

# A RUSH RESPONSE TO SOCIAL DETERMINANTS OF HEALTH

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# Disclosures

- I have no relevant financial or nonfinancial relationships to disclose

## Just Yesterday...

- Started the day with 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 situations with implications on health outcomes

“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.”

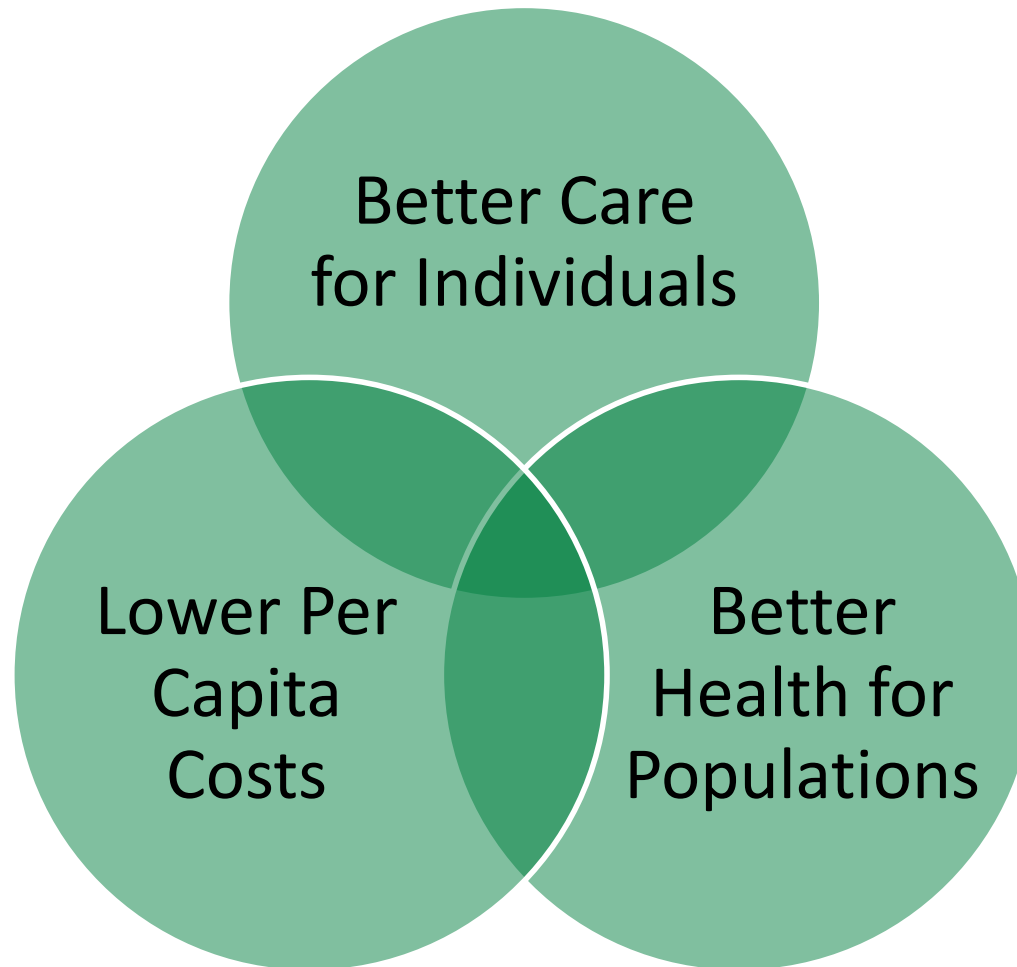
-- Yale Global Health Leadership Institute<sup>1</sup>

# Social Need

- Social factors influence health outcomes
  - Socioeconomic status
  - Education
  - Stress
  - Early life
  - Addiction
  - Food
  - Transport
  - Work/Unemployment
  - Social exclusion or support
  - Physical environment



# Triple Aim of Health Reform



# THE ISSUES

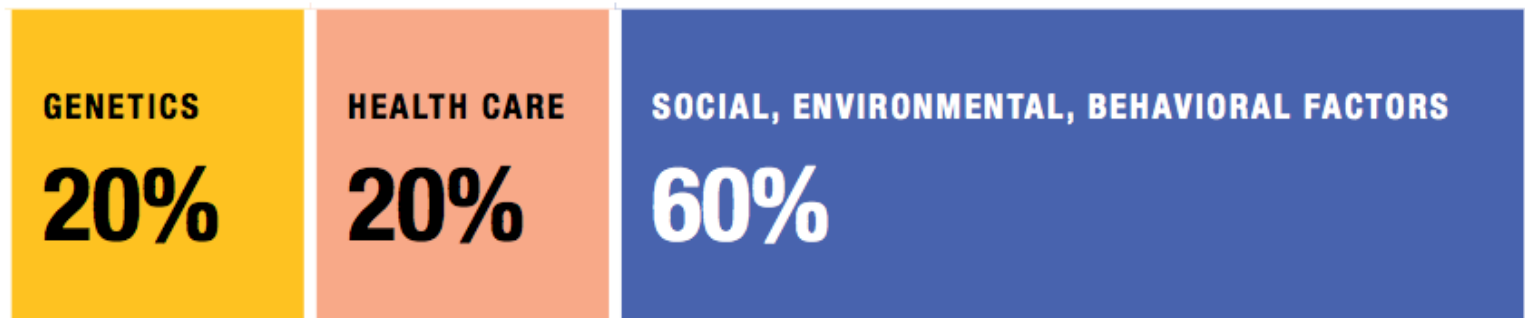
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## Yale Global Health Leadership Institute:

“The existing literature is clear about the importance of social determinants of health in improving the health of populations. Extensive scientific literature has investigated the relative contributions of genetics, health care, and social, environmental, and behavioral factors in promoting health and reducing premature mortality (Chiu et al., 2009; Lee & Paxman, 1997). *The studies uniformly suggest that nonmedical factors play a substantially larger role than do medical factors in health.*”

