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## THE CARE SPAN

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

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**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.

**T**he Institute for Healthcare Improvement's Triple Aim of better care for individuals, better health for populations, and lower per capita costs<sup>1</sup> 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<sup>2</sup> to other initiatives driven by the Affordable Care Act, such as the Community-Based Care Transitions Program,<sup>3</sup> 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

community practice settings, suggests that integrating services to address social factors can reduce health care use and costs and improve patient outcomes. This article explores the role of social support in health care outcomes, summarizes the current evidence on the impact of coordinated care models with strong components of social support, and suggests ways to ensure that the social dimension of care is adequately addressed in health care system change.

## Social Determinants In Health Care And Health Outcomes

The role of social factors in population health has been extensively documented in the past decade, starting with Richard Wilkinson and Michael Marmot's seminal identification of ten key social determinants influencing health outcomes.<sup>4</sup> These determinants are the social gradient—that is, an individual's or group's position in society and possession of resources such as education, employment, and housing; stress; early life experiences; degree of social exclusion; work; unemployment; access to social support; addiction; food; and transportation.

Although much of the research on social determinants of health has focused on societal-level impacts, these factors also exert influence at the individual level. Many vulnerable patients, including older adults and people with low incomes or chronic illnesses, face social challenges daily. As a result, one's compliance with one's medical care plan may become secondary to meeting needs that are perceived as more urgent, such as obtaining food, caring for a loved one, or seeking employment.

The impact of social issues is reflected in numerous individual-level health outcomes. For example, social exclusion and lack of social support are associated with poor medical self-management<sup>5</sup> and reduced medical care plan adherence.<sup>6</sup> Difficulties with housing<sup>7</sup> and transportation<sup>8</sup> result in greater use of health resources. Preventable hospitalizations<sup>9</sup> and mortality<sup>10</sup> are heavily influenced by social determinants and are associated with health disparities, such as being under- or uninsured, and psychosocial issues, such as lack of employment and limited income.<sup>11</sup> Emerging research points to social and environmental factors such as limited access to care, poor functional status, and lack of social support as drivers of unplanned hospital readmissions.<sup>12</sup>

Medical providers in hospital and community practice settings are well positioned to play a vital role in identifying the social factors that may influence a patient's health. For example, people often visit emergency departments or

primary care settings with physical symptoms whose root cause may be social needs, such as shortness of breath resulting from the inability to afford medications. However, physicians may not have the time or skills to assess or attend to these underlying causes of a patient's symptoms. As a result, physicians may treat the physical symptoms but leave the underlying social causes unidentified or unaddressed.<sup>13</sup>

In a 2011 Robert Wood Johnson Foundation survey,<sup>14</sup> four out of five physicians reported that they lacked confidence in their capacity to meet patients' social needs, and that this deficit impeded their ability to provide high-quality care.<sup>15</sup> The phenomenon of addressing only the physical manifestations is also present in the inpatient setting, where the priority is stabilizing a patient medically rather than delving into his or her social circumstances and overall well-being.

Physicians nevertheless understand the impact of social issues on patients. In the same Robert Wood Johnson Foundation physician survey, 85 percent of primary care physicians agreed that “unmet social needs—things like access to nutritious food, reliable transportation, and adequate housing—are leading directly to worse health for all Americans.”<sup>15</sup> This rate increased to 95 percent among physicians serving patients in low-income urban communities.

An array of community-based services exists that can be engaged to address social issues with medical consequences. For example, there is a robust system of community-based organizations, a network for the aging and those with disabilities, long-term services and supports, and mental health services. Social service providers offer in-home support, assistance with activities of daily living, and transportation, and they often become privy to information that can be useful in health care planning for patients in various settings.

In a recent report, the Institute of Medicine highlighted the capacity of such community-based service organizations to assess social service needs, deliver services in the community, and communicate issues to the patient's medical team.<sup>16</sup> It recommended that medical providers partner with community agencies to improve health and reduce costs.

Unfortunately, fragmentation presents a major barrier to integrating the health care delivery and social service systems. The two systems operate with separate funding streams, different delivery vehicles and eligibility rules, varying training programs and expectations, and differences in terminology that hamper communication. Financing barriers have been a particular problem. The absence of financial incentives from payers for care coordination has resulted

in a lack of clear accountability for outcomes as patients move from one care setting to another or return to the community.

