



# The AIMS Model: Addressing the Social Determinants of Health in Primary Care

Part of the Aging and Disability Business  
Institute Series- a collaboration of n4a and ASA



## The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

[www.n4a.org/businessinstitute](http://www.n4a.org/businessinstitute)



## Partners and Funders

### Partners:

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence

### Funders:

- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Marin Community Foundation



## On today's webinar

- **Robyn L. Golden, LCSW**
  - Associate Vice President of Population Health and Aging  
Rush University Medical Center
- **Matthew Vail, LCSW**
  - Clinical Social Worker, Social Work & Community Health  
Coordinator, Center for Health and Social Care Integration  
Rush University Medical Center
- **Sharlyn Pech, LCSW**
  - Clinical Social Worker, Aging Care Connections

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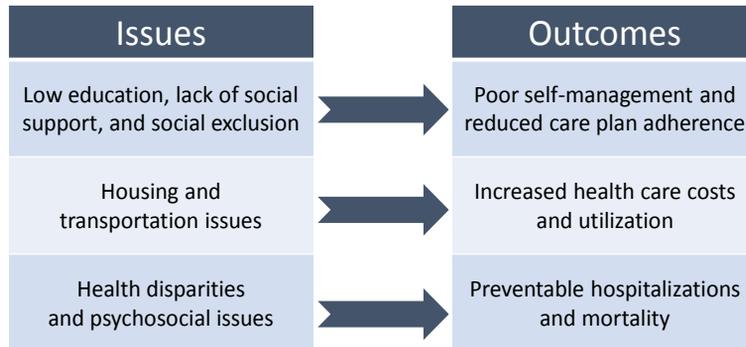
## Why now?

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## The problem

Social needs have  
individual-level impact



## Social Needs and Cost Outcomes: Older Adults

- Poor health outcomes
- Increased service utilization
  - Emergency Department
  - Hospital Admissions
  - Readmissions

= **increased costs**



## The problem

- A growing body of research suggests that **social determinants of health**—social, functional, environmental, cultural and psychological factors—are intricately linked to health and wellness
- Our fragmented medical and social services are underequipped to address these needs.



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## Health care's blind side – It takes a team!

- **2011 Robert Wood Johnson Foundation survey of 1,000 primary care physicians**
  - 4 out of 5 not confident can meet social needs, hurting their ability to provide quality care
  - 85% feel social needs directly contribute to poor health
  - R<sub>x</sub> for social needs, if they existed, would be 1 in 7 R<sub>x</sub>s written
  - Psychosocial issues often treated as physical concerns
- **Role for social workers in augmenting the patients' and families' healthcare encounters**
  - Address gaps in care from insufficient time, staff, resources
  - Assess patients' psychosocial and long-term services and supports (LTSS) needs
  - Educate patients and providers on patient self-management practices

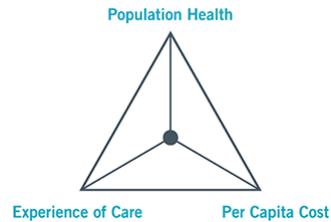
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## Moving toward value

- **Healthcare reform**
  - Focus on changes to payment and care delivery, to achieve “Triple Aim”
  - Efforts to reduce unnecessary acute care visits
  - Move toward community, outpatient care
  - Consumerism and consolidation
- **Patient-Centered Medical Homes**
  - Improving upon “the 15 minute visit”
  - Opportunities for social work and care coordination
  - Supported by Medicare reforms

### The IHI Triple Aim



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## Our Imperative

**“The health care system must acknowledge and systematically address those realities of patients’ lives that directly impact health outcomes and costs.”**

-- Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014

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## Defining Social Work's Role in Health Care

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## Social Work Valued but Underrepresented

- Social workers present on some interprofessional geriatric health teams
  - Valued, yet sometimes uncertainty regarding their role
    - “Refer to social worker”
- Undefined role = undefined value
  - Lack of clarity regarding what makes social workers uniquely different from other members
  - Lack of buy-in from providers/payers
  - Social work underrepresented on primary care teams

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## Challenge for Social Workers

- Need to define role
  - Clinical tasks/activities
- Need to describe unique contributions
  - Specialized skill sets
  - Soft skills (relationship-based care)
- Need to operationalize/protocolize interventions
- Need to encourage publications
  - Interprofessional manuscripts

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## Defining Social Work's Role within Health Care