### WHAT DETERMINES HEALTH?

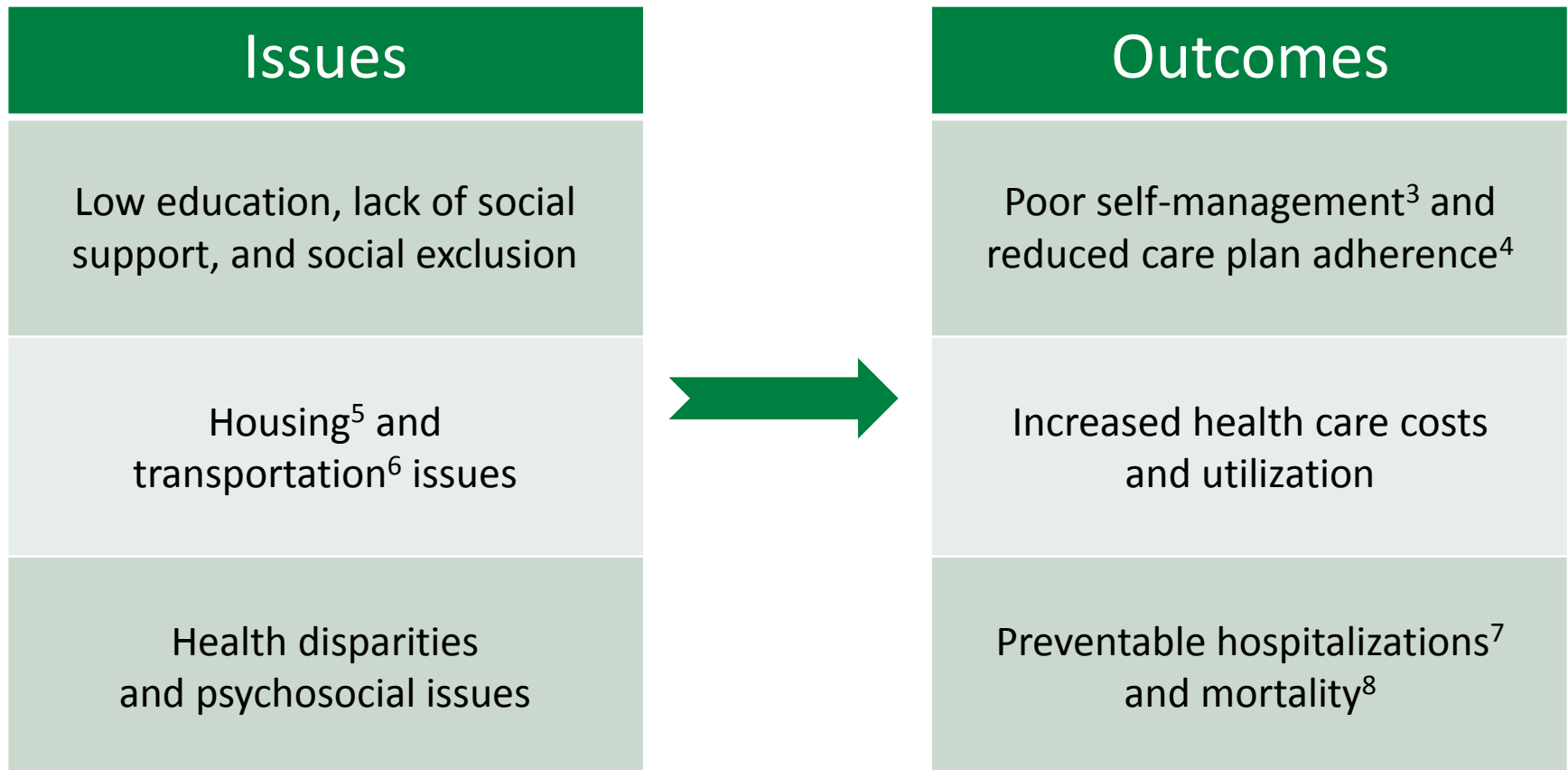
(ADAPTED FROM MCGINNIS ET AL., 2002 )





# Social Factors and Health Outcomes

Societal-level social determinants have individual-level impact<sup>2</sup>

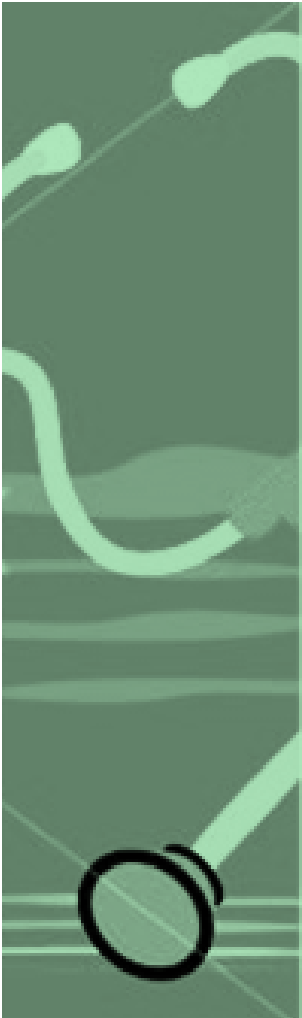


# Fragmentation as a Major Obstacle

- “Siloed” health and social service systems
  - Funding streams
  - Delivery systems
  - Eligibility rules
  - Training programs
  - Terminology
- Person- and family-centered, coordinated care with links to the community are rare in care models, but are critical
  - Mental health often forgotten
  - Not “bilingual” or “bicultural” to bridge medical and social systems

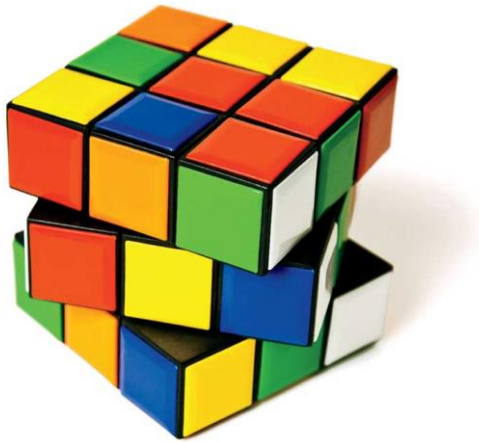


# Health Care's Blind Side – It takes a team!



- 2011 Robert Wood Johnson Foundation survey of 1,000 primary care physicians <sup>9</sup>
  - 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care<sup>10</sup>
  - 85% feel social needs directly contribute to poor health<sup>10</sup>
  - R<sub>x</sub> for social needs, if they existed, would be 1 in 7 R<sub>x</sub>'s written<sup>10</sup>
- Psychosocial issues treated as physical concerns<sup>11</sup>
- Responsibility cannot solely reside with the physician, or with acute care, or with the family caregiver, or with older adults themselves

# Complex Challenges Ahead



- Ingrained focus on discrete episodes of care
  - History of volume-based financial incentives
  - Regulatory constraints
  - Medical technology
  - Ignores big picture of daily living, social factors
- Increasing rates of chronic conditions across ages, along with an aging population
  - Reliance on unpaid and underpaid caregivers
  - Socioeconomic disparities in outcomes

