

The Evolving Role of Social Workers in Team-Based Advanced Care Delivery

NOVEMBER 9, 2023

About the Maryland Health Care Commission (MHCC)



WHO WE ARE

Independent State regulatory agency

WHAT WE DO

Transform care delivery into a value-based care system in which providers collaborate to provide high-quality, coordinated care that emphasizes quality and outcomes and includes financial incentives tied to value

HOW WE HELP

 Collaborate with payers and providers to transition to quality-aligned, value-based care and to harness the potential of data in facilitating meaningful change

CME and Disclosures



- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society (MedChi) and the Maryland Health Care Commission (MHCC). MedChi is accredited by the ACCME to provide continuing medical education for physicians
- MedChi designates this virtual online educational activity for a maximum of 1 AMA PRA Category 1 Credits™
- Physicians should claim only the credit commensurate with the extent of their participation in the activity
- The planners and reviewers for this activity have reported no relevant financial relationships to disclose
- The presenters have reported no relevant relationships to disclose

Learning Objectives



- Learn about the evolving role of social workers in team-based models
- Demonstrate how advanced care delivery practices share social worker resources
- Understand why some advanced care delivery practices employ an in-house social worker



AGENDA

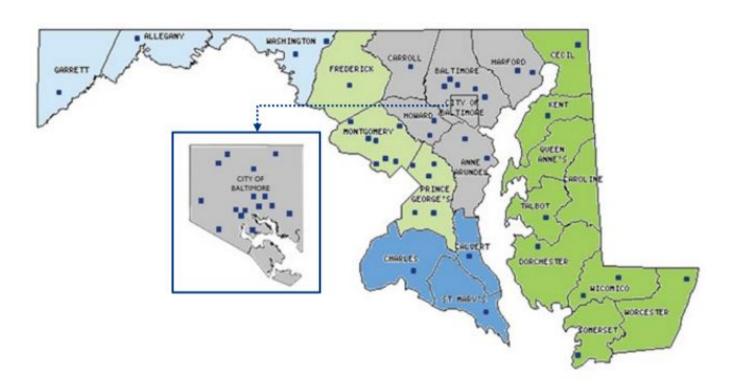
- Overview of Maryland Landscape
- **►** Panel Discussion
- ► Q&A



State of Maryland Health Care Landscape



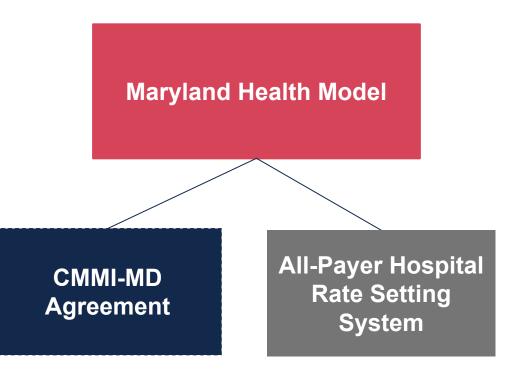
- 6.17 million people
- 16.3% of population is age 65 and over
- Highest median household income by State
- 43 acute care hospitals



Maryland's Unique Health Care Payment System



- Maryland's approach:
 - Enables cost containment for the public
 - Incentivizes better health outcomes through pay-for-performance programs
 - Avoids cost shifting across payers and provides equitable rates to self-pay customers
 - Funds investments in population health
 - Establishes Maryland as a leader in linking quality and payment



TCOC Model Components





Component	Purpose
1. Hospital Population-Based Revenue	Expands hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk (e.g., Medicare Performance Adjustment, reduction of potentially avoidable utilization, and reduced readmissions)
2a. Care Redesign and New Model Programs	 Fosters care transformation across the health system: Expands incentives for hospitals to work with others Opportunity for development of "New Model Programs" for non-hospital providers (e.g., EQIP) MACRA eligibility with participation
2b. Maryland Primary Care Program	Enhances chronic care and health management for Medicare enrollees
3. Population Health	 Encourages programs and provides financial credit for improvement in statewide diabetes, opioid addiction, and at least one other state priority area Develops a Statewide Integrated Health Improvement Strategy



