

RECOMMENDATIONS

SEPTEMBER 2019 • INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE:
MOVING UPSTREAM TO IMPROVE THE NATION'S HEALTH

GOAL 1: DESIGN HEALTH CARE DELIVERY TO INTEGRATE SOCIAL CARE INTO HEALTH CARE.

Recommendation 1. Health care organizations should take steps to integrate social care into health care.

Specific steps include:

- a. Make and communicate an organizational commitment to addressing health-related social needs and health disparities at the community and individual levels.
- b. Recognize that comprehensive health care should include understanding an individual's social context. Evidence is rapidly accumulating concerning the most effective strategies for screening and assessing for social risk factors and social needs. Such strategies should include standardized and validated questions, as available, and should use interoperable data systems to document results.
- c. Use patient-centered care models¹ to more routinely incorporate social risk data into care decisions.
- d. Design and implement integrated care systems using approaches that engage patients, community partners, frontline staff, social care workers, and clinicians in the planning and evaluation and in incorporating the preferences of patients and communities.
- e. Include social care workers as being integral to a team-based approach to designing and delivering health care.
- f. Establish linkages and communication pathways between health care and social service providers. This is important for personal care aides, home care aides, and others who provide care and support for seriously ill and disabled patients and who have extensive knowledge of patients' social needs.
- g. Develop and finance referral relationships with selected social care providers when feasible, supported by operational integration such as co-location or patient information systems. Social care providers and health care providers should establish a formal understanding and accountability within their contracting and referral relationships.
- h. Support the development of those infrastructure components needed to meet the goal of care integration, including the redesign and refinement of workflows, technical assistance and support, staff with the ability to support the redesign, champions of the redesign, information on best practices, health information technology to enhance integration, and support for community partners and their infrastructure needs.

¹Patient-centered care is defined as providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions (Institute of Medicine. 2001. *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press. <https://doi.org/10.17226/10027>).

GOAL 2: BUILD A WORKFORCE TO INTEGRATE SOCIAL CARE INTO HEALTH CARE DELIVERY.

Recommendation 2a. State legislatures, licensing boards, professional associations, and federal agencies should develop, expand, and standardize the scopes of practice of social workers, community health workers, gerontologists, and other social care workers.

Recommendation 2b. Social workers and other social care workers should be considered to be providers who are eligible for reimbursement by payers. Public and private payers should create standards for the reimbursement of social care, including assessment and such treatment as chronic care management, behavioral health integration, and transitional care management. Medicare/Medicaid payment advisory commissions should evaluate models in which social workers and other social care workers are reimbursement-eligible providers of social care services.

Recommendation 2c. Funders of health care workforce training (e.g., the U.S. Department of Health and Human Services, the U.S. Department of Veterans Affairs, and foundations) should include the social care workforce in their education, training, and practice initiatives.

Recommendation 2d. Schools for health professions (including schools of medicine and nursing) as well as continuing education programs should incorporate competency-based curricula on social care. Curricula should include evidence on the social determinants of health, protocols for working in interprofessional teams to address social needs in health care settings, interpersonal and organizational approaches to advancing health equity and decreasing health disparities, and competencies relating to collecting, securing, and using data and technology to facilitate social and health care integration. Schools of health professions should also engage social workers in instructional roles in order to model their participation in interprofessional teams and to provide information on social risk screening and social care resources and referrals.

Recommendation 2e. Credentialing organizations for medicine, nursing, and other health professions should incorporate knowledge about the social determinants of health and the importance of addressing social needs in licensing examinations and continuing education requirements.

Recommendation 2f. Schools of social work as well as continuing education programs should use competency-based curricula on social care. In addition to educating students about the social determinants of health and health disparities, the curricula should include information about effective models that integrate social care and health care delivery, the interprofessional workforce, technology, and payment models that facilitate implementation and competencies relating to collecting, securing, and using data and technology to facilitate social and health care integration.

Recommendation 2g. State agencies and academic institutions, including community colleges, should develop standards for training and advancement (e.g., career ladder programs) for community health workers and other emerging social care workers.

