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

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DISCLAIMER

- 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

Age: 21 to 86 years
Average age: 40 years
Veterans: 18%
Retirement eligible: 9%
Median Years Served: 7

SW Supervisors: 1,823

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

Data Source: VSSC Human Resources Employee Cube as of May 2020

VA SOCIAL WORK

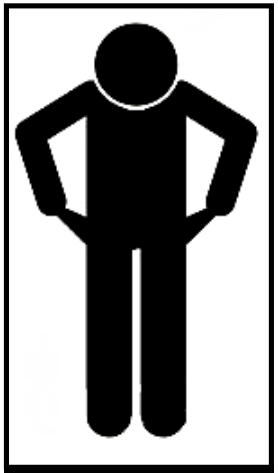
- Primary focus is to assist Veterans, their families, and caregivers in resolving Social Determinants of Health (SDOH) challenges to health and well-being
- Social Work is woven into the fabric of VA health care, providing services in all clinical programs across the continuum of care
- Integrating 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)

HEALTH IS MORE THAN BIOLOGICAL

"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)

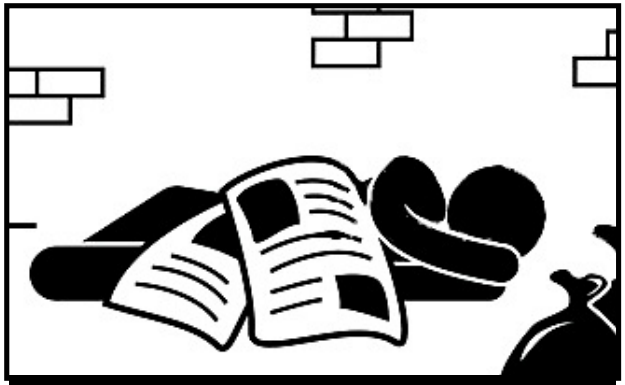


Financial concerns

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

Screen

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

Intervene

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

Support & Refer

Improve health outcomes and collaborate or coordinate services with community programs to strengthen or improve the continuity of care

SDOH IMPACT ON ACCESS

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

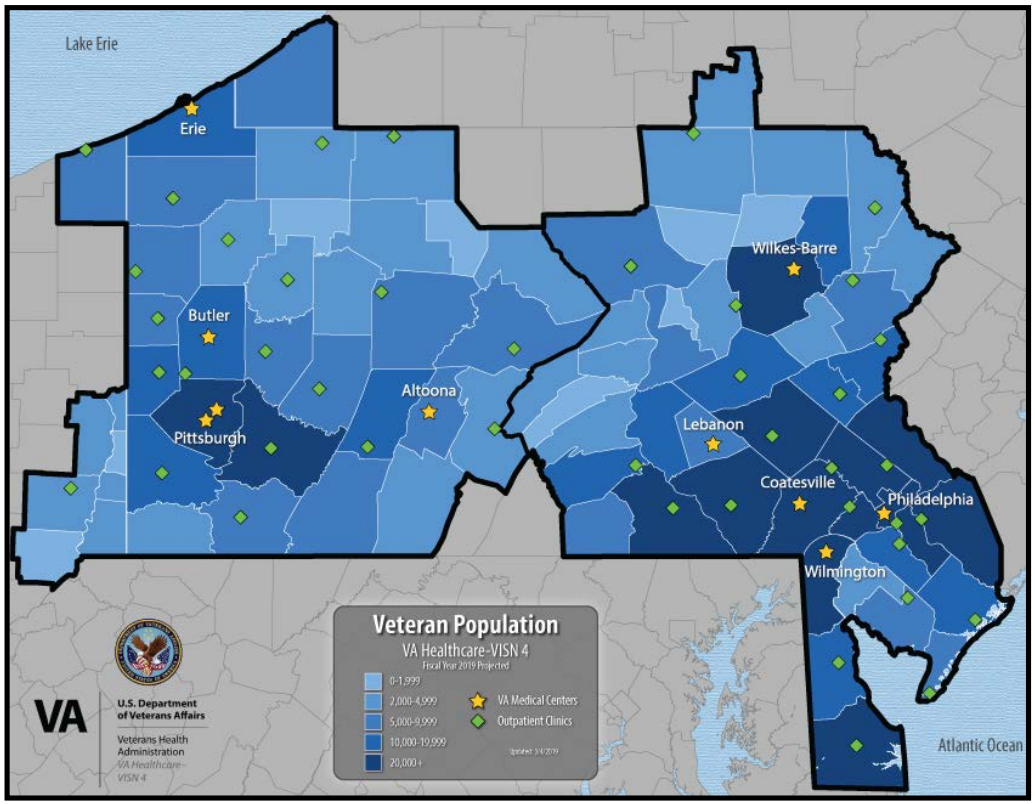
RESEARCH TO UNDERSTAND SDOH

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)

