



Gravity Project

- Consensus-driven advancements on terminology, tech/interoperability, and pilots

https://www.cms.gov/files/document/zcodes-infographic.pdf, https://thegravityproject.net/overview/

Integrating social care into health care requires new financing approaches

Recommendations from 2019 NASEM report:

1. Update legal definitions of health care.
2. Reform health care payment.
3. Boost accountability.

4. **Streamline financing for dually eligible Medicare and Medicaid beneficiaries.**

5. Increase administrative capacity of social service providers.

https://nap.nationalacademies.org/resource/25467/Social_Care_Financing_FINAL_05192020.pdf

Care coordination and social care are built into initiatives to serve dually-eligible Medicare & Medicaid beneficiaries

- **Medicaid managed care**
  - + Medicare as secondary
- **Dual-Special Needs Plans (D-SNPs)**
  - Via Medicare Advantage
- **Innovation Center**
  - State demonstrations via the Financial Alignment Initiative
- **Program for All-Inclusive Care of the Elderly (PACE)**
  - Expected to offer comprehensive services, including: personal care services, home care, adult day health care, recreational therapy, meals, dental care, nutritional counseling, social services, social work counseling, end of life care, transportation

https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/ , https://www.cms.gov/medicare/health-plans/pace/downloads/r1so.pdf

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4. Streamline financing for dually eligible Medicare and Medicaid beneficiaries.

5. **Increase administrative capacity of social service providers.**
   To enable bi-directional workflow and integration across sectors.

https://nap.nationalacademies.org/resource/25467/Social_Care_Financing_FINAL_05192020.pdf

Opportunities for enabling bi-directional collaboration across sectors

Demand for CBO services is increasing

- More healthcare delivery systems screening for health-related social needs

Common challenges for CBOs

- Technological systems
- Hard to sustain partnerships with unreliable funding
- Governmental funding coverage limitations, less competitive rates for recruiting and retaining staff

SHARPs facilitate information sharing and direct referrals (e.g., UniteUS, Find Help)

- Some markets have multiple SHARPs in use by different entities – burden and confusion
- Some public-facing resource inventories can initiate a direct self-referral

National Academies of Sciences, Engineering, and Medicine. 2019. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/25467.

Partnership to Align Social Care

A National Learning & Action Network

A national collaboration of leaders from across sectors

- Initiated by leaders from community-based organizations (CBOs)

Goal: successful partnerships between health care organizations and networks of CBOs delivering social care services

Key activities:

1. Identifying core competencies and an approach for qualifying CBO networks
2. Encouraging widespread use of existing and proposed billing codes
3. Developing a streamlined contracting process between health systems, payers, and CBOs
4. Promoting common IT security and interoperability standards
5. Enabling organization and financing strategies for sustainable CBO network infrastructures and lifting up current best practices among CBO networks
6. Producing a framework that reflects a balanced, common vision for achieving and sustaining an “ideal state” of health and social care alignment

https://www.partnership2asc.org/

CCH: Community Care Hub = Health Equity Solution

Consumer Negatively Impacted by Social Drivers of Health

Care Team Completes Limited SDOH Screen and Refers to CCH

CCH acts as Single Point of Referral for a Network of CBOs – Organized Into a **Social Care Delivery System (SCDS)**

CCH Partner Org. Completes a Comprehensive, Evidence-Based SDOH Screen

CCH Team Develops a Person-Centered Plan to Address Social Drivers of Health

CCH Works to Blend & Braid *All Available Resources* to Address Identified Needs:
Public + Private + Healthcare + Philanthropy

CCH Submits Closed-Loop Referral Data: Z-Codes, Social Intervention Codes, and Outcome of Social Care Svcs

CCH + Healthcare Conduct CQI to Document the Impact: Health-Related Social Needs Addressed (Pop Health), ROI, + Measures of Health Equity

CAMPAIGN FOR SOCIAL WORK'S VALUE IN IMPROVING OUR NATION'S HEALTH

A spotlight on social workers as one key workforce

Too many people face preventable barriers to health and to quality healthcare.

Social workers make an impact by skillfully supporting people today while working to build stronger systems for tomorrow.

Social workers promote health.

Social workers enhance hope.

Social workers improve healthcare outcomes.