Recommendation 2h. Foundations and other funders should commission a follow-up comprehensive report on the role of social work in health care as social care and health care integration continues to evolve.

Recommendation 2i. Foundations and other funders should fund a campaign to raise awareness among the health care professions and others about the value and contributions of social workers and other social care workers in health care.

GOAL 3: DEVELOP A DIGITAL INFRASTRUCTURE THAT IS INTEROPERABLE BETWEEN HEALTH CARE AND SOCIAL CARE ORGANIZATIONS.

Recommendation 3a. The federal government should establish a 21st-century social care digital infrastructure on a scale similar to that described in the Health Information and Technology for Economic and Clinical Health Act of 2009,² and it should identify and deploy policies and resources to build the internal capacity necessary for social care organizations and consumers to interoperate and interact with each other and the health care system.

Recommendation 3b. The Office of the National Coordinator (ONC) should be resourced to act on the Patient Protection and Affordable Care Act of 2010³ Section 1561 recommendations, including the adoption of modern, secure, interoperable digital systems and processes that will allow all partners to share the administrative and other data necessary to enable consumers to seamlessly obtain and maintain the full range of available health care and social care services.

Recommendation 3c. The Office of the National Coordinator (ONC) should support states and regions as they identify the appropriate interoperable platforms for their communities, based on open standards and a modern technical architecture that supports flexible interfaces to allow the health and social care systems and consumers to share the structured data necessary for care coordination, avoidance of error, and a reduced burden on organizations and people being served.

Recommendation 3d. The Federal Health Information Technology Coordinating Committee should facilitate data sharing at the community level across diverse domains such as health care, housing, and education so as to support social care and health care integration.

Recommendation 3e. Integrating social care and health care requires the sharing of new types of data between new partners, some of whom are covered by the privacy rule promulgated by the Health Insurance Portability and Accountability Act of 1996⁴ and some of whom are not; therefore, the U.S. Department of Health and Human Services should work with the private sector to disseminate educational tools and guidance on the data security and privacy issues that arise when collecting and sharing personally identifiable information.

Recommendation 3f. The parts of the public and private sectors involved in developing and implementing analytic and technology resources, including cell and Internet access, should do so with an explicit focus on equity; the goal should be to avoid unintended consequences such as perpetuation or aggravation of discrimination and bias and the further marginalizing of populations and to proceed with an appreciation of the impact on the existing social care system.

²Public Law 111-5, February 17, 2009.

³Public Law 111-148, March 23, 2010.

⁴Public Law 104-191, August 21, 1996.

GOAL 4: FINANCE THE INTEGRATION OF HEALTH CARE AND SOCIAL CARE.

Recommendation 4a. The Centers for Medicare & Medicaid Services should clearly define which aspects of social care that Medicaid can pay for as covered services (e.g., in the context of providing care management, targeted case management, and home- and community-based long-term care services and supports as well as within the context of managed care).

Recommendation 4b. State Medicaid agencies should use the flexibility described by the Centers for Medicare & Medicaid Services in the social care that Medicaid pays for as a covered service and make the opportunities and limitations associated with that flexibility clear to health plans and health care and social care service providers.

Recommendation 4c. The Centers for Medicare & Medicaid Services (CMS) should accelerate learning about how the integration of health and social care can improve health and reduce health care costs by encouraging and approving waivers that support social care. Sustainable financing for effective interventions piloted in the waiver should be identified by the state and CMS as an outcome of the waiver.

Recommendation 4d. States should pursue policies of continuous program eligibility to, among other benefits, create stable pools of populations for which entities can be held accountable.

Recommendation 4e. The Centers for Medicare & Medicaid Services should consider additional Medicare reforms that can broaden Medicare coverage rules in a way that is consistent with lessons from Medicaid populations and the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2018 (CHRONIC Care Act). Health plans should take full advantage of the flexibility provided under the CHRONIC Care Act for supplemental benefits under Medicare.

Recommendation 4f. The Centers for Medicare & Medicaid Services and the states should coordinate the coverage and benefits administration of their Medicare and Medicaid dually eligible populations consistent with the emerging lessons of the financial alignment demonstrations. Efforts to improve alignment should be aggressively pursued over the short and long term, with an intentional focus on social care integration.