- **Social workers use evidence-based clinical skills/frames**
  - Person in environment perspective (Ecological Systems Theory)
  - Stages of change/Motivational Interviewing
  - Behavioral/psychotherapeutic techniques
    - Acceptance and Commitment Therapy
    - Cognitive Behavioral Therapy
    - Relational psychodynamics
  - Cultural humility
- **Social workers engage in DOZENS of highly complex clinical activities**



## Our Work at Rush

- **Large urban hospital on the West Side of Chicago**
  - 664 beds, 27 care units
  - Diverse socioeconomic, cultural, racial and ethnic, and educational background of clients
- **Rush Social Work & Community Health programming**
  - Resource centers for clients, families, community members
  - Health promotion and disease prevention
  - Social work care coordination services
    - *Outpatient: AIMS Model*
    - *Transitional care: Bridge Model*
  - Mental health services
  - Population health and policy advocacy



## The Ambulatory Integration of the Medical and Social (AIMS) Model

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## AIMS: An Outpatient Social Work Intervention

- **“Ambulatory Integration of the Medical and Social”**
  - Team of Master’s level clinical social workers integrated into outpatient primary and specialty care settings
  - Mix of in-person and telephonic care management, with some social workers physically embedded in their respective clinic
- **Wraps around medical care by addressing psychosocial needs**
  - 5-step guided protocol
  - Typical cases open 4-6 weeks, but can be much longer
  - Integrates evidence-based social work core competencies, patient-identified goals and care preferences
  - Connects patients to evidence-based disease self-management

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## Snapshot of AIMS

Clinical case management and care coordination for complex patients in primary and specialty care by master’s-level social workers.

### Intervention:

- Primary/Specialty care provider identifies non-medical needs and places referral for social work services through Epic (EHR)
- Comprehensive biopsychosocial assessment
- Development of concrete goals and action plans in partnership with patient and other providers
- Navigation of and linkage to community resources
- Integration of psychotherapeutic techniques to promote behavior change
- Connection to evidence-based disease management

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## The AIMS Approach

- **Builds on social work core competencies and skills:**
  - Engagement and assessment
  - Resource linkage
  - Counseling
  - Motivational Interviewing
  - Care coordination
  - Interprofessional team collaboration
- **Client-centered**
  - Self-identification of goals
  - Collaboration on plan to meet them
- **Interprofessional communication key**
  - Access to EHR, fax/email communication, paging system

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## Clinical Skills / Frames

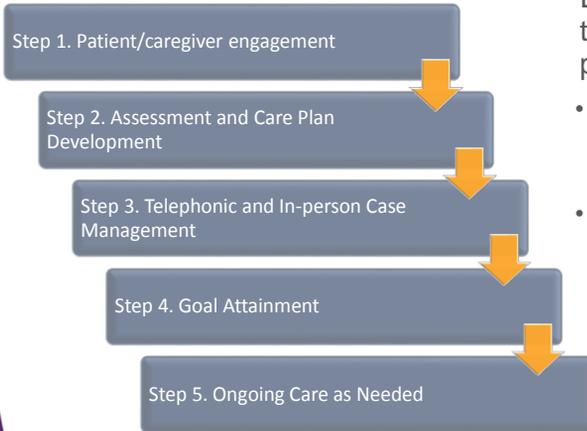
- AIMS social workers integrate clinical skills /frames throughout intervention
  - Person-in-Environment perspective
  - Stages of change / Motivational interviewing
  - Psychotherapeutic techniques: Acceptance and Commitment Therapy, Cognitive Behavioral Therapy, Relational Psychodynamics
  - Cultural humility



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## AIMS Intervention Protocol



Each step rooted in the following principles:

- Patient empowerment and self determination
- Motivational interviewing strategies

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## Referral

- Eligible patients
  - No specific criteria for referral
  - Adults 18+
  - Caregivers of patients
- Methods
  - Direct from PCP or other provider
    - Printed/faxed referral forms
    - Order in Electronic Medical Record
    - Colocation
    - Page from a provider
    - *Warm hand-off is ideal*
  - Telephone contact from patient (self-referral)
- Reviewed upon receipt and triaged if urgent



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## Patient / Caregiver Engagement

- Pre-intervention planning
  - Review MD order, EMR if able
- Develop rapport and patient trust
- Ensure patient understands the rationale for a social work intervention
  - And ensure that patient has clear expectations of social worker and self
- Begin to identify issues patient feels are important