Policy change needed to maximize social work's impact

Social workers are often not viewed as health care providers and often rely on grant funding

- Not everyone has equal access to SW services

CSWs are restricted to billing Medicare only for the services they offer directly as mental health providers

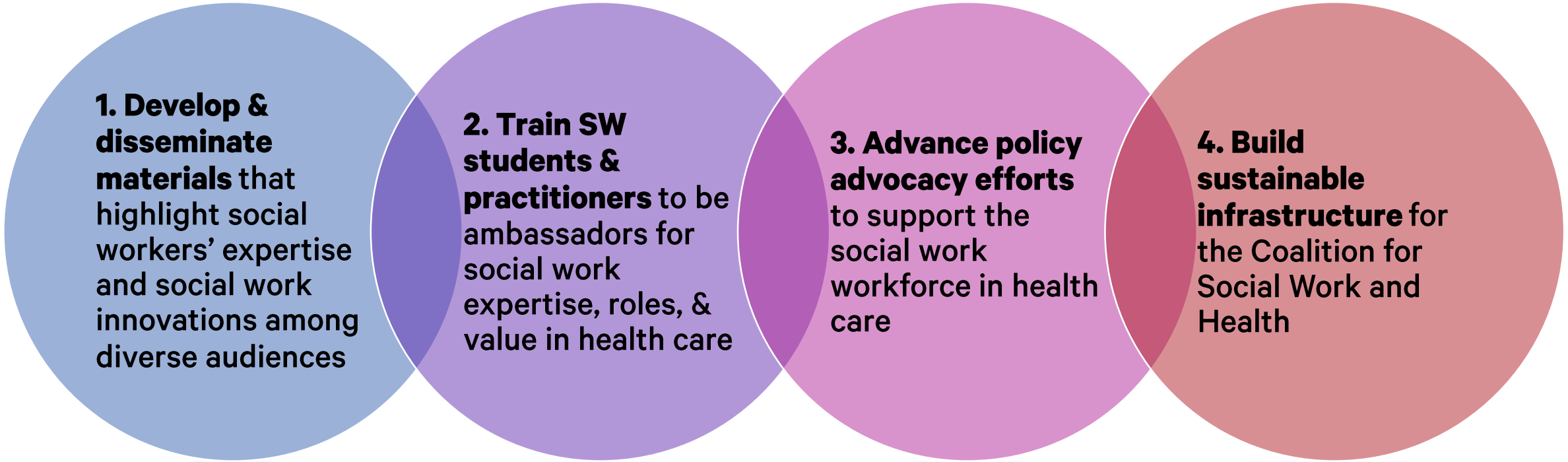
- Restrictive definition of clinical social worker services within the Social Security Act
  - → CMS has restricted CSWs from billing for Health Behavior Assessment & Intervention services
    - → Limited funding streams for organizations to finance this type of care
      - → Limited access for Medicare beneficiaries

Coalition for Social Work and Health

- A collective dedicated to elevating and expanding social work's impact in improving health and healthcare
- Coalition engages in advocacy, research, and education via the participation of organizations, practice and academic leaders, and allies
  - Representation from over 30 social work professional groups and schools – including CHAS @ UChicago
- Led efforts to design, fundraise for, and act on recommendations from the NASEM consensus study on health and social care integration
  - Made possible by 12 philanthropic and social work association funders, plus 60+ SW schools

2022-2024: Campaign for Social Work's Value In Improving Our Nation's Health

Coordinated advocacy and communications campaign, with support from The New York Community Trust