Recommendation 4g. The Centers for Medicare & Medicaid Services should develop incentives for health care organizations and the managed care programs that contract with Medicaid and Medicare to collaborate with community-based social services, such as area agencies on aging and centers for independent living.

Recommendation 4h. The Centers for Medicare & Medicaid Services, state Medicaid agencies, employers, and health plans should accelerate the movement to alternative payment models. The measurements aimed at assessing value in these models should include activity-based measures for social care integration and outcome measures that reflect social risk and protective factors. These value-based payment and outcome measurement models should incorporate social risk adjustment and stratification in a way that is consistent with previous recommendations from the National Academies of Sciences, Engineering, and Medicine.⁵

Recommendation 4i. The U.S. Department of Health and Human Services, payers, and other private organizations, such as foundations and institutions with community-benefit obligations, should provide funding and technical assistance to support formal contractual relationships between community-based organizations and health care entities.

Recommendation 4j. Federal and state policy makers, health plans, health systems, and private-sector investors should consider collective financing mechanisms to spread risk and create shared returns on investments in social care so that returns do not accrue to a single investor.

Recommendation 4k. Health systems subject to community benefit regulations should comply with those regulations by considering partnering with community organizations to respond to identified community gaps in social care.

Recommendation 4l. States should pursue opportunities to align their hospital licensing requirements and public reporting with federal regulations regarding community benefits to ensure consistent obligations for health systems and to explicitly link their community benefits to the provision of social care.

⁵National Academies of Sciences, Engineering, and Medicine. 2017. *Accounting for social risk factors in Medicare payment*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/23635>.

GOAL 5: FUND, CONDUCT, AND TRANSLATE RESEARCH AND EVALUATION ON THE EFFECTIVENESS AND IMPLEMENTATION OF SOCIAL CARE PRACTICES IN HEALTH CARE SETTINGS.

Recommendation 5a. Federal and state agencies, payers, providers, delivery systems, and foundations should contribute to advancing research on and the evaluation of the effectiveness and implementation of social care practices.

- The National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Patient-Centered Outcomes Research Institute, the Health Resources and Services Administration (HRSA), and other funders of research and program evaluation should encourage payers, providers, and delivery systems to incorporate a range of study designs and methods that include rapid learning cycles and experimental trials.
- NIH, AHRQ, CMS, foundations, and other funders of research and program evaluation should cultivate and support researchers who have expertise in health services, social sciences, and crossdisciplinary research.
- CMS should fully finance (without state contributions) independent state waiver evaluations to ensure robust evaluation of social care and health care integration pilot programs and to facilitate the dissemination of findings.
- The U.S. Department of Health and Human Services should establish and support a clearinghouse containing information on the best and most promising practices for social care integration in order to provide “lessons learned” to health systems, community-based organizations, researchers, and others.

Recommendation 5b. Funders of health care workforce research (e.g., the Agency for Healthcare Research and Quality and foundations) should include the social care workforce in studies of the effect of the social care workforce on the health and financial outcomes of health care delivery organizations.

Recommendation 5c. The Health Resources and Services Administration and other funders should support studies of the contribution of the social care workforce, including additional workers such as gerontologists and public interest lawyers, to addressing the social determinants of health in health and community care settings.

Recommendation 5d. The Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services, state Medicaid agencies, the National Quality Forum, and the National Committee for Quality Assurance should establish mechanisms that ensure that research on effective demonstrations informs more permanent health care reforms, including the development of accountability measures and payment models.

Recommendation 5e. To enable comparative research and evaluation, researchers, evaluators, and agencies that develop measures and standards (e.g., the National Quality Forum, the National Committee for Quality Assurance, and the Centers for Medicare & Medicaid Services) should develop a consensus on and use a common core of measures reflecting social risk and protective factors as well as key health and social outcome measures. These measures should not be limited to clinical or economic metrics, but should include patient-reported outcomes and other outcomes relevant to a range of stakeholders, including patients, families, caregivers, communities, social care organizations, health care organizations, and payers. The Agency for Healthcare Research and Quality should curate these measures in a publicly available item bank.

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