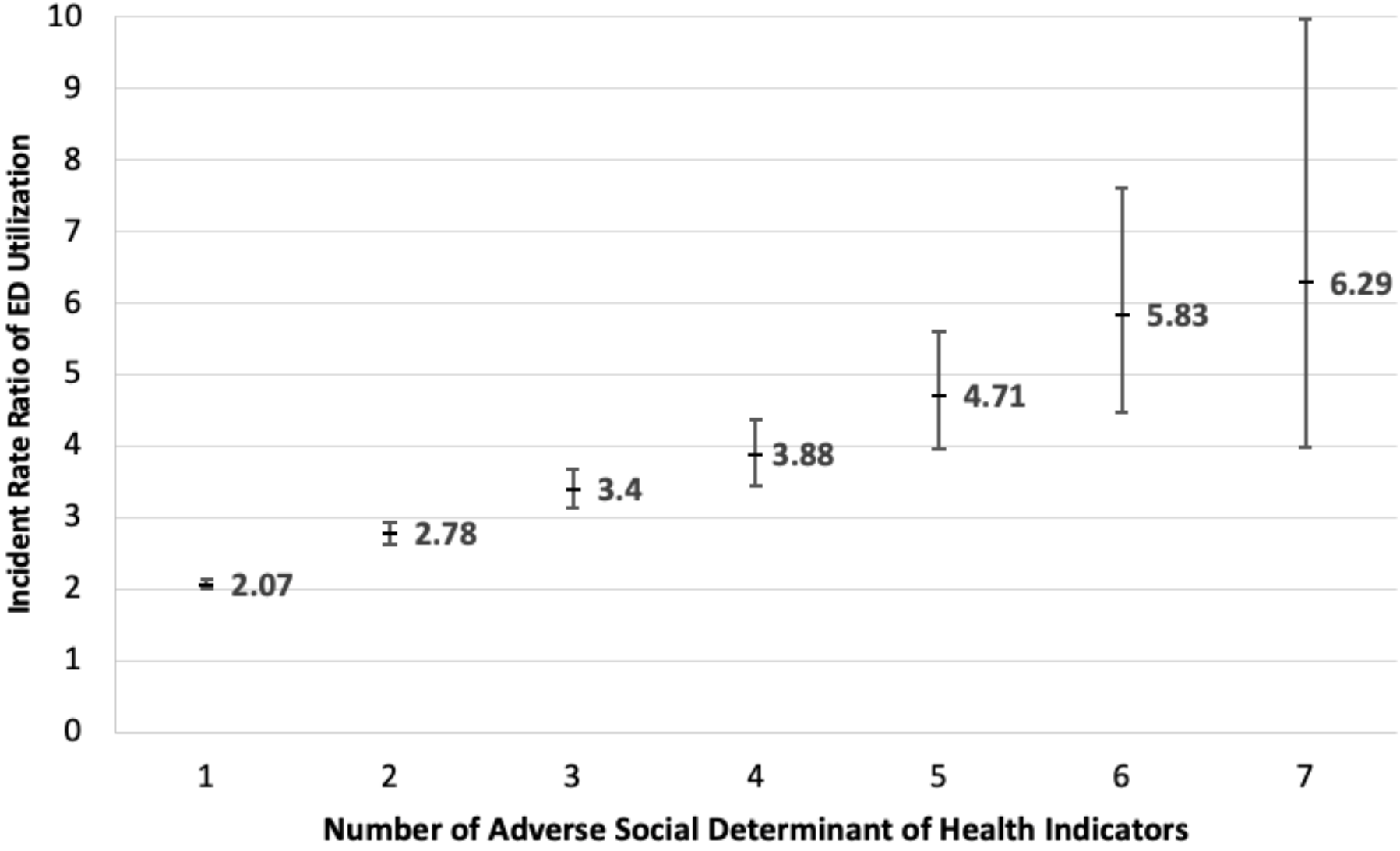


Study approved by Institutional Review Board of VA Pittsburgh Healthcare System

PREVALENCE OF SOCIAL DETERMINANTS OF HEALTH

	n	%
Type of Social Determinant of Health		
Violence	9,646	3.3
Housing Instability	17,738	6.0
Employment/Financial Problems	10,353	3.5
Legal Problems	4,561	1.5
Social/Family Problems	7,954	2.7
Lack Access to Care/Transportation	5,443	1.9
Non-specific Psychosocial Needs	20,145	6.9
Number of Types of Social Determinants of Health		
0	245,793	83.6
1	31,717	10.8
2	9,546	3.3
3	3,914	1.3
4	1,722	0.6
5	777	0.3
6	305	0.1
7	98	0.03