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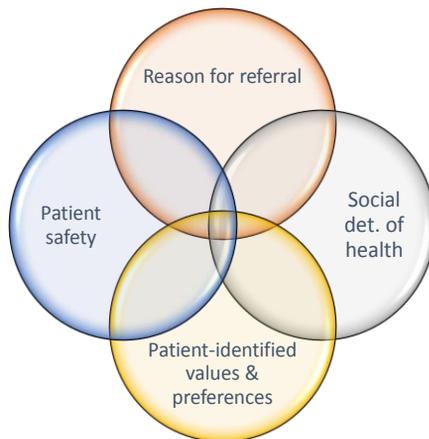
## Assessment and Care Plan Development

- Comprehensive biopsychosocial assessment including strengths and barriers in each area
  - Medical history, including medication
  - Functional abilities
  - Social history
  - Cognition
  - Mental health including alcohol and substance use
  - Patient values
- AIMS Protocol includes detailed comprehensive assessment scripting and template

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## Assessment and Care Plan Development



- Care plan goals developed collaboratively with patient using motivational interviewing techniques
  - 1-5 goals selected based on complexity and patient ability to independently work on goal

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## Telephonic & In-person Case Management

- Assess progress on goals and provide support or shift the goal attainment plan as necessary
  - Patient's work toward goals
    - Problem-solve patient barriers to goal attainment using motivational interviewing techniques and psychoeducation
    - Transition active work from patient to social worker if necessary
  - Social worker's work toward goals, if applicable

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## Goal Attainment

- AIMS social worker and patient/caregiver summarize goal attainment
- Ensure appropriate community-based resources are in place to continue supporting patient and caregiver in sustaining goals
- Discuss non-AIMS resources and methods as needed

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## Ongoing Care, As Needed

- Summarize goal achievement or negotiate continued intervention
- Educate patient on resources and methods for additional goal attainment independent from active social work intervention
- Encourage patient to contact social worker should he/she develop new goals or challenges



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## Sustainability and Impact

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## Seeking Sustainability

- **Having robust impact data is imperative for developing a business case and sustaining AIMS programs**
- **Move toward value-based care, shared savings creates new opportunities in primary care**
  - AIMS's community-specific focus is a different approach than many health plans and health systems' one-size-fits-all approach to care coordination
- **Medicare Chronic Care Management CPT codes – promising route for Medicare FFS beneficiaries**

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## Measuring our Impact

- **To date: Positive patient and provider feedback in surveys, promising results in promising results retrospective study of utilization for AIMS participants vs. similar Rush population**

| Utilization Metric  | AIMS Mean<br>(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                      |

- **Currently doing 2-year quasi-experimental study with Commonwealth Fund support** (results expected spring 2018), measuring:
  - Health risk / Enabling Factors (Health insurance; housing status; transportation; food; living arrangement)
  - Utilization (ED, admissions, readmissions)
  - Physical and mental health (SF-12 version2, CESD-10)
  - Patient satisfaction (CSQ-8)
- **Positive feedback from patients and providers; continuing to study impact here as well**

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## Patient & Provider Satisfaction

### *Satisfaction surveys from intervention 2010-2014:*

- Survey outcomes from patients/caregivers
  - **100%** would recommend services from the social worker to friends and family
  - **86%** reported all their needs were met by the social worker; **14%** reported most of their needs were met
  - **85%** better know where to turn for services and resources in addition to their doctor
  - **82%** are able to focus more time on medical issues with their doctor and better able to talk about medical needs
- Survey outcomes from providers
  - **97%** agree or strongly agree that since before the referral, they are able to spend more time on medical issues with patients
  - **97%** agree or strongly agree that since before the referral, their patients seemed to have decreased levels of distress
  - The **top 2 reasons for referral:**
    - "I felt their non-medical needs were impacting their medical care"
    - "I didn't have the expertise to address the needs they were presenting"

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## Health and Human Service Efforts

- **HHS stated goal:**
  - **90%** of all Medicare FFS payments tied to quality or value by 2018
  - **50%** of Medicare FFS payments via alternative payment models by 2018
- **Significant new Medicare FFS reimbursement opportunities to help get there**
  - Chronic Care Management
  - Transitional Care Management
  - Behavioral Health Integration

***“CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible patients need to stay on track with their treatments and plan for better health.”***



## Why Chronic Care?

- 2/3 of Medicare beneficiaries have 2+ chronic conditions
- 99% percent of Medicare spending is on patients with chronic conditions
- Annual per capita Medicare spending increases with beneficiaries' number of chronic conditions