# Other Barriers to Meeting the Demand

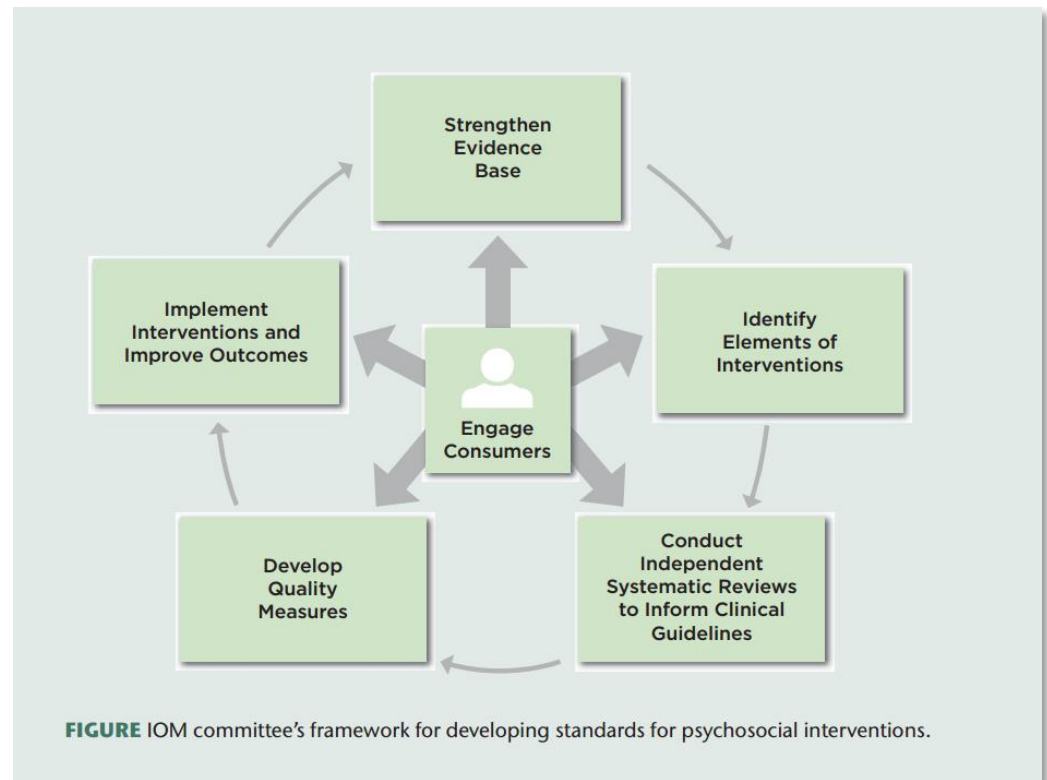
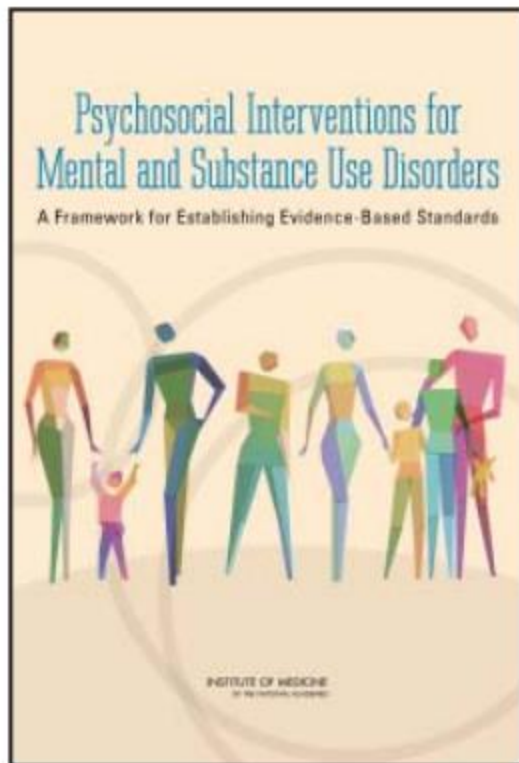
- Financing barriers to integrated care
  - Social services not reimbursed
  - Undercapitalization of social safety net
  - No investment in team-based care and workforce development
- Value of social services, social workers to health care delivery system undefined
  - Need to value services, negotiate fees, and determine costs
- Business case not clear



# Systems Change

- New delivery systems and reimbursement structures driving “professional disruption”
  - Finding approach for integrating skills and expertise in new delivery systems will keep professions relevant and efficient
- Will reimbursement drive us to a team?
  - Medical Homes
  - Accountable Care Organizations
  - Bundled payment
- Now will be paid for:
  - Performance
  - Value
  - Outcomes
- We need to make the business case

# Institute of Medicine Report – July 2015



# Care Coordination After the Hospital

- After hospital discharge, particular need for care coordination (“transitional care”)
  - New care plans, new medications
  - New provider organizations
  - Change in ability to complete tasks
- Lack of hospital- community collaboration
  - Little post discharge follow-up
  - Outpatient and inpatient care disconnected
  - Clients/caregivers take responsibility of care at home
  - External providers (e.g. home health agency) assumed to be providing care as ordered/needed
  - Lack of follow up on community service referrals
  - Little to no accountability for problem resolution between providers



# The Typical Transition Home

## Hospital

Physicians

Discharge  
Planner

Nursing  
Staff

Other  
Services

## Community

Home  
Health  
Providers

PCP  
Specialists

Community  
Based  
Services

Other  
Outpatient  
Care

Hospital and Community providers are fragmented across disciplines and settings

# What are the risks of a poor transition?

- **19%** of clients experience an adverse event within 3 weeks of hospital discharge<sup>12</sup>
- **17%** of Medicare beneficiaries readmitted in 30 days<sup>13</sup>
- **75%** of readmissions preventable<sup>14</sup>
- Each older adult readmission costs CMS average of **\$9,600**<sup>15</sup>
  - According to CBO, 43% of Medicare costs can be attributed to 5% of Medicare's most costly beneficiaries<sup>16</sup>



# A Fundamental Change is Imperative

“The hospital of the future will be a health center, not just a medical center...the hospital will offer valuable resources to the community on matters of health and well-being, and will be held increasingly accountable for the community’s health status.”