SDOH DEFICITS AND ED USE



SOCIAL WORK PATIENT ALIGNED CARE TEAMS (PACT)

- 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

SOCIAL WORK PRACTICE MODEL

Assessment and intervention model that focuses on social determinants of health domains:

Access to Care	Psychological Status
Economics	Functional Status
Housing	Social Support

PROGRAM EVALUATION

Center of Innovation in Long-Term Services and Supports for Vulnerable Veterans (LTSS-COIN) - Providence

Data Source: Corporate Data Warehouse (CDW)

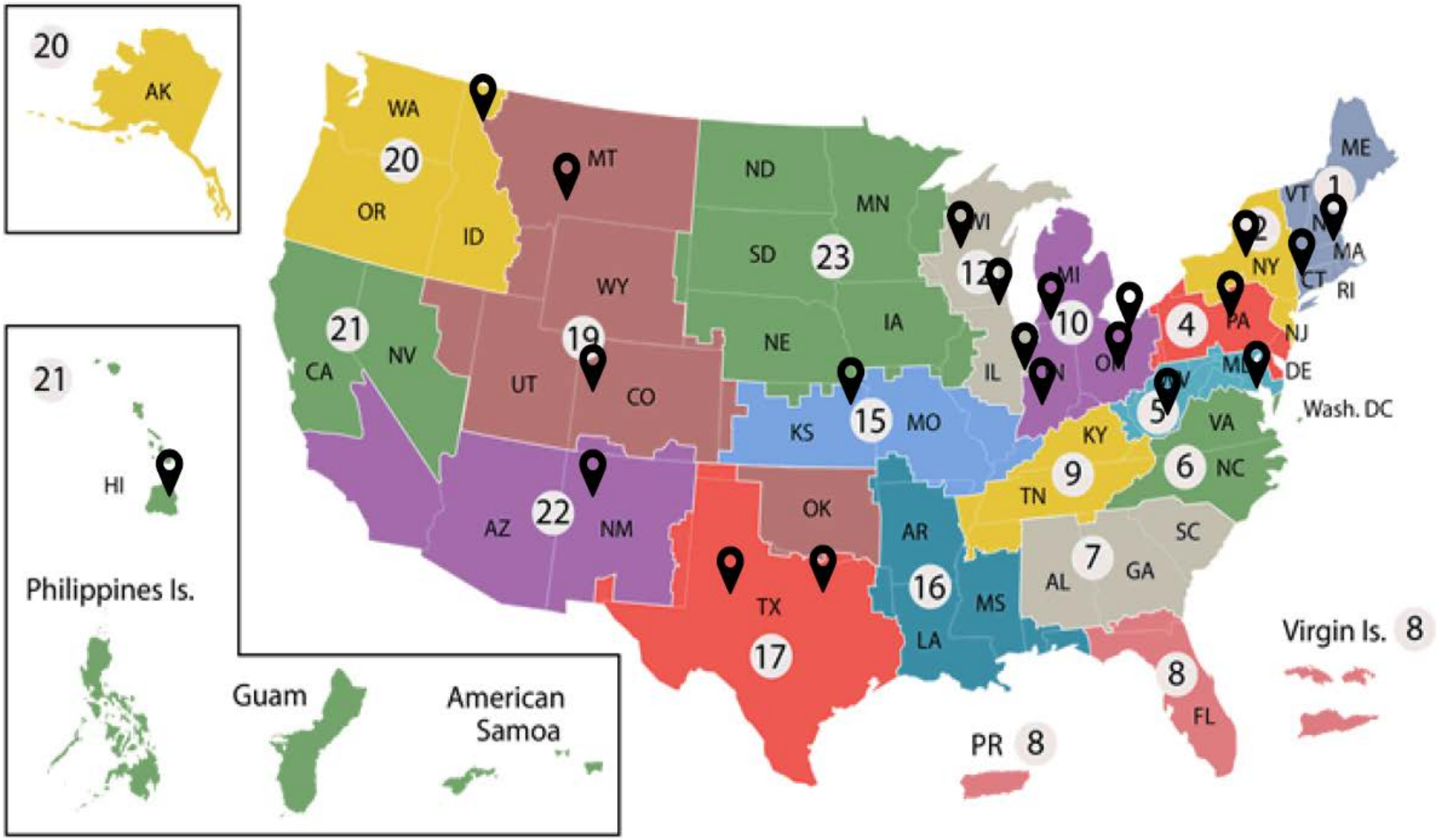
Timeframe: October 2016-June 2019

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

SAMPLE POPULATION REACH



FINDINGS

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)