## Chronic Care Management

- **99490:** 20+ minutes / month of CCM services
- **99487:** 60+ minutes / month of “complex” CCM services
  - 99489: 30-minute add-ons
- **Billed by Medicare Part B provider each calendar month services are provided**
- **Overseen and billed by:**
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist, Certified Nurse Midwife
- **Other clinical staff can provide services, too**
  - Social work
  - RN
  - MA

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## CCM Requirements

### Comprehensive Care Plan

- Electronic
- Provide patient/caregiver with a copy
- Ensure it is available to and shared with the rest of the care team

### Access & Continuity of Care

- 24/7 access to physicians or other clinical staff
- Continuity of care with a team member to schedule successive appts
- Provide more opportunities for patient/caregiver to communicate with practitioner (phone, secure messaging, email, etc.)

### Management of Care Transitions

- Exchanging continuity of care documents for the following:
  - Referrals to other clinicians
  - ED/Hospital follow-up
  - Post-Acute transitions

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## Things to Note about CCM

- **All codes must be billed by a physician and/or non-physician practitioner (PA, NP, CNS, CNM: “qualified health providers”)**
  - Typically primary care, but may be of another specialty (e.g., cardiology)
  - Verbal consent needed (obtained by billing provider, documented in EHR)
  - Can include time from clinical staff on interprofessional team (e.g., SW, RN, MA – based on state and facility policy; staff or subcontract)
- **Subject to Medicare Part B’s 20% co-insurance**
  - May be ideal to target duals or individuals with a Medicare supplement/Medigap or secondary insurance to help cover this 20%
  - At beginning of calendar year, patients may have to pay bills related to CCM to meet their Part B or secondary insurance deductible

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## Growing the AIMS Model

- **Continuing to study AIMS, align it with health system needs and quality goals**
  - Key contributions to meeting NCQA’s Patient Centered Medical Home and MACRA (Medicare Part B) standards
- **Continuing to test and refine model**
  - Replicating in other communities (various target populations and partnership types)
    - Adapting protocol (e.g., optional in-person visits, targeting high-utilizers)
  - Rush team provides training and ongoing support (clinical & project management)
- **Seeking more organizations interested in implementing AIMS**
  - Maybe you!

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## The Community Perspective

**Aging Care Connections**  
La Grange, IL

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## Aging Care Connections

- Private, nonprofit founded in 1971
- Provides comprehensive range of social work services, education, and health and wellness programs
- Aging & Disability Resource Center
- Primary mission, individuals over the age 60 or caregivers of older adults
- Services 22 west and southwest suburban Cook County communities
- Adult Protective Services and Caregiver Specialist Services extends to 10 more communities

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## ACC Social Work Services

- Caregiver Supports (support groups, respite)
- In-home services (private pay or CCP)
- Legal (POA, Living Wills, Advanced Directives)
- Transportation (taxi vouchers, township cars)
- Nutrition (Congregate meals, HDM's)
- Financial Services (SNAP, LIHEAP)
- Healthcare (Medicare, Medication Management)
- Mental Health (Depression, Anxiety, Grief)
- Housing (ALF, SNF, Independent Senior Living)
- Chronic Disease Self Management Classes

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## Why Did we Replicate?

- Enhanced the Continuum of Care
  - Transitional Care in began in 2007 with one of the first Community Based Organizations providing transitional care onsite at an acute hospital setting
  - Expanded transitional care to skilled care facilities
  - Community Based Service provider that has the ability to follow patients to their home post discharge
  - The AIMS intervention completes the continuum
    - Long Term Goals: prevent ER visits, unnecessary hospital readmissions, enhance health literacy, identify barriers to health related to social determinants of health
- Opportunity to partner with Rush Health and Aging

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## Using the AIMS Model

- ACC was trained by Rush and continues working together to adapt the model for use in a community-based setting
- Maintain boundaries of AIMS model
- Each social worker adapts the “script” to compliment her style and the needs of the client
- Complete entire assessment in order to appraise the big picture (The reason for referral given by PCP may not be the only goal of the client)

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## Maintaining Integrity

- Thoroughly explain the program from the first interaction with client and caregivers
- Establish that goals and interventions will be set collaboratively
- Role of Social Worker as a guide to manage health and wellness
- Focus is not only services; shift our own vision
- Referrals may be made within your own agency or to other private or nonprofit agencies & resources – not a long term intervention

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## Adapting to our Community