ADVANCING PRACTICE TRANSFORMATION



Health Equity Practice Roundtable



- The MHCC convened a Health Equity Practice Roundtable (HE Roundtable) in March 2022 with representatives from advanced care delivery practices to identify challenges and opportunities for practices seeking to address key health equity concerns in their communities
- The goal of the HE Roundtable was to advance health equity in ambulatory practices in Maryland through the development of practice resources informed by HE Roundtable feedback
- Feedback from the HE Roundtable informed a Health Equity Symposium in March 2023 focused on strategies for identifying patterns of need in the community, building referral networks for services related to social needs, and connecting patients to resources
- More information about the HE Roundtable is available at: <u>mhcc.maryland.gov/mhcc/pages/apc/apc_icd/apc_icd_learning_networks.aspx</u>

Advancing Practice Transformation in Ambulatory Practices Program



- The MHCC released an Announcement for Grant Applications in May 2021 to identify a Care Transformation Organization (CTO) to engage eligible primary care and specialty practices (practices) in a practice transformation program (program)
- Grant objectives include:
 - Preparing practices to deliver efficient, high-quality care while improving health outcomes
 - Laying the foundation for practices to provide team-based, patient-centered care, and efficient use of health information technology
 - Supporting Total Cost of Care model goals by readying practices to participate in value-based care (VBC) models

Program Overview



- In June 2021, MedChi CTO was competitively selected to complete transformation activities
- A crucial role of MedChi CTO is providing practice coaching on specific transformation topics and approaches, such as quality improvement and tools to help sequence and manage change essential to succeed in a VBC model
- Program milestones:
 - Milestone 1 Readiness Assessment
 - Milestone 2 Workflow Redesign
 - Milestone 3 Training
- Approximately 24 practices completed the program in June 2023.
- An additional 18 practices are projected to complete Round 2 by June 2024

Learning Network Events



- The MHCC convenes peer learning network events in collaboration with local and national health care leaders on topics, such as telehealth, advanced care delivery, and practice transformation
- More information on learning network events is available at: <u>mhcc.maryland.gov/mhcc/Pages/apc/apc/apc/apc.aspx</u>



Advanced Care Delivery Events



Prior events available on the <u>Learning Network</u> include:



Health Equity Symposium

March 2023

Challenges around addressing discussed during this symposiu in collaboration with the Health Commission and MedChi, The Society. Discussions focus on s patterns of need in the commur networks for services related to connecting patients to resource

Watch Now



Assessing and Vetting Community Resources

May 2022

Clinicians from Carroll Hospital and Adventist HealthCare discuss identifying statewide community resources, determining capacity of community resources, and leveraging and prioritizing partnerships with community resources.