CONCLUSION

- 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
- VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook www.va.gov/vhapublications/viewpublication.asp?pub_id=2977
- VHA Handbook 1110.04, Case Management Standards of Practice www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2884
- 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
- Blosnich, J.R., Montgomery, A.E., Dichter, M.E., Gordon, A.J., Kavalieratos, D., Taylor, L., Ketterer, B., Bossarte, R.M. (November 2019). Social determinants and military Veterans' suicide ideation and attempt: A cross-sectional analysis of electronic health record data. Journal of General Internal Medicine. https://link.springer.com/article/10.1007/s11606-019-05447-z
- Cornell, P.Y., Halladay, C.W., Ader, J., Halaszynski, J., Hogue, M., McClain, C., Silva, J., Taylor, L., Rudolph, J.(April 2020) Embedding Social Workers in Veterans Health Administration Primary Care Teams Reduces Visits to the Emergency Room. Health Affairs. http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01589
- Davis, C.I., Montgomery, A.E., Dichter, M.E., Taylor, L.D., Blosnich, J.R. (In Press). Social determinants and emergency department utilization: Findings from the Veterans Health Administration. American Journal of Emergency Medicine.

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 case 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.

LEVEL 1

Patients generally have all their personal needs met.

Access to care: Patients are entitled to care and have transportation.
Economics: Patients have sufficient income for their needs.
Housing: Patients have adequate housing for their needs.
Psychological Status: Stable mood and behavior.
Social Support: Patients have supportive relationships.
Functional Status: Patients are functionally independent.

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 homes, vocational rehabilitation, etc).

Prepare Advance Directives

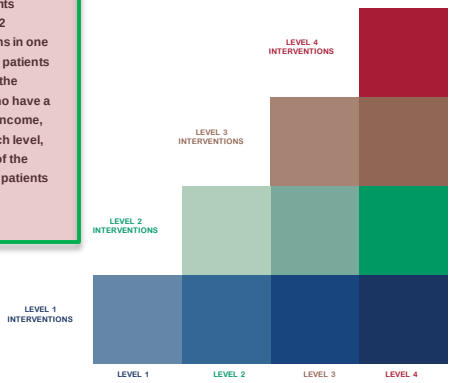
Schedule/reschedule appointments, ensure that ordered equipment/services are received, and provide information and assistance with transportation arrangements.

Provide supportive counseling to assist patient and family with their adjustment to a diagnosis or disability.

Order respite care.

Provide patient/family education about health promotion, disease prevention and management of self.

Refer for competency exams (neuropsychological assessments, payee, guardianship, fiduciary, etc) consult with PCP.



LEVEL 2

Patients have a minor concern with access to care, economics, housing, psychological status, social support or functional status.

Access to care: Patients may have questions or need assistance with the means test/eligibility for care or need assistance to arrange for transportation to the VA. They may need to have appointments rescheduled due to transportation problems.
Economics: 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.
Housing: Patients have housing, but it isn't entirely adequate for their needs.
Psychological Status: Patients may have a minor mood or behavioral disturbance that occasionally interferes with daily functioning.
Social Support: Patients have supportive relationships, but they aren't receiving all the support or assistance that they need.
Functional Status: They may need assistance with IADL's

LEVEL 2 INTERVENTIONS
in addition to Level 1 Interventions

Access to Care:
- Assist patients as needed to get their means tests updated (to determine co-payment).
- Schedule/reschedule appointment if patient no-shows.
- Prepare Handicapped Parking Placard applications.
- Prepare applications for reduced fare public transportation programs.
- Arrange for temporary lodging.
- Provide bus tickets and other transportation assistance.

Economics:
- Refer for financial counseling.
- Provide assistance with application pensions/ benefits.
- Provide assistance with application for Social Security.
- Refer for 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.
- Refer for mortgage refinancing.
- Refer for legal assistance.

Housing:
- Refer for city programs to assist with home maintenance.
- Refer for weatherization programs/loans.
- Assist patient to keep utilities on.
- Refer for assistance with rodent/insect infestations.