Many provisions of the Affordable Care Act have the potential to reduce these barriers by providing financial incentives for care coordination, particularly in patient-centered medical homes and accountable care organizations. The health reform law also created the Community-Based Care Transitions Program<sup>3</sup> to link hospitals and community organizations in an effort to reduce hospital readmissions. And a major federally funded initiative is under way to expand health information technology in order to reduce communication barriers.

**Current Evidence: Promise And Gaps**

A number of emerging care models explicitly include consideration of social factors and delivery of appropriate social services as fundamental

components of health care provision. Five innovative programs profiled in *Health Affairs*<sup>17-21</sup> and two models examined as part of the National Coalition for Care Coordination’s best practices research<sup>22</sup> provide early evidence on how and why to address social issues, especially for populations of patients with medically complex conditions, in various care settings.

These programs and models, which have been described in detail elsewhere, are the Vermont Blueprint for Health,<sup>23</sup> Senior Care Options,<sup>20</sup> Comprehensive Care Program,<sup>21</sup> Mercy Health System,<sup>24</sup> Geriatric Resources for Assessment and Care of Elders (GRACE),<sup>25</sup> Care Management Plus,<sup>26</sup> and the Enhanced Discharge Planning Program.<sup>27</sup>

**SOCIAL SERVICE INCLUSION IN MODELS OF CARE** An examination of the depth and breadth of social services that may be provided when implementing these care models makes it obvious that incorporating the social dimension requires more than simply adding a care coordinator to the team. Rather, an array of interventions that involve all members of the care team should be incorporated. As shown in Exhibit 1, the seven care coordination models considered here incorporate social services in a variety of ways.

Typically, the process begins with a baseline health assessment of a patient’s social and medical needs. The assessment may be initiated at an outpatient primary care practice (as is the case at the Vermont Blueprint for Health, Mercy Health System, and GRACE), at a hospital (as in the Enhanced Discharge Planning Program), or by a health plan and provider organization (as with Senior Care Options).

Each model provides a formal link from the medical setting—that is, the hospital or medical practice—to the community to be used by a specified care coordinator or an interprofessional care team. Although their exact approaches differ, the models all provide for individualized care planning, coordination, and management, and they share the goal of establishing stability in the patient’s home environment while attending to his or her medical needs. For example, GRACE guides the creation of individualized plans using evidence-based protocols for addressing issues such as mobility and medication management.<sup>19</sup>

The next step is similar in all the models. Care coordinators familiar with the community’s typically complex menu of social service options identify, suggest, and arrange for interventions based on each patient’s individual needs. Care coordination is often supported by an electronic health record system or other technology that facilitates communication and the transfer of information. For example, the Vermont Blueprint

**EXHIBIT 1**

**Summary Of Features And Components For Models Linking Medical Care And Social Support Services**

	VBH	SCO	CCP	Mercy	GRACE	CMP	EDPP
<b>INTERVENTION PROCESS</b>							
Baseline health assessment	•	•	•	•	•	•	•
Social assessment	•	•	•	•	•	•	•
Individualized care plan	•	•	•	•	•	•	•
Interdisciplinary care team	•	•	•	•	•	•	•
Specialized intervention protocols	•				•	•	•
Specialized training for service providers	•	•	•	•	•		
Ongoing monitoring	•	•	•	•	•	•	
Coaching in self-management	•		•	•	•	•	•
Link to or communication with primary care physician or practice	•	•	•	•	•	•	•
Use of electronic health records	•	•	•	•	•	•	•
<b>SERVICE</b>							
Case management	•	•	•	•	•	•	•
Medication management	•	•	•	•	•	•	•
Mental health services	•	•			•		•
Referral to or arrangement for social or supportive services	•	•	•	•	•	•	•
Referral to or arrangement for medical services	•	•	•	•	•	•	•
Caregiver support					•		•

**SOURCE** Authors’ analysis of information in Notes 17–21 and 23–28 in text. **NOTES** This exhibit shows whether the elements considered vital for care coordination are present in each model described. VBH is Vermont Blueprint for Health. SCO is Senior Care Options. CCP is Comprehensive Care Program. Mercy is Mercy Health System. GRACE is Geriatric Resources for Assessment and Care of Elders. CMP is Care Management Plus. EDPP is the Enhanced Discharge Planning Program.

for Health captures patient data in a web-based central health registry,<sup>17</sup> which allows for decision support, information exchange, and seamless coordination across providers and settings.