Watch Now

Download Slides



Gene Ransom

CEO

MedChi, The Maryland State Medical Society





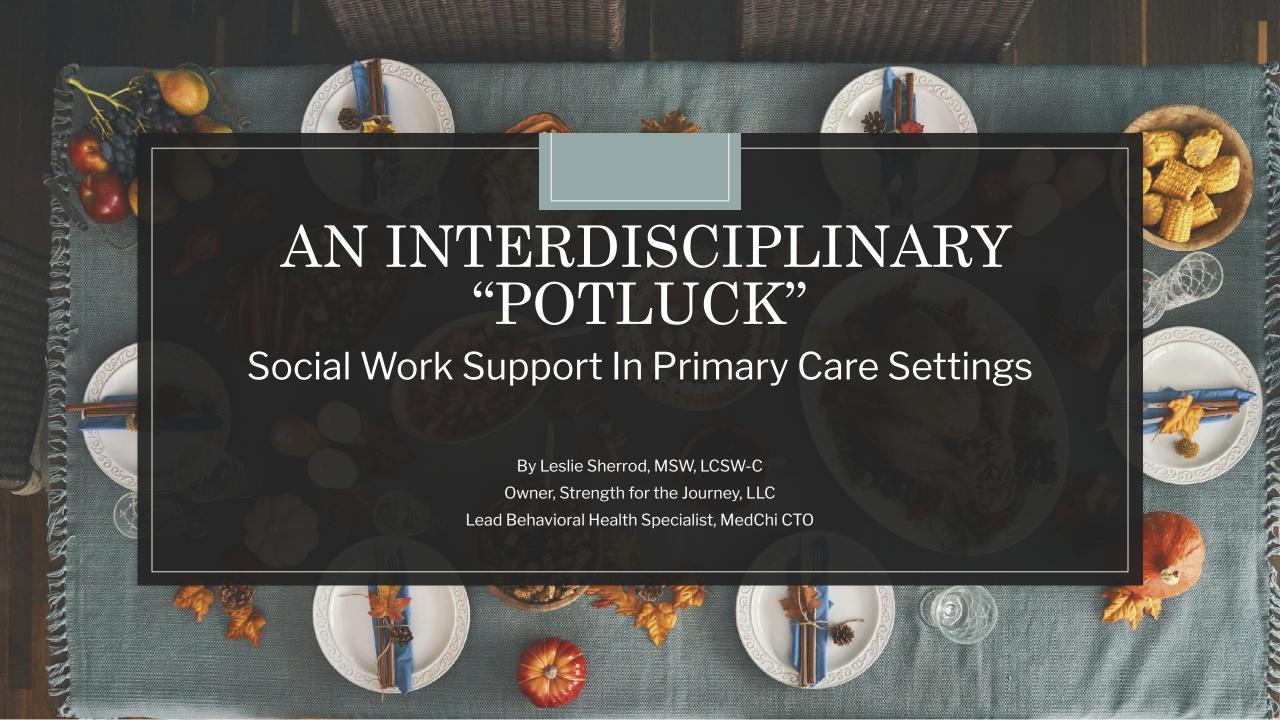
PANEL DISCUSSION

Moderated by Sarah Johnson Conway, MD

Chief Medical Officer,
Johns Hopkins Clinical Alliance

Senior Medical Director,
Physician Alignment and Integration, Office of
Johns Hopkins Physicians

Assistant Professor of Medicine, Johns Hopkins School of Medicine



When all health care disciplines bring their best to the table, the hungriest among us are nourished and fed.



AGENDA

- Review of the Expertise Social Workers Bring to the Table
- Roles Social Workers Can Serve in Primary Care Settings
- Resources for Social Work Support in Health Care Practices

Social Work's "Special Dish"

Training: LCSW-C (Licensed Certified Social Worker-Clinical)

- MSW with foundational and advanced field placements
- Two years of clinical experience under the supervision of an LCSW-C
- Clinical Exam

 Licensed to independently formulate a diagnostic impression of, assess, and treat mental and behavioral disturbances



Perspective: P-I-E (Person-In-Environment)

Micro (Clinical/Individual Impacts)	Macro (Community Impacts)
Patient-Centered	Advocacy
Strengths-Based	Equity
Self-Empowerment	Access

Specialized Knowledge and Skills

• Assessments, Clinical Interventions, Case Management, Counseling, Organizing, Consultation and More!

Social Work Roles in Medical Settings

(In-person and Virtual)

Outreach Social Worker/Care Advocate

- Program Development
- Trainings
- Groups (support, therapeutic)

Case Management/Care Advisor

- Psychosocial Assessments and Screenings
- Information and Referrals

Behavioral Health Support/Psychotherapy

- Collaborative Care Model (CoCM)
 - □ Integrated Behavioral Health Team
- Primary Care Behavioralist Model
- ☐ Warm Hand-off with Treatment Collaboration



Ingredients for Success

Resources for Social Work Support in Health Care Practices



Outcomes

- <u>Health benefits of primary care social work for adults with complex health and social needs: a systematic review PubMed (nih.gov)</u>
- Integrated Primary Care and Social Work: A Systematic Review | Journal of the Society for Social Work and Research: Vol 9, No 2 (uchicago.edu)

Next Steps

- Integrating Social Workers Into Primary Care Teams | Playbook (bettercareplaybook.org)
- MDPCP Behavioral Health Integration: Choose What's Best for Your Practice

Questions? Comments?