--Shi & Singh, 2004

# OPPORTUNITIES

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# Structural Shift

- Shift away from activity-based reimbursement
  - Toward payment that rewards providers and incentivizes interdisciplinary collaboration
  - Care quality, outcomes, cost-effectiveness
- Payment reform encourages addressing social determinants of health and illness
  - Personal choices in everyday life
  - Health literacy and engagement
  - Isolation, family structure/issues, caregiver needs
  - Environment – home safety, neighborhood
  - Economics – affordability, access

# Addressing the Psychosocial

- Psychosocial issues can lead to deterioration of physical symptoms or non-adherence to the clinical care plan
  - → visits to the hospital or outpatient practices to treat physical symptoms of psychosocial issues
  - → negative impact on patient outcomes, population health, and health care expenditures
- Strong evidence that increased investment in social services and in partnerships between health care and social services can help reach Triple Aim (BCBSIL, 2015)



# Comprehensive Care Coordination

- Integrate health and social services
- Interdisciplinary
  - Involve range of providers – from PCP to PT to SW to direct care workers
- Person and family-centered
- Based on an assessment of individual's preferences, needs, and strengths
- Multicultural approach
- Focus on:
  - Medical aspects
  - Social aspects
  - Behavioral aspects
  - Communications



# Interprofessional Teams

- Solid outcomes for interprofessional teams in inpatient and outpatient medical systems
  - Reduction in health service utilization
  - Improvements in patient satisfaction and communication with provider team
- 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.”



“Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need.”

-- Wagner et al.<sup>17</sup>

# What will it take?

- Prevention and wellness strategies
- Care coordination
- Collaborative team-based care
- Community connections



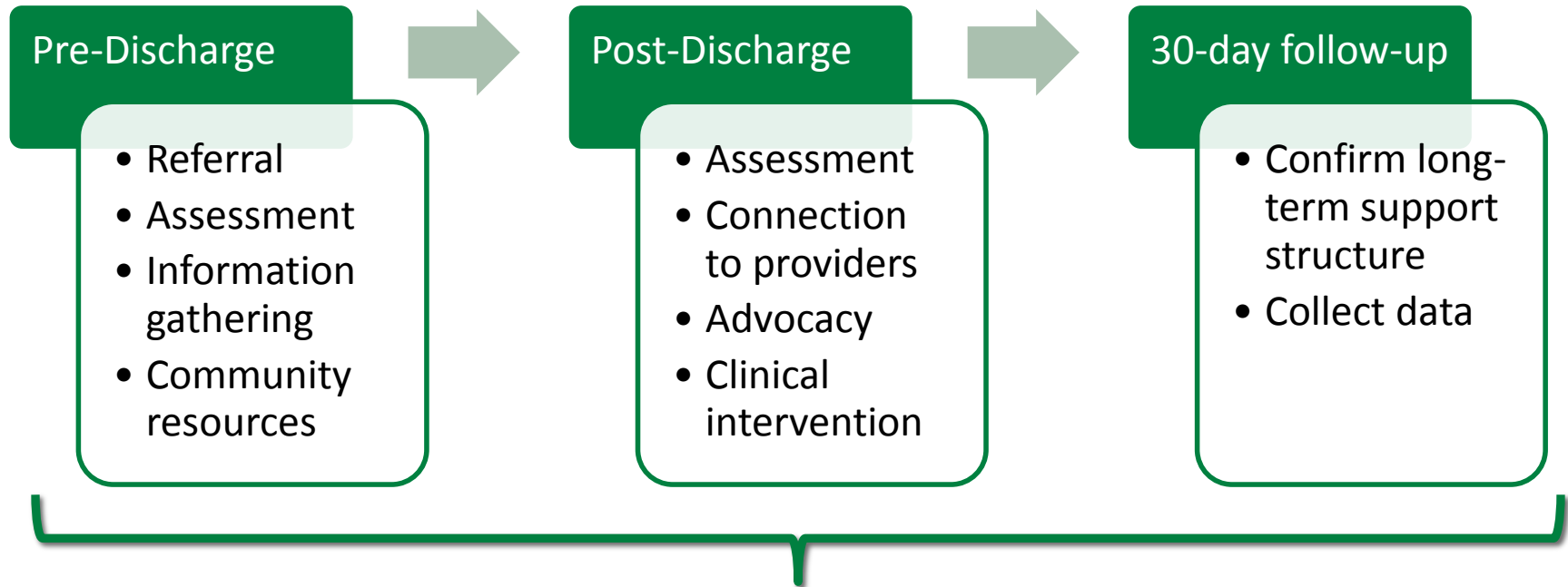
# RUSH'S RESPONSE

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# The Bridge Model

- Developed in partnership between RHA and community-based providers, health policy and research stakeholders
  - Piloted as Enhanced Discharge Planning Program in 2009
- Short-term intervention, pre- and post-discharge
- Bridge Care Coordinator serves as primary care coordinator and extension of the inpatient clinical team
  - Conduit of information between inpatient and outpatient settings
    - One foot in medical side, other foot in community side
  - Manages care coordination tasks
  - Incorporates motivational interviewing and counseling to support emotional/mental health needs
  - Facilitates inclusion of other team members

