Supporting Integrated Care & Meeting Social Needs for America’s Heroes

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Care Management and Social Work Service
• As a federal employee, I am public domain
• I have no financial or non financial conflicts of interest to disclose
• We begin with the assumption that those listening already agree with NASEM that “integrating social care into health care delivery holds the potential to achieve better health outcomes for the nation and address major challenges facing the U.S. health care system.”

If not, please refer to Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. (National Academies Press, 2019)
VA HEALTHCARE EMPLOYEES

VA is one of the largest civilian employers in the federal government and one of the largest health care employers in the world.

340,000+ Total VHA Employees

16,000+ Masters Level Social Workers

1,500+ Graduate SW Trainees
### VA SOCIAL WORK DEMOGRAPHICS

**Grade Levels**
- Grade 09: 788
- Grade 11: 6,856
- Grade 12: 7,076
- Grade 13: 882
- Grade 14: 188
- Grade 15: 10
- Total: 16,162

**Gender**
- 77% Female
- 23% Male

**SW Supervisors**
- 74% Female
- 26% Male

**Race**
- 69% White
- 20% African American
- 6% Hispanic
- 3% Asian
- 1% Native Hawaiian/Pacific Island/Other

**Age**
- 21 to 86 years
- Average age: 40 years

**Veterans**
- 18%

**Retirement eligible**
- 9%

**Median Years Served**
- 7

**SW Supervisors**
- 1,823

*Data Source: VSSC Human Resources Employee Cube as of May 2020*
• Primary focus is to assist Veterans, their families, and caregivers in resolving Social Determinants of Health (SDOH) challenges to health and well-being

• Social Work is woven into the fabric of VA health care, providing services in all clinical programs across the continuum of care

• Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. NASEM (September 2019)

• Greater burdens of social determinants are associated with greater emergency department utilization: Findings from the Veterans Health Administration. American Journal of Emergency Medicine (In Press)

• Embedding Social Workers in Veterans Health Administration Primary Care Teams Reduces Visits to the Emergency Room. Health Affairs. (April 2020)
“The social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.”

- World Health Organization
SOCIAL DETERMINANTS OF HEALTH (SDOH)

Financial concerns

Legal concerns

Relationship concerns

Employment

Housing or food concerns
GUIDING PRINCIPLES OF SOCIAL WORK

Holistic View of Individual
A key value of Social Work promotes a holistic view of the individual and their functioning within the systems they live, work, and play in.

Bio-Psycho-Social Perspective
Social Work professional practice utilizes a bio-psycho-social perspective and assists Veterans, their families, and caregivers in resolving psychosocial, emotional and economic barriers to health and well-being while building on their strength and abilities.

Individual Preferences
Social Workers respect individual preferences, needs, and values in a shared decision making approach. We believe all people have a right to self-determine their path to optimal wellness/recovery.
SOCIAL WORK CLINICAL SKILLS

Identify
Identify Veterans who may be high risk or experience social determinants of health or other barriers to care

Assess
Complete clinical assessments of Veteran’s biopsychosocial situation, including mental health and substance use disorders

Intervene
Develop person centered goals and interventions relevant to needs, deficits, and problems identified

Screen
Complete relevant clinical screenings (such as suicide risk assessment, PHQ-2/9, PTSD, BAM/AUDIT-C, Zarit Burden)

Support & Refer
Improve health outcomes and collaborate or coordinate services with community programs to strengthen or improve the continuity of care
Access is not optimized when SDOH deficits are not identified:

- Higher no show rate
- Repeat Emergency Room visits
- Unnecessary appointments
- Increase in inpatient stays (number & duration)
- Ability to coordinate own care, esp. when there are multiple providers and specialties
- Difficulty with treatment plan adherence
Data: VA Administrative Data, Suicide Prevention Applications Network (SPAN) data

Sample: 293,872 patients with >1 visit in Fiscal Year (FY) 2016 in VISN 4

Analyses: Multiple logistic regression to adjust for demographics and medical comorbidity

Manuscript: Greater burdens of social determinants are associated with greater emergency department utilization: Findings from the VHA (In Press)

Study approved by Institutional Review Board of VA Pittsburgh Healthcare System
## PREVALENCE OF SOCIAL DETERMINANTS OF HEALTH

<table>
<thead>
<tr>
<th>Type of Social Determinant of Health</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>9,646</td>
<td>3.3</td>
</tr>
<tr>
<td>Housing Instability</td>
<td>17,738</td>
<td>6.0</td>
</tr>
<tr>
<td>Employment/Financial Problems</td>
<td>10,353</td>
<td>3.5</td>
</tr>
<tr>
<td>Legal Problems</td>
<td>4,561</td>
<td>1.5</td>
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<tr>
<td>Social/Family Problems</td>
<td>7,954</td>
<td>2.7</td>
</tr>
<tr>
<td>Lack Access to Care/Transportation</td>
<td>5,443</td>
<td>1.9</td>
</tr>
<tr>
<td>Non-specific Psychosocial Needs</td>
<td>20,145</td>
<td>6.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Types of Social Determinants of Health</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>245,793</td>
<td>83.6</td>
</tr>
<tr>
<td>1</td>
<td>31,717</td>
<td>10.8</td>
</tr>
<tr>
<td>2</td>
<td>9,546</td>
<td>3.3</td>
</tr>
<tr>
<td>3</td>
<td>3,914</td>
<td>1.3</td>
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<tr>
<td>4</td>
<td>1,722</td>
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<td>777</td>
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<td>6</td>
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<td>0.1</td>
</tr>
<tr>
<td>7</td>
<td>98</td>
<td>0.03</td>
</tr>
</tbody>
</table>
Data-backed innovative program that addresses barriers separating rural Veterans from quality care