Contact: Leslie Sherrod, MSW, LCSW-C

Email: <u>LSherrod@medchi.org</u> or <u>LSherrod@strengthforthejourney.net</u>

Phone: (410) 769-0002

Web: www.StrengthfortheJourney.net



Denisse Mueller, MD

Medical Director, East Baltimore Medical Center





East Baltimore Medical Center Team Based Care

Social Work

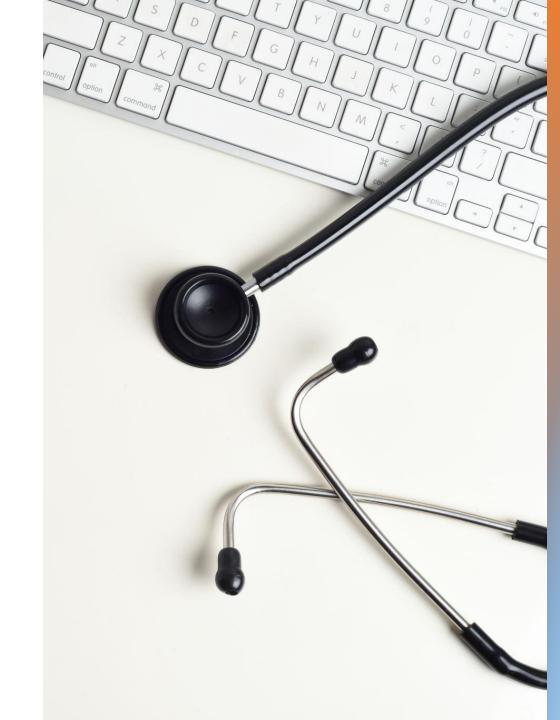
- SW Manager oversees all patient supports at EBMC
- MAT Social Worker
- 2 Team Social Workers

Roles

- Address acute barriers to care and well being including brief therapeutic support, crisis intervention, assessment and referral to community-based providers
- Substance abuse treatment resources
- Medicare concerns
- Home care and aging resources
- Medication affordability and Patient Assistance Programs
- Immigration support
- Support with acute and chronic illness
- Patient Advocacy
- Housing

Team Based Care Hopkins Community Connection

- Program within EBMC comprised of Johns Hopkins undergraduate students led by a Program Coordinator
- Screen patients for Social Determinants of Health needs
- Weekly follow-up to connect patients to community and government resources including:
 - food assistance
 - SNAP applications
 - health insurance navigation
 - energy assistance
 - commodities applications
 - transportation





Team Based Care Community Health Workers

- 2 Community Health Workers
 - Work closely with SW and HCC
 - Work with patients who have identified SDOH needs, require additional coaching and follow-up to achieve goals and address barriers in care
 - Help with outreach to engage patients in care



Panel Discussion



RESOURCES



First Steps for Help

Community Resource Guide

Maryland Access Point/Anne Arundel County Dept of Aging and Disabilities North (410-222-4257)

- Serves as the entry point for screening, information, and referrals for programs and services serving seniors, adults with disabilities, their families, and professionals
- Programs and services include tax assistance, legal and financial aid, aging resource database, assisted living information, in-home services eligibility screening, home-delivered meals, workshops, caregiver support, respite care referral program, health insurance assistance, taxi voucher program, telephone reassurance program, and more

Anne Arundel County Department of Social Service/Glen Burnie Office (410-269-4500)