# Bridge Model of transitional care

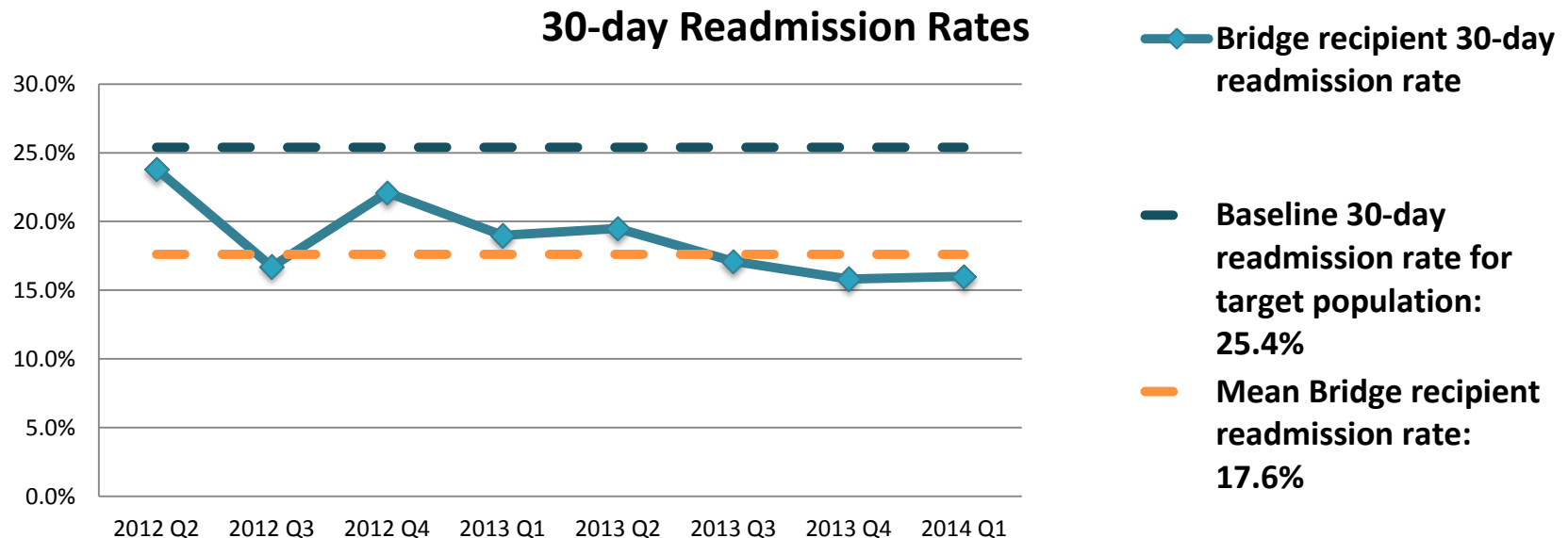


## ***Outcomes of Bridge intervention:***

- *Decreased readmissions*
- *Decreased mortality*
- *Increased physician follow-up*
- *Increased understanding of medications and discharge plan of care*
- *Decreased client and caregiver stress*

# Bridge's Impact on Readmissions

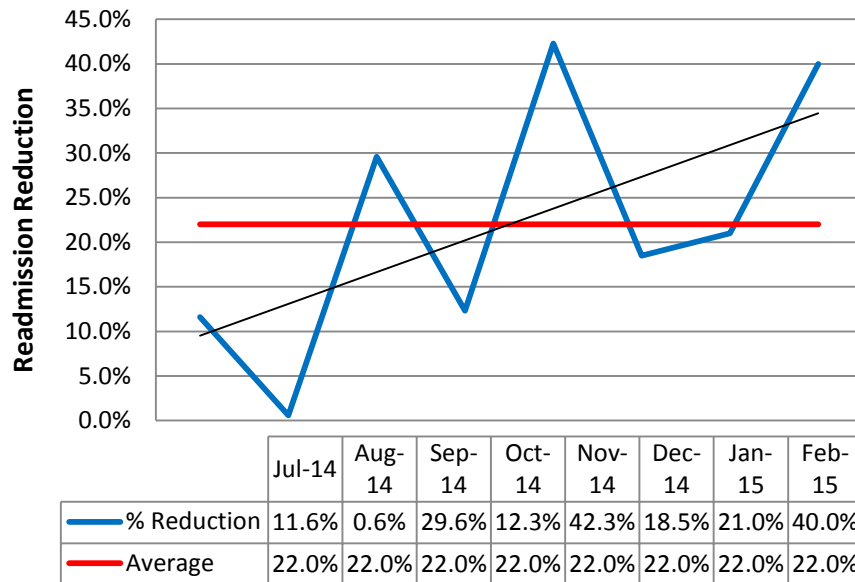
- Impact of Bridge on readmissions at Rush and 5 other sites in Chicago area, in Community-based Care Transitions Program (2012-2014; n=5,753)
  - 30-day: 30.7% fewer (vs. baseline)
  - 60-day: 9.4% fewer (vs. weighted hospital average)
  - 90-day: 13.9% fewer (vs. weighted hospital average)



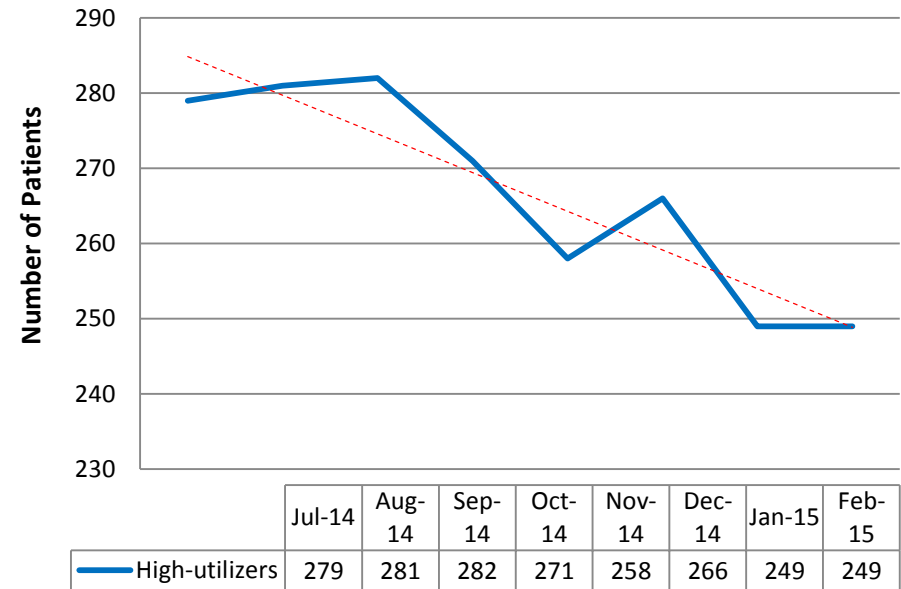
*\*CMS disclaimer: The readmission data presented here are calculated using raw, unadjusted Medicare claims for the specified periods of time. They do not indicate impact or take trends or other initiatives into consideration. These metrics are provided by CMS for performance monitoring purposes only and while they inform evaluative results, they do not constitute the entirety of the program evaluation.*

# High Utilizer Bridge Pilot @ Rush

## 30-day Readmission Reduction



## Number of Medicare High-utilizers at Rush



- “High-utilizer” – Medicare beneficiary with 5+ admissions within a calendar year
  - Less than 3% of the patient population, but responsible for nearly 50% of the readmissions
- Additional protocols added to Bridge
  - Care Coordination Calls
  - Longer-term support

# Enhancing Primary Care

- Primary care-based care coordination initiatives also gaining prominence
  - Shared decision making
  - Improved patient experience
  - Facilitates communication
  - Reducing costs
- Integrating behavioral health with primary care has huge potential to impact Triple Aim
  - Reduces stigma of accessing mental health services





# An Opportunity to Contribute

- Role for social workers in augmenting the patient's primary care encounter
  - Address gaps in care resulting from insufficient time, staff, resources
  - Provide compensatory support to meet patients' medical and psychosocial concerns
  - Assess patients' psychosocial considerations and their impact on medical status
  - Educate providers how to support patient self-management