In many models, patient engagement is integral to sustained success in improving adherence to the care plan and producing positive health outcomes. Models encourage patients' active involvement in developing medical self-management skills; provide health education and coaching on medication adherence; and identify person-centered goals with patients who are emotionally, functionally, and cognitively capable of achieving them.

The role of caregivers is often less clearly and formally defined in the models. However, interventions that explicitly acknowledge caregivers' roles and emotional and tangible needs, such as the Enhanced Discharge Planning Program, have been shown to relieve the stress and burden associated with caregiving.<sup>28</sup> In this program, questions about the caregiver's needs, well-being, and ability to carry out necessary caregiving tasks are included in the baseline assessment. The plan developed from this assessment then includes services and strategies to address the caregiver's needs as well as the patient's.

Some models may provide for referrals to social services in the community, whereas the most comprehensive and integrated models, such as Senior Care Options, provide for direct delivery of services. But even when a referral-based model is employed, the patient is not simply given a telephone number to call to establish the necessary connection. Instead, care coordinators follow protocols that guarantee the establishment of the desired relationship between the patient and the referred service. Ongoing relationships with community service providers and the effective use of information technology tools strengthen the links between providers of medical and social services.

The specific types of patients targeted for care coordination vary across programs. Most models draw from a pool of high-need or high-risk patients, employing model-specific eligibility criteria. Typical criteria include age, generally sixty-five or older; enrollment in Medicare or dual eligibility for Medicare and Medicaid; low-income status; and either a chronic illness or a qualifying condition, such as heart failure or diabetes.

To allow for initial and ongoing identification of areas and intensity of social needs and associated services, models often call for home visits by nurses, social workers, or both; standardized baseline assessments; specialized intervention protocols; the identification of and linkage with providers and appropriate community services;

and ongoing monitoring and reassessment. Electronic health records or registries are often used to identify appropriate patients, as in the Enhanced Discharge Planning Program.

The models described use two types of teams—either established or ad hoc—depending on the local health system, community characteristics, and team members' knowledge and experience. An established care team, as used by the Vermont Blueprint for Health and GRACE, includes the same core members when working with any patient from the defined population, often for an extended period of time. The core members are all trained in the model's protocols, culture, and goals.

The second type, the ad hoc care team, is employed by the Enhanced Discharge Planning Program and Mercy. Such teams are usually spearheaded by a single care coordinator trained in the model. The coordinator brings together a team of providers or consultants from various disciplines for each patient, selected to address that person's needs, typically for a short period of time.

Both established and ad hoc teams include a variety of professionals such as nurses, social workers, primary care physicians (often geriatricians), community health workers, behavioral health professionals, physical therapists, pharmacists, and palliative care specialists. Together, the professionals develop and implement a patient's individualized care plan.

**MODEL OUTCOMES** A growing body of empirical evidence suggests that care coordination models with a strong social support services component can produce positive outcomes. Although the analysis of the models considered in this article does not provide detailed insights on how, why, and to what extent these models achieve their results, the models nevertheless provide encouraging indications that greater attention to social supports may benefit patients and payers alike.

Several models generated reductions in inpatient hospital stays. The Vermont Blueprint for Health demonstrated a 21 percent reduction in inpatient use of services year over year, resulting in a 22 percent reduction in per person per month cost.<sup>23</sup> Senior Care Options, which serves targeted 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.<sup>20</sup>

The Comprehensive Care Program's high-risk patients' hospital use declined by 20 percent in two years.<sup>21</sup> High-risk patients receiving care coordination at Mercy experienced a 17 percent reduction in annual hospital readmission rate

per 1,000 from 2008 to 2009.<sup>18</sup> Care Management Plus's patients with diabetes had a significantly lower hospitalization rate (21 percent) than other patients with diabetes receiving care from the designated intervention and control clinics within the Intermountain Health Care system (26 percent).<sup>26</sup>

Reductions in emergency department use were also observed. Use for the Vermont Blueprint for Health declined by 31 percent, reducing associated costs by 36 percent.<sup>23</sup> GRACE's two-year emergency department use was lower in the intervention group than in the group receiving usual care.<sup>25</sup>

Overall cost reductions were observed as well. The Vermont Blueprint for Health's costs dropped by 11.6 percent,<sup>23</sup> while the Comprehensive Care Program generated an estimated \$2 million in annual cost savings for every 1,000 members.<sup>21</sup> Mercy calculated that its care coordination program generated cost savings of \$37.70 per member per month.<sup>24</sup> Use reductions for Care Management Plus's patients with diabetes have been anticipated to save \$70,000 per participating clinic.<sup>26</sup>