- Social Services to Adults
 - Information & referrals, crisis intervention, and case management for vulnerable adults
- In-Home Aide Services
 - Personal care and chore services to individuals meeting state guideline requirements
- Food Supplement Program (SNAP)
- Medical Assistance (Medicaid)

Crisis Support (24/7)

- Anne Arundel County Crisis Warmline & Addictions Helpline (410-768-5522)
- Maryland Statewide Crisis Hotline (800-422-0009)
- Suicide and Crisis Lifeline (9-8-8)

Maryland Tobacco Quitline 1-800-QUIT-NOW (1-800-784-8669)

· Free and confidential services to help stop smoking and become tobacco-free

Prescription Assistance

- Senior Prescription Drug Assistance Program (SPDAP) 800-551-5995
 - Prescription assistance for income eligible Maryland residents
- Medicare Extra Help Subsidy Program (1-800-772-1213)
 - Prescription assistance through Social Security based on eligibility requirements

Additional Help:

- 2-1-1
 - Information and referrals to community resources, including food, shelter, rent and utilities assistance, as well as the Caregiver Services Corps
- North County Emergency Outreach Network (410-766-1826)
 - Open M, W, F from 10 am to 2 pm and assists with food, eviction prevention, utilities assistance, medications, special emergency situations, and referrals
- Community Action Agency of Anne Arundel County (410-626-1900)
 - Housing and energy assistance programs; multiple locations
- Maryland Senior Legal Helpline (1-800-896-4213 ext. 7750)
 - o Free telephone service for persons living in Maryland ages 60 and older
 - Talk to a lawyer for legal advice, brief legal services, or referral to another lawyer, or to an appropriate public or private agency

"Once you choose hope, anything's possible."

-Christopher Reeve



Social Determinants of Health (SDOH) Resources

CRISP

Provides an SDOH suite of tools that improve SDOH data sharing between members of a care team

211 Maryland

A comprehensive health and human services resource database with over 7,500 resources. Local partners and agencies including local health departments, social services, etc.

FindHelp.Org

A free comprehensive search tool that streamlines care management and helps providers connect patients to social services in their area