# Developing a Solution

- “Ambulatory Integration of the Medical and Social (AIMS) Model”
- Team of Master’s level clinical social workers
- Wrap around medical care by addressing non-medical needs that are negatively impacting patient outcomes
  - Increase primary/specialty care clinician and team awareness of these issues
  - Increase practice efficiency by best utilizing skills of each discipline
  - Connect patients to evidence-based disease management
- Primarily telephonic with in-person components

# Impact of AIMS Social Workers

- Compared utilization rates for AIMS participants vs. similar Rush population, for 6 months after intervention
- Admissions, 30-day readmissions, and ED visits were significantly lower in AIMS participants in 6 month period

Utilization Metric	AIMS Mean (n=640)	Rush Comparison (n=5,987)
Hospital Admission	0.51	1.0*
30-day Readmissions	0.15	0.35*
ED Visits	0.10	0.95*

\*Statistically significant using one-sample t-test



# Ask your Doctor

## SOCIAL WORK SERVICES IN YOUR DOCTOR'S OFFICE

Our staff includes a social worker who works with your healthcare provider to help you identify things in your day-to-day life that may be making it hard to manage your health as well as you would like to.

- Do you sometimes have difficulty managing your health conditions?
- Are there barriers to following up on your healthcare provider's recommendations?
- Is stress a problem for you?
- Do you need help with transportation, health insurance or other issues?

If you answered "yes" to any of these questions or would like information about our Social Work Services, ask your healthcare provider to refer you to our social worker or call (800) 757-0202.

*Social Work Services provided by Rush Health and Aging*

### RUSH HEALTH AND AGING

Rush Health and Aging social workers have the expertise to address non-medical and mental health needs using a culturally competent and patient-centered approach. For more information call (800) 757-0202.

# RHA Resource Centers

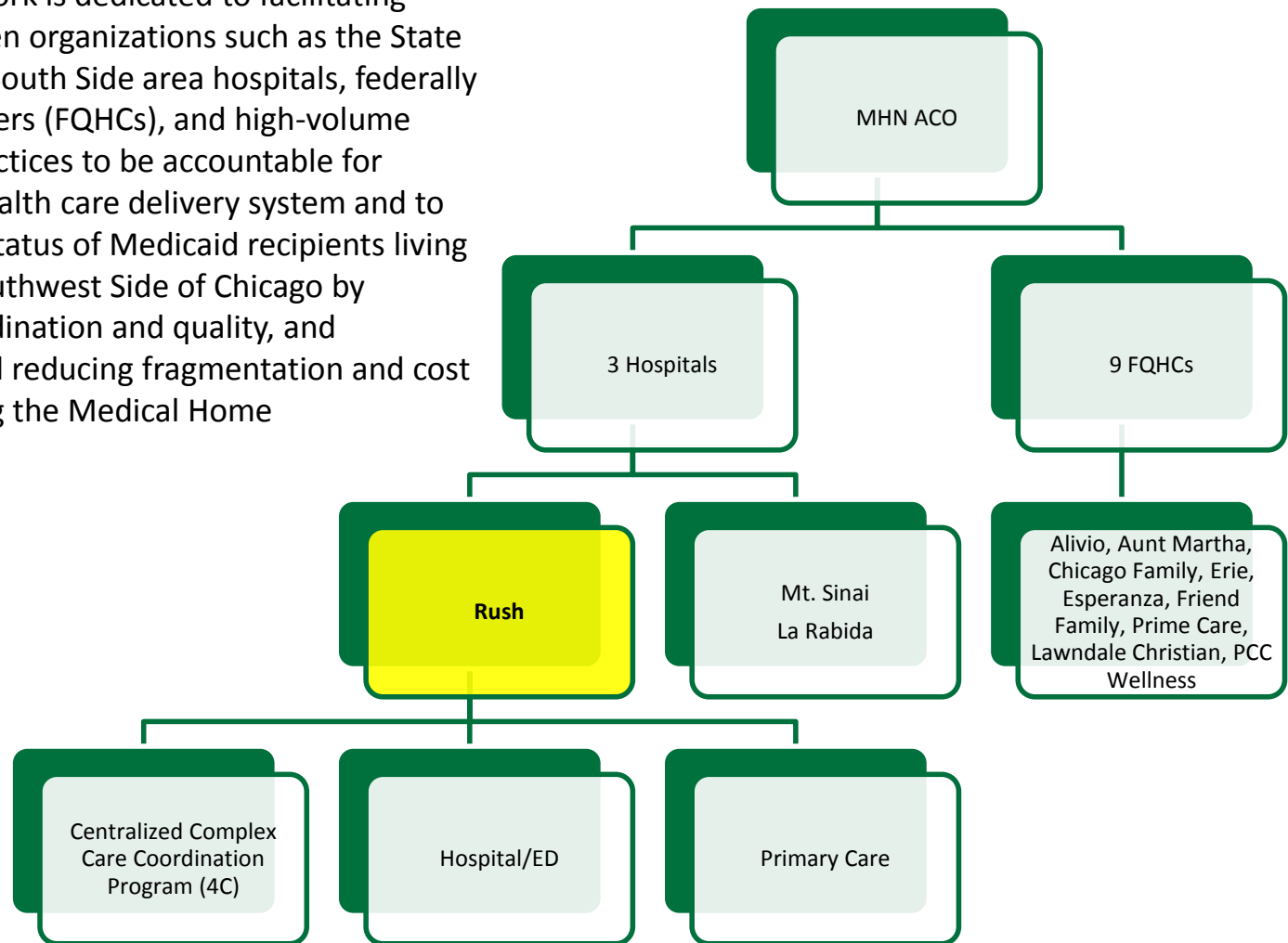
- Offer assistance with health information, emotional support, connection to Rush services, and navigation of community resources
- Open to *everyone*, not just Rush patients
- Visitors welcome to browse literature, use the computers, and request guidance from RHA staff
  - Individual social work consultation available as well
- Also deliver a service called Resource Center Rounding, where staff visit waiting lounges and other public spaces to identify and address resource needs of all visitors, upholding RUMC's commitment to person-centered care