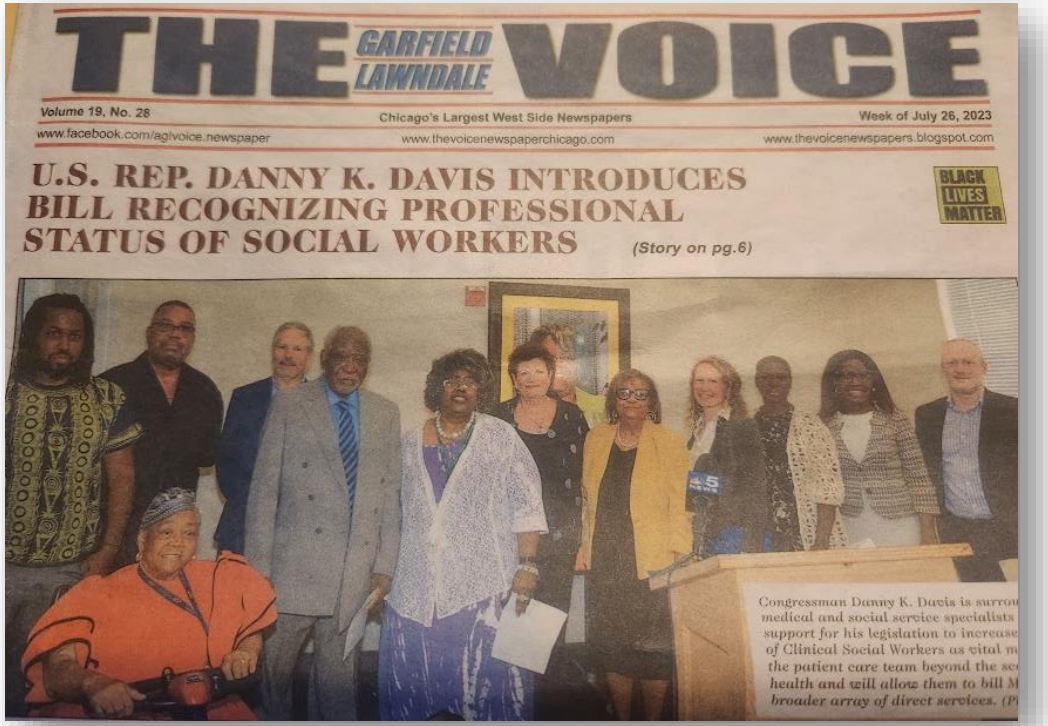


Integrating Social Workers Across Health Care Settings Act (H.R. 4638)

Introduced July 14, 2023

Led by Rep. Danny Davis (D-IL) and Rep. Jen Kiggans (R-VA)

Amends the definition of "clinical social worker services" to allow CSWs to bill Medicare Part B for the services already permitted under their state scope of practice



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www.facebook.com/aglvoice.newspaper | www.thevoicenewspaperchicago.com | www.thevoicenewspapers.blogspot.com

U.S. REP. DANNY K. DAVIS INTRODUCES BILL RECOGNIZING PROFESSIONAL STATUS OF SOCIAL WORKERS

(Story on pg.6)

BLACK LIVES MATTER

Congressman Danny K. Davis is surrou
medical and social service specialists
support for his legislation to increase
of Clinical Social Workers as vital m
the patient care team beyond the sc
health and will allow them to bill M
broader array of direct services. (P

Help us increase access to social work services

1. Shine a light on the imperative around social work in health care

- Share materials about social work's role, expertise, and value in health care with diverse stakeholders within your own network
  - *www.chasci.org/cswh-resources*
  - *@C4SWHealth on Twitter*
- Partner with us to contribute to op-eds, host local presentations, present at conferences, compile resources, conduct workforce research, etc.

2. Help advocate to address policy barriers (including provisions in H.R. 4638)

- Visit www.chasci.org/cswh-action for toolkits and more
- Organizational endorsements: awheeler@guidelobby.com

3. Partner with us on or provide support for future Coalition activities

CLOSING THOUGHTS

What we've covered today

- Imperative for social care
- History of attention to care coordination and social care
- Overview of social care financing mechanisms and opportunities
- Campaign for social work's value in improving our nation's health

Opportunities for impact

Adapt CMS health equity priorities in your own organization, as applicable

Advocate for policies that invest in social care workforce, programs, and community investments

Engage in practice-based research or research-based practice in a way that is relevant for policy and education

“We'll keep making equity and justice our North Star because we know healthcare is about more than just mending bones or dispensing pills; it's about giving people access to peace of mind, to economic security, and to a brighter future.

And that should belong to everyone, no matter where you come from, what your color, what language you speak. We think all Americans have that opportunity.”

- Xavier Becerra, Secretary, US Department of Health and Human ServicesHealth Affairs Briefing: Racism & Health

https://www.healthaffairs.org/do/10.1377/he20220125.966408/

Thank you! Questions? Comments?

Robyn Golden

Associate Vice President of Social Work and Community Health,
RUSH University Medical Center, Robyn_L_Golden@rush.edu

Bonnie Ewald

Managing Director, Center for Health and Social Care Integration
Social Work and Community Health @ RUSH, Bonnie_Ewald@rush.edu

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