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The Convergence of Health and Human Services

How the convergence of health and human services is improving medical care, reducing costs, and changing the delivery of health and human services.

The delivery of medical and human services in the United States is a landscape of fragmented care, with services split among multiple programs and providers, each of whom is often unaware of services delivered by other care providers. This siloed approach subjects recipients of healthcare and human services to a myriad of overlapping and non-coordinated care plans which leads to poor outcomes.

Healthcare providers have historically viewed medical care as wholly contained within the framework of diagnosis and treatment with little consideration for a patient's circumstances outside the scope of traditional medical care. Human service organizations, meanwhile, have focused primarily on assisting clients with human service needs and have been content to cede delivery of medical care to other health providers. In this paradigm, the roles of healthcare providers and human service providers are complementary, but separate. Human service agencies address the human needs of food, clothing, transportation, housing, and employment while healthcare providers address physical and mental health needs.

Because the healthcare industry is subject to market forces it prioritizes patients who are able to afford care, either through direct payment for services or through services covered under a health insurance plan. Under the predominant fee-for-service payment system, healthcare providers are incentivized to provide all medically necessary services for patients who are able to afford care. These two points comprise the inherent limitations in the fee-for-service reimbursement model: it rations care by the patient's ability to pay and it economically incentivizes providers to perform medical procedures that are covered by insurance, even if alternative treatments (or no treatment) may provide equally acceptable outcomes.

Yet industry forces are underway that disrupt the status quo model of healthcare and human services. The healthcare industry is moving away from the fee-for-service reimbursement model and toward value-based reimbursement that promotes improved health outcomes. Under this model, providers are compensated based on the actual health outcomes achieved by a specific population. This "whole-person care" approach incentivizes providers to take into account the complete picture of patient well-being, including the social determinants of health that often go unaddressed in a typical medical encounter.

THE SOCIAL DETERMINANTS OF HEALTH AND MEDICAL DECISION-MAKING

The social determinants of health—the nonclinical combination of personal, family, economic, and social circumstances that impact an individual's health—are newly being considered as the most important frontier in the campaign to improve health.

By not taking into account the social determinants of health, medical providers are operating half-blind to underlying circumstances that directly impact patient health. As an example, the CFO of a twenty-facility hospital system relates a story that illustrates the critical need for clinicians to consider the social determinants of health when making medical decisions. At one of the hospitals in his organization a patient was seen for a condition whose treatment necessitated a limb amputation. The surgeon recommended proceeding with the amputation and the patient agreed to the procedure.

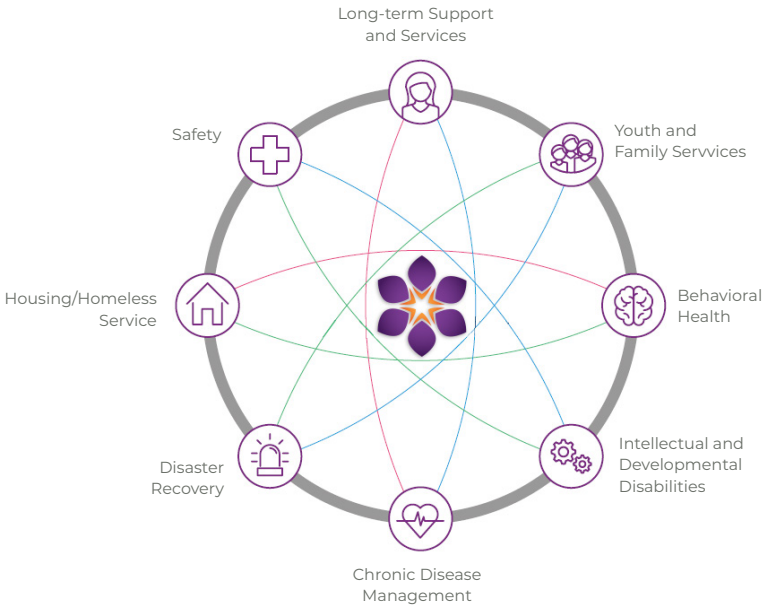
When viewed solely through the lens of medical decision-making, the care was appropriate to the situation—the patient's condition warranted the recommended treatment. However, when the case was reviewed prior to the operation it was discovered that the patient was homeless and sleeping on a friend's front porch—hardly ideal conditions for a successful post-op recovery! By not investigating the patient's non-clinical circumstances as part of a comprehensive care plan, the surgeon nearly created a potentially serious situation of almost certain post-op complications followed by a likely hospital readmission.

As outcome-based reimbursement becomes more prevalent, cases like this will become increasingly rare as provider compensation is linked to the outcome, rather than merely the performance, of a medical service. Providers will be more cognizant of the social determinants of health as patients who are unable or unwilling to follow a care plan (because of cost, for example) become a potential risk to the medical provider.

Just as medical providers are incorporating the social determinants of health as part of an overall medical plan, human service organizations are including medical services as a vital part of their service offering. Providing medical services is a natural extension of a mission to improve quality of life and a medical offering diversifies the revenue sources for an organization. The Affordable Care Act dramatically altered the landscape for recipients of medical services. Twenty million people who have traditionally been uninsured are now covered under the Affordable Care Act[1]. This historically uninsured population overlaps significantly with the clients of human service organizations and now has the coverage necessary to obtain medical care.