Goal is to embed Social Workers (SW) in rural and highly rural areas to increase Veteran access to high quality social work interventions

Funded by VA’s Office of Rural Health (ORH)

Provide comprehensive assessment, intervention, and follow up through the Social Work Practice Model with standardized national note templates
Assessment and intervention model that focuses on social determinants of health domains:

- Access to Care
- Psychological Status
- Economics
- Functional Status
- Housing
- Social Support
Center of Innovation in Long-Term Services and Supports for Vulnerable Veterans (LTSS-COIN) - Providence

Data Source: Corporate Data Warehouse (CDW)

Timeframe: October 2016-June 2019

Sample: 379,214 Veterans who had at least one primary care visit at participating site during time period

Veteran Cohort (High Risk): 46,828 Veterans with CAN Score >95 for at least one month

Analysis: Difference in difference estimate
After introducing a Social Worker to the team, outcomes for Veterans (High Risk cohort - Care Assessment Needs score >95) demonstrated:

- 4.4% decrease in Veterans who had one or more hospital admission
- 3% decrease in Veterans who had one or more ED visits
- 23% increase access to SW intervention
- Overall program outcomes:
  - 35% increase in SW visits
  - 42% increase for Veterans residing in rural areas

Health Affairs: Embedding Social Workers in Veterans Health Administration Primary Care Teams Reduces Visits to the Emergency Room (April 2020)
• Social determinants of health (SDOH) factors experienced by Veterans impact access

• Human centered design (i.e. Veterans need to be at the center) of access measures

• Routine identification of SDOH is critical to improve access

• Recommend adding SDOH deficits to access measure(s) to better understand systemic needs

• Recommend inclusion of social work staffing in access measurement(s)
QUESTIONS?
ADDITIONAL INFORMATION
REFERENCES

- VHA Primary Care Website http://www.va.gov/health/services/primarycare/pact/index.asp
## Patient Aligned Care Team (PACT) Social Work Practice Model

### ABSTRACT

Patient Aligned Care Team (PACT) focuses on health promotion, prevention and management of chronic disease. Preventive care and the successful management of many conditions is dependent on the behavioral changes that patients are willing and able to make as well as environmental factors.

The role of a social work care manager in the PACT is to assess and treat psychosocial and environmental factors that impact the patient's ability to achieve maximum health and wellness. Social work case managers assess the patient’s psychological and emotional adjustment to illness within the context of medical diagnosis, prognosis, and treatment options. An assessment of environmental factors includes a review of the dynamics of the patient's support system, functional status, vocational, economic, housing, spiritual, cultural and legal factors that influence their ability to adhere to medical recommendations and management of self. The social worker assesses the underlying factors that contribute to the presenting concerns and develops interventions designed to promote lasting positive change to decrease stress, promote health and wellness and remove barriers to care. Psychosocial treatment options are reviewed with the patient, family and PACT team. A treatment plan based on the patient's identified concerns and goals is established. Patients are given supportive assistance and referrals to appropriate resources to lessen the acuity of psychosocial stressors.

This social work model describes the process for assessment, treatment, and interventions. The patient is assessed in 6 domains: access to care, economics, housing, psychological status, social support, and functional status. A level of acuity is assigned for each domain. Level 1 represents patients whose basic needs are met. Level 2 represents patients that have minor concerns in one or more of the domains. Level 3 represents patients that have major concerns in one or more of the domains and Level 4 represents patients who have a crisis in one or more domains (i.e. have no income, no social support or are homeless). For each level, possible interventions are listed. The goal of the intervention(s) is to lessen acuity and move patients toward Level 1.