## Locations

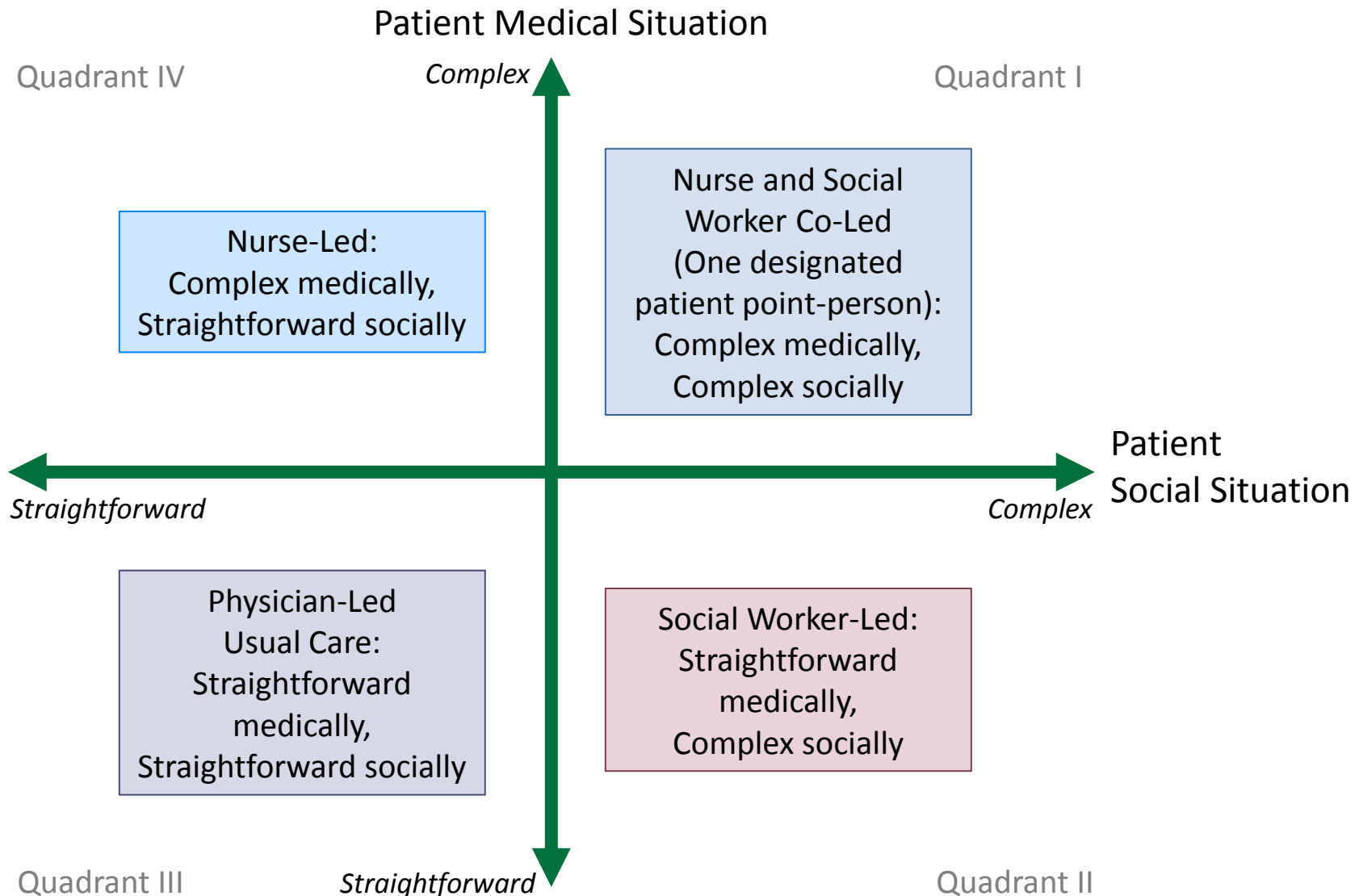
- **Anne Byron Waud Resource Center for Health and Aging**  
Johnston R. Bowman Health Center (JRB), Fourth floor, Suite 438
- **Tower Resource Center**  
The Tower, Fourth floor, Suite 04527

# Medical Home Network

Medical Home Network is dedicated to facilitating collaboration between organizations such as the State of Illinois Medicaid, South Side area hospitals, federally qualified health centers (FQHCs), and high-volume Medicaid private practices to be accountable for strengthening the health care delivery system and to improve the health status of Medicaid recipients living on the South and Southwest Side of Chicago by enhancing care coordination and quality, and improving access and reducing fragmentation and cost – all while reinforcing the Medical Home