UniteUs.Com

Provides a platform to connect patients with community-based resources



HOW TO USE FINDHELP.ORG

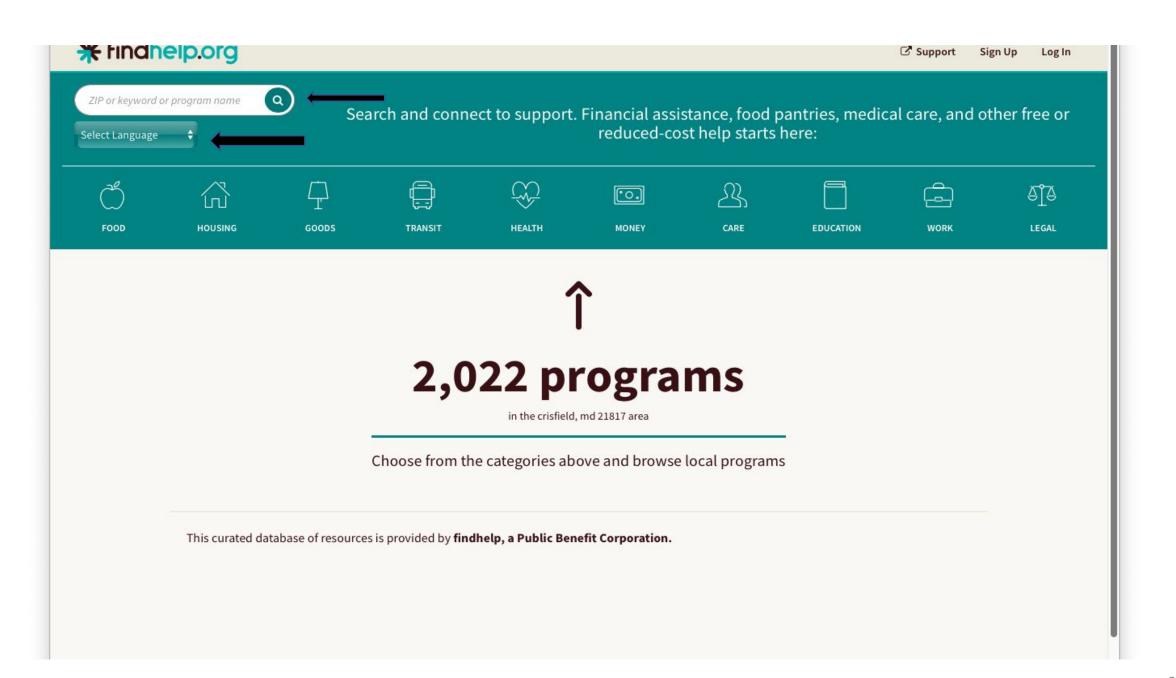


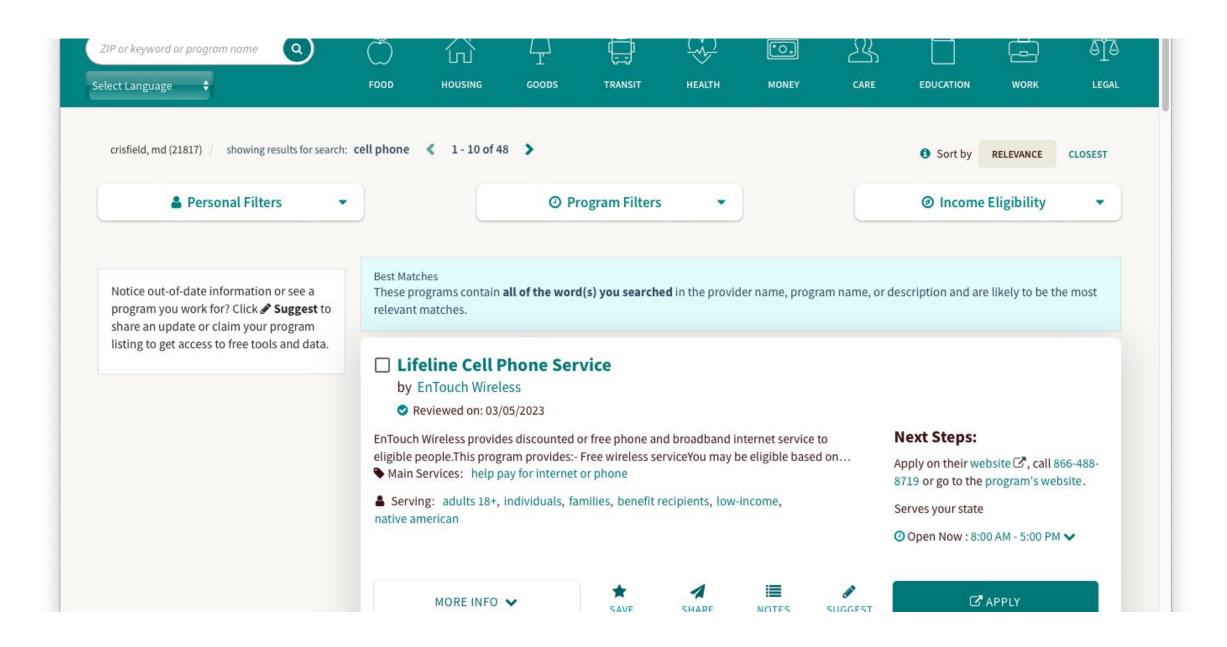
Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost **help starts here:**



If you or someone you know is in crisis, call or text 988 to reach the Suicide and Crisis Lifeline, chat with them online via their website, or text HOME to 741741 (multiple languages available). If this is an emergency, call 911.

By continuing, you agree to the Terms & Privacy









THANK YOU



Melanie Cavaliere Chief, Innovative Care Delivery melanie.cavaliere@maryland.gov



mhcc.maryland.gov