<table>
<thead>
<tr>
<th>LEVEL 1 INTERVENTIONS</th>
<th>LEVEL 2 INTERVENTIONS</th>
<th>LEVEL 3 INTERVENTIONS</th>
<th>LEVEL 4 INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to care: Patients are entitled to care and have transportation. <strong>Economics</strong>: Patients have sufficient income for their needs. <strong>Healthcare Services</strong>: Patients have adequate housing for their needs. <strong>Psychological Status</strong>: Stable mood and behavior. <strong>Social Support</strong>: Patients have supportive relationships. <strong>Functional Status</strong>: Patients are functionally independent.</td>
<td>Patients have a minor concern with access to care, economics, housing, psychological status, social support or functional status. <strong>Access to care</strong>: Patients may have questions or need assistance with the means test/eligibility for care or need assistance to arrange for transportation to the VA. <strong>Economics</strong>: Patients have some income. They may need financial counseling to manage within their means. They may need assistance to either increase their income, or decrease their expenses. <strong>Psychological Status</strong>: Patients may have a minor mood or behavioral disturbance that occasionally interferes with daily functioning. <strong>Social Support</strong>: Patients have supportive relationships, but they aren't receiving all the support or assistance that they need. <strong>Functional Status</strong>: They may need assistance with IADL's.</td>
<td>Patients have a major concern with access to care, economics, housing, psychological status, social support or functional status. <strong>Access to care</strong>: Patients may have limited or cost prohibitive transportation to the VA. They may need to have many appointments scheduled for the same day, or schedule overnight accommodations due to transportation problems. <strong>Economics</strong>: Patients have to-little income to support basic human needs. Their expenses exceed their income. Patients need immediate assistance to either increase their income, or decrease their expenses. <strong>Psychological Status</strong>: Patients may have a major mood or behavioral disturbance that interferes with daily functioning. <strong>Social Support</strong>: Caregiver is overwhelmed and stressed by patient care needs. Patients have strained relationships and do not receive adequate assistance. <strong>Functional Status</strong>: Patients may be at risk for falls or other injuries. They may need assistance with ADL's/IADL's.</td>
<td>Patients have a crisis with access to care, economics, housing, psychological status, social support or functional status. <strong>Access to care</strong>: Patients may be unable to afford or find transportation. <strong>Economics</strong>: Patients have no income. Patients need immediate assistance to either find work or receive benefits. <strong>Psychological Status</strong>: Patient needs inpatient psychiatric admission. <strong>Social Support</strong>: Patient lacks social supports. <strong>Functional Status</strong>: Patient is functionally dependent.</td>
</tr>
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**LEVEL 1 INTERVENTIONS**

- Answer questions regarding the business of health care to include the cost of health care in the VA and outside the VA (utilizing Medicare, Medicaid, private health insurance, and supplemental insurance policies). Refer to community dental programs if not eligible in the Veterans Health Administration.
- Answer questions regarding Veterans Benefits (health benefits, pensions/compensation, burial benefits, veterans' affairs, vocational rehabilitation, etc.)
- Prepare Advance Directives
- Schedule/reschedule appointments, ensure that ordered equipment/services are received, and provide information and assistance with transportation arrangements.
- Provide supportive counseling to assist patient and family with their adjustment to a diagnosis or disability.
- Order respite care.
- Provide family/patient education about health promotion, disease prevention and management of self.
- Refer for competency exams (neuropsychological assessments, paper, guardianship, fiduciary, etc.) consult with POC.

**LEVEL 2 INTERVENTIONS**

- Provide financial counseling.
- Provide assistance with application for Social Security.
- Provide assistance with application for Social Security.
- Refer to Vocational Rehabilitation Program.
- Refer to subsidized housing.
- Provide assistance to apply for a reduction of property taxes.
- Provide assistance to apply for energy assistance programs.
- Provide mortgage refinancing.
- Refer for legal assistance.
- For city programs to assist with home maintenance.
- For weatherization programs.
- Provide assistance to keep utilities on.
- Refer for weatherization programs.
- Refer to mental health programs.
- For substance abuse treatment programs.
- Address family relationship issues.
- For meals on wheels.
- For inpatient rehabilitation to improve functional ability/psychosocial issues.
- Refer to inpatient psychiatric unit to improve functional ability.
- For home health aid to assist with ADL's and IADL's.
- For group homes to assist with medication management.
- For Adult Day Health Care.
- For inpatient home rehabilitation to improve functional ability/psychosocial issues.
- For home health aid to assist with ADL's and IADL's.
- For group homes to assist with medication management.
- For Adult Protective Services.

**LEVEL 3 INTERVENTIONS**

- For city programs to assist with home maintenance.
- For weatherization programs.
- Provide supportive counseling to assist patient in adjusting to a diagnosis or disability.
- For mental health programs.
- For substance abuse treatment programs.
- Address family relationship issues.
- For meals on wheels.
- For homeless shelters.
- For public housing.
- For inpatient rehabilitation to improve functional ability.
- Refer to group homes.
- For assisted living facilities.
- For nursing homes.

**LEVEL 4 INTERVENTIONS**

- For city programs to assist with home maintenance.
- For weatherization programs.
- Provide supportive counseling to assist patient in adjusting to a diagnosis or disability.
- For mental health programs.
- For substance abuse treatment programs.
- Address family relationship issues.
- For meals on wheels.
- For homeless shelters.
- For public housing.
- For inpatient rehabilitation to improve functional ability.
- Refer to group homes.
- For assisted living facilities.
- For nursing homes.
SW PACT PROGRAM IMPACT

Days and Visits Averted Per Year Among All Enrolled Veterans with CAN score >95

- Number of ED visits: -7900
- Number of preventable ED visits: -2100
- Ambulatory Care Sensitive Condition (ACSC) Hospital Days: -2100
- Total Inpatient Hospital Days: -9300