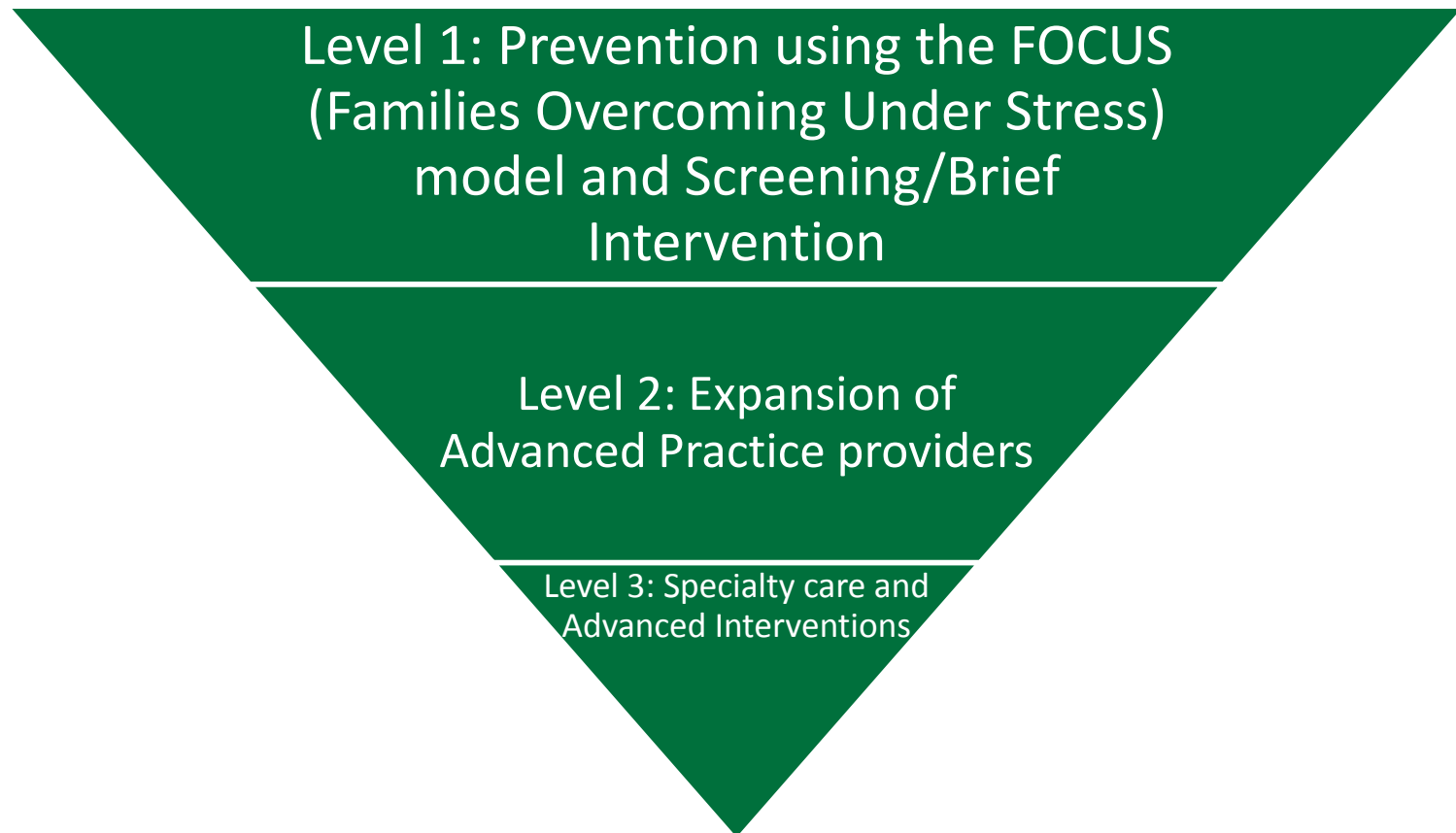


# Interprofessional Approach (Triads)



# Multi-level Clinical & Preventive Behavioral Health Intervention Structure

Majority of adult inpatient hospitalizations are driven by substance abuse disorders and a plurality of pediatric hospitalizations are driven by psychiatric disorders (MHN & CCHHS data)





# Health Legacy Program

- Health education and support program
  - Participants: African American women who are overweight, pre-diabetic, or diabetic
  - 12-session program incorporating health education, exercise, support circles, and meal-planning assistance
- Community-based initiative
  - Works with community churches on south and west sides of Chicago
- Impact:
  - Avg. weight loss 4.5 lbs
  - 90% retention rates throughout 12 sessions
  - Connecting participants with services (e.g. mammography, smoking cessation, PCP)



# Geriatrics Workforce Enhancement Program of Illinois (GWEPI)

## Project Details

- Funded by the Health Resources and Services Administration (HRSA)
- Intent to improve quality of health care for older adults
- \$749,308/year to Rush, 3 years
- Statewide collaborative with 34 partners

## GWEPI Primary Aims

- (1) **Educate** older adults, families, caregivers, direct care workers, health professions providers, students, residents, fellows, and faculty about person-centered, culturally competent management of MCC among diverse older adults, especially those with cognitive decline, and ADRD.).
- (2) **Transform existing primary care systems** to meet the needs of older adults with MCC/ADRD by implementing evidence-based programs that utilize provider, patient and community resources.

“Nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicines as the only approach to health care.”

-- George Engel, 1977

# References

1. Taylor, L. et. al. *Leveraging the Social Determinants: What works?*, Copenhagen: Yale Global Health Leadership Institute, prepared for the Blue Cross Blue Shield Foundation of Massachusetts. 2015.
2. Shi L, Singh D. *The Nation's Health. 8<sup>th</sup> ed.* Sudbury, MA: Jones and Bartlett Learning, LLC; 2011.
3. Gallant MP. The influence of social support on chronic illness self-management: a review and directions for research. *Health Educ Behav.* 2003;30(2):170-95.
4. DiMatteo MR. Social support and patient adherence to medical treatment: a meta-analysis. *Health Psychol.* 2004;23(2):207-18.
5. Krieger J, Higgins DL. Housing and health: time again for public health action. *Am J Public Health.* 2002;92(5):758-68.
6. American Public Health Association. The hidden health costs of transportation. [http://www.apha.org/NR/rdonlyres/A8FAB489-BE92-4F37-BD5D-5954935D55C9/0/APHAHiddenHealthCosts\\_Long.pdf](http://www.apha.org/NR/rdonlyres/A8FAB489-BE92-4F37-BD5D-5954935D55C9/0/APHAHiddenHealthCosts_Long.pdf). Published February 2010. Accessed January 10, 2012.
7. Centers for Disease Control and Prevention. CDC health disparities and inequalities report – U.S. 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.
8. Robert Wood Johnson Foundation. Overcoming obstacles to health care. [www.commissiononhealth.org/PDF/ObstaclesToHealth-Highlights.pdf](http://www.commissiononhealth.org/PDF/ObstaclesToHealth-Highlights.pdf). Published February 2008. Accessed January 10, 2012.
9. Robert Wood Johnson Foundation. Health care's blind side: the overlooked connection between social needs and good health. <http://www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf>. Published December 2011. Accessed January 10, 2012.
10. Physicians highlight overlooked connection between social needs and health. Robert Wood Johnson Foundation Web site. <http://www.rwjf.org/vulnerablepopulations/product.jsp?id=73646>. Published December 8, 2011. Accessed January 10, 2012.
11. Ring A, Dowrick CF, Humphris GM, Davies J, Salmon P. The somatising effect of clinical consultation: what patients and doctors say and do not say when patients present medically unexplained physical symptoms. *Soc Sci Med.* 2005;61(7):1505-15.
12. Forster, A.J., Murff, H.J., Peterson, J.F., Gandhi, T.K., and Bates, D.W. (2003). The incidence and severity of adverse events affecting clients after discharge from the hospital. *Annals of Internal Medicine*, 138(3):161–167.
- 13 CMS Medicare Medicaid Research Review. 2013. Data Shows Reduction in Medicare Hospital Readmission Rates During 2012. <http://www.cms.gov/mmrr/Briefs/B2013/mmrr-2013-003-02-b01.html>
- 14 Studies of Rehospitalizations: Reducing Avoidable Hospital Readmissions. June 2009. Agency for Healthcare Research and Quality, Rockville, MD. <http://archive.ahrq.gov/professionals/systems/hospital/red/readmissions/readslide5.html>
- 15 CMS internal documents to awardees of Community-based Care Transitions Program.
- 16 Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008; Friedman, B., & Basu, J. (2004). The rate and cost of hospital readmissions for preventable conditions. *Medical Care Research and Review* (2), 225.
- 17 Wagner, E., Austin, B. T., & Von Korff, F. M. Organizing care for patients with chronic illness. *Milbank Quarterly*, 1996, 74, 511–544.

# QUESTIONS?

# THANK YOU!

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