Psychological Status:
- Provide supportive counseling to allow patient to ask for and accept assistance.
- Refer to mental health programs.
- Refer to substance abuse treatment programs.

Social Support:
- Address family relationship issues.
- Refer to senior centers for meal/socialization.
- Refer to peer support group.

Functional Status:
- Refer for meals on wheels.
- Refer for homemaker services.
- Refer for rehabilitation to increase functional ability.

LEVEL 3

Patients have a major concern with access to care, economics, housing, psychological status, social support or functional status.

Access to care: Patients may have limited or cost prohibited transportation to the VA. They may need to have many appointments scheduled for the same day, or schedule overnight accommodations due to transportation problems.
Economics: Patients have too-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.
Housing: Patients have housing that is inadequate for their needs.
Psychological Status: Patients may have a major mood or behavioral disturbance that interferes with daily functioning.
Social Support: Caregiver is overwhelmed and stressed by patient care needs. Patients have strained relationships and do not receive adequate assistance. Functional Status: Patients may be at risk for falls or other injuries. Patients may need assistance with ADL'S/ IADL'S.

LEVEL 3 INTERVENTIONS
In addition to Level 1 and 2 Interventions

Access to Care:
- If not eligible for all healthcare at the VA, and have no health insurance, apply for Medicaid.
- If patient needs to pay privately for an ambulance to access care, coordinate appointments on the same date.
- Prepare applications for wheelchair van service.
- Check community resources for transportation.
- Work with support system to see if other possibilities exist for transportation.

Economics:
- Refer patient for temporary welfare benefits and food stamps.
- Refer to community programs or legal assistance to prevent eviction.
- Refer to community programs that provide financial aid.
- Refer for employment resources.

Housing:
- Refer to programs to assist with/pay for renovations to make home handicapped accessible.
- Assist patient to keep utilities on or resume service.

Psychological Status:
- Provide a warm hand-off to mental health provider, substance abuse treatment program or day program.

Social Support:
- Provide supportive counseling to improve relationships with family/friends.
- Refer for Adult Day Health Care.

Functional Status:
- Refer for inpatient/home rehabilitation to improve functional ability/ improve safety.
- Refer for home health aid to assist with ADL's and IADL's.
- Refer to group homes/assisted living/nursing homes.
- Refer to Adult Protective Services.

LEVEL 4

Patients have a crisis with access to care, economics, housing, psychological status, social support or functional status.

Access to care: Patients may be unable to afford or find transportation.
Economics: Patients have no income. Patients need immediate assistance to either find work or receive benefits.
Housing: Patients have no home.
Psychological Status: Patient needs inpatient psychiatric admission.
Social Support: Patient lacks social supports.
Functional Status: Patient is functionally dependent.

LEVEL 4 INTERVENTIONS
In addition to Level 1, 2, and 3 Interventions

Access to Care:
- Give bus tickets.
- Arrange transportation.

Economics: (as listed previously in level 2 & 3, but with increased emphasis and advocacy).
- Refer for employment resources.
- Refer for pensions/benefits.
- Refer for temporary welfare benefits.
- Refer for public housing/HUD/Veterans Home.
- Apply for Medicaid.

Housing:
- Refer to homeless shelters.
- Refer to public housing.
- Refer to the Veterans Home.
- Refer to group homes.
- Refer to assisted living facilities.
- Refer to nursing homes.

Psychological Status:
- Refer to inpatient psychiatric unit to improve functioning and safety.

Social Support:
- Provide supportive counseling to improve relationships with family/friends.

Functional Status:
- Refer for inpatient rehab to improve functional ability and safety.
- Refer for nursing home placement.

Levels of Case Management
Case management will be determined by clinical assessment and acuity scoring as well as the severity and urgency of the presenting problem(s). Veterans with an acuity level of 2, 3, or 4 will receive case management services. Those at level 1 will receive episodic care.

- Episodic - Level 1
  Patient generally has all personal needs met with low psychosocial acuity rating.
  Generally one to two contacts required.
- Supportive - Level 2
  Patient has minor concerns with access to care, economics, housing, psychological status, social support or functional status. Monthly-quarterly contact as clinically indicated to ensure sufficient support to meet case management goals.
- Progressive - 3
  Patient has major concerns with access to care, economics, housing, psychological status, social support or functional status. Weekly-monthly contact as clinically indicated to ensure sufficient support to meet case management goals.
- Intensive Level - 4
  Patient has a crisis with access to care, economics, housing, psychological status, social support or functional status. Daily-weekly contact as clinically indicated to meet case management goals.

SW PACT PROGRAM IMPACT