Other meaningful outcomes include Senior Care Option's 30 percent reduction in nursing home placements for eligible Medicaid beneficiaries from 2005 to 2009<sup>20</sup> and the Enhanced Discharge Planning Program's 30 percent increase in patients' keeping their follow-up medical appointments within thirty days of discharge.<sup>27</sup>

## Research, Design, And Policy

**REMAINING UNKNOWNNS** The results from research on the models profiled here have been limited by study design. In some cases, formal evaluations have not been conducted; in others, evaluations did not focus on the model's social aspects. Further research is necessary to specifically explore the relationship between positive outcomes and the model's social support component.

In addition, future work must develop an evidence base about the professional skills and knowledge that are required to address social needs successfully within health care settings; the activities, tasks, and services addressing social needs that directly result in improved outcomes; and 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.

**DESIGN AND POLICY CONSIDERATIONS** Current health care transformation initiatives provide valuable opportunities to test various methods

for integrating social services into health care. The Community-Based Care Transitions Program<sup>3</sup> creates a sustainable way to integrate community-based social support services into transitional care, with Medicare providing payment on a per discharge basis for activities that historically have had limited or no reimbursement.

Although the impact of this initiative remains to be seen, the mere existence of the program—which requires that community-based resources be linked with acute care—reinforces and validates the importance of addressing social needs. Experience from existing models should inform the design of medical homes and accountable care organizations, ensuring that social supports and links to community resources are integrated into multiple care settings.

As accountable care organizations are implemented in a variety of forms, social support services will play a critical role in achieving the patient-centeredness criteria specified in the final rule for the Medicare Shared Savings Program.<sup>29</sup> To achieve cost savings, accountable care organizations will need to address care coordination, including social needs, at least for patients with the most complex conditions.

As accountable care organizations move away from the limitations of fee-for-service reimbursement and toward partial capitation and other payment models, their ability to support effective care coordination will increase. In particular, the Pioneer Accountable Care Organizations, intended by the Center for Medicare and Medicaid Innovation to test truly integrated models of care, have the potential to implement effective care coordination models that incorporate community-based social services.

For example, Sharp HealthCare, one of the Pioneer organizations, and the County of San Diego's Health and Human Services Agency partnered to pilot a Care Transitions Intervention Program that empowered chronically ill adults discharged from the hospital to take an active role in their health care. This program reduced the thirty-day readmission rate from 12.6 percent to 2.3 percent in one year<sup>30</sup> and provided the foundation for the creation of the San Diego Care Transition Partnership, one of the new Community-Based Care Transitions Programs announced by the Centers for Medicare and Medicaid Services in January 2013.<sup>31</sup>

## Conclusion

Patients do not exist solely in acute, outpatient, or long-term care settings. Instead, they move across settings, often repeatedly. And as they move, their social needs follow, requiring the

coordination of medical and social services so that social supports can remain continuous and appropriate.

Satisfying the Triple Aim will require better integrated care—care that challenges the current silos that foster limited communication, collaboration, and coordination not only between medical professionals in different settings, but also between medical and social services. Care that is better integrated in all of these respects is particularly important for older patients, those with chronic conditions, and those with complex care needs. In essence, achieving the Triple Aim requires uninterrupted attention to patients' social needs, which may evolve but are unlikely to

disappear as a patient moves across settings.

The models considered in this article are beginning to shed light on the required elements of new coordinated care models with respect to social service needs, and they provide evidence and guidelines for addressing these needs. Although the models represent a meaningful starting point, more research is required to determine which service components yield desired outcomes for specific patient populations. Gaining these deeper insights, incorporating them into best practices, and then disseminating them widely offer the promise of considerable benefit for patients and the health care system as a whole. ■

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In this month's *Health Affairs*, Gayle Shier and coauthors report on their review of the evidence from seven innovative care models that meeting patients' social needs can lower health care use and costs and produce better outcomes for patients. Although the early evidence is encouraging—and social supports should be incorporated into new care models, such as accountable care organizations—the authors contend that more research is required to determine which social service components yield desired outcomes for specific patient populations.

Shier is program coordinator of the Health and Aging Department at Rush University Medical Center, where she evaluates social work's role in health care reform, including transitional care and patient-centered medical homes,

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