- ACC and Rush realized the need for model integrity that allowed for adaptation to a community based organization
- ACC educated PCP's on the social determinants of health to establish value – Rush assisted with training at our practice
- ACC adaptation incorporates **face-to-face appointments** along with telephonic follow-up calls
- Social worker office hours were scheduled at the PCP office, this is the site of most interventions
- AIMS social worker also follows patients of the primary practice at a local skilled facility per MD order
- AIMS social worker bridges the patient to ACC care coordinators if in-home support programs are needed, care coordinators follow the patients not the AIMS social worker

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## Limitations and Going Forward

- Access Electronic Medical Record and to share patient information
- Lows and highs of referrals
- Continue educating MD office and integrating ACC in office
  - Including social worker in regular staff meetings
  - AIMS social worker to discuss with MD and MD RN client cases after Session 1 and Termination
  - Connecting AIMS model with transitional care BRIDGE model

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## Center for Health and Social Care Integration (CHaSCI)

at Rush University Medical Center

- The Center for Health and Social Care Integration (CHaSCI) envisions a transformed health care system that addresses the social determinants of health, promotes whole-person care, and achieves health equity for all.
- To achieve this vision, CHaSCI serves as a national convening and technical assistance hub to advance practices that break down barriers to health



## The Opportunity

With generous funding from the Harry and Jeannette Weinberg Foundation, we are offering a **no-cost AIMS replication training** to interested organizations to help improve care for vulnerable older adults across the country.

### CHaSCI will also assist with:

- follow-up implementation support and technical assistance to help facilitate the integration of services
- partnership-building
- sustainability avenues

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| WHAT CHaSCI WILL PROVIDE TO PARTICIPANTS:   | WHAT PARTICIPANTS WILL COMMIT TO:  |
|---|--|
| Explanatory and exploratory materials and discussions to help organization prepare for the project and to answer initial questions  | Identify and engage clinical partner(s), and identify staff with capacity (time and skills) to serve as AIMS social worker   |
| Initial AIMS Model training (logistics TBD, but likely a day-long offering in June in Chicago area, with webcast option available)  | Attend initial AIMS Model training: <ul style="list-style-type: none"> <li>• AIMS social worker</li> <li>• supervisor, such as Director of Social Services</li> <li>• organizational leadership and/or operations staff (optional)</li> <li>• representative(s) of clinical partner, such as RN clinic manager or others on interprofessional team (optional)</li> </ul> |
| Monthly clinical support and AIMS technical assistance calls for AIMS sites, to provide targeted support and facilitate peer-to-peer learning. Bimonthly educational webinars (not AIMS specific) regarding best practices for integrating health and social care, sustainability avenues, etc. | Implement the AIMS Model in partnership with clinic and participate in ongoing technical assistance and clinical support activities as able  |
| Collect process data on numbers served from participating sites and report grant deliverables to Weinberg Foundation  | Track and submit process data on number of clients 55+ or family caregivers that are served with the AIMS Model  |
| Encourage and support participants in their efforts to evaluate the impact of their programs (via surveys and utilization data)   | Consider surveying clinical partners as well as clients and caregivers for program quality improvement   |
| Further opportunities for growing organizations' engagement in the field of complex care, such as conference presentations, advocacy work, or pursuing new grant funding  | Consider working with partner clinic and the state's Quality Improvement Organization to evaluate impact on healthcare utilization   |

**Interested in partnering?**

**Matthew Vail, LCSW**

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## Questions & Answers: Please Submit Using the “Questions” Box



## Please join us for future webinars in the Aging and Disability Business Institute Series

“The CHRONIC CARE Act: New Opportunities to  
Advance Complex Care Through Community-  
Clinical Partnerships” – May 30, 2018

Learn more and pre-register here:

<http://www.asaging.org/series/109/aging-and-disability-business-institute-series>



## Browse the Spring *Generations* Issue “Fundamentals of Community-Based Managed Care: A Field Guide” online at no cost to you.

Part of the Aging and Disability Business Institute,  
this field guide focuses on how best to build and  
preserve community-based organization (CBO)  
partnerships with the healthcare sector.

Learn more at [www.asaging.org/adbi](http://www.asaging.org/adbi)

View the Generations issue at [bit.ly/2qvBmuh](http://bit.ly/2qvBmuh)



# Questions about the Aging and Disability Business Institute?

Email us:

**[BusinessInstitute@n4a.org](mailto:BusinessInstitute@n4a.org)**