Whether human service organizations offer medical services directly or partner with a medical provider to offer services, the desired result is achieved: clients receive both medical care and assistance with human services needs under the same service umbrella. New, innovative programs apply the "medical home" concept to human services with a single, unified approach that addresses the social determinants of health as an integral part of a coordinated care plan.

Communities and organizations are beginning to take advantage of the untapped potential in addressing human services needs and healthcare needs together. In Chicago, the AIDS Foundation of Chicago has formed partnerships with insurance carriers who have HIV positive members in the Chicago area.



... the health system must take a broader approach to health care financing and delivery to include certain social services and supports. This new vision seeks to shift attention and dollars toward systematically addressing the social determinants of health that collectively have a greater impact on the health of a community than access to or quality of care.

[Source: Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health, CSH Whitepaper, July 2014]

Through the partnership, the insurance carriers identify at-risk members who are not adhering to their prescribed medical care plan. AIDS Foundation of Chicago performs outreach efforts to locate patients, assign them a case manager, and assist them through the medical system to receive the appropriate level of care.

The partnership is an example of the symbiotic benefits of such coordinated community efforts. The patients benefit from receiving improved medical care and access to human service resources, the health insurance plan benefits by minimizing risk of future catastrophic care costs, and the community organization benefits through increased access to at-risk members of the population segment it seeks to serve through its programs.

In other communities, providing supportive housing has become an important tactic in improving population health. Consisting of a collaborative effort between property owners, public health departments, and healthcare providers; housing for health programs have an impressive track record in Los Angeles, Denver, Massachusetts, New Jersey, and other communities.

1 Department of Health and Human Services news release; March 3, 2016; http://www.hhs.gov/about/news/2016/03/03/20-million- people-have-gained-health-insurance-coverage-because- affordable-care-act-new- estimates; accessed July 15, 2016]

Providing housing as a means to achieve better health outcomes has proven to be an effective use of community resources.

CARE COORDINATION AND THE IHI TRIPLE AIM

Programs that combine care coordination with supportive housing have demonstrated success in improving health outcomes. What is even more impressive is that these programs have also reduced overall cost while improving outcomes, thereby achieving the Institute for Healthcare Improvement (IHI) "triple aim" to improve the patient experience, improve health outcomes, and reduce the cost of healthcare.

Several studies demonstrate that linking care coordination to supportive housing leads to improved health outcomes. A Denver study found that 50 percent of supportive housing residents experienced improved health status, 43 percent had better mental health outcomes and 15 percent reduced substance use.

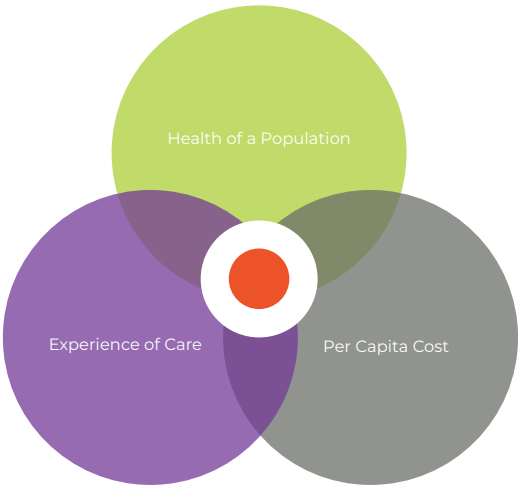
[Source: Perlman, J. Parvensky, J. 2006. Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report. Available at: http://shnny.org/uploads/Supportive_Housing_in_ Denver.pdf]

Including care coordination in housing for health programs makes the elusive IHI triple aim a reality because all three aspects are addressed simultaneously – a dimension lacking in today's segregated model of healthcare and human service delivery.

Because no one in the current system of healthcare delivery is responsible for all three aspects of the IHI triangle, improvement efforts are often short-lived attempts that wither and fade as soon as the next initiative comes along. Frequently an effort to improve one aspect of the IHI triangle results in worse performance in another area; for example, attempts to improve the patient healthcare experience add additional cost or implementing cost-reduction measures results in poor health outcomes.

In most health care settings today, no one is accountable for all three dimensions of the IHI Triple Aim. For the health of our communities, for the health of our school systems, and for the health of all our patients, we need to address all three of the Triple Aim dimensions at the same time.

[Source: Institute for Healthcare Improvement web site, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default. aspx Accessed July 2, 2016]



THE TRIPLE AIM

But introducing care coordination into the picture changes the equation. Housing for health programs have demonstrated that incorporating case management into program delivery results in a better patient experience, better health outcomes, and reduced cost even when accounting for the additional cost to provide housing and case management services.

Interestingly, the housing for health programs rely on a model for care delivery that neatly dovetails with IHI recommendations for transforming the healthcare paradigm:

1. Incorporating the social determinants of health into healthcare decisions
2. Linking primary care and community services
3. Creating a seamless journey through the systems of care[2]

Care coordinators working in cross-organizational programs are uniquely situated to enact these changes to the system. Care coordinators address multiple client needs simultaneously, including both health and human service needs. They command resources from multiple programs and agencies, expanding the role of primary care and linking health and community services. And care coordinators work directly with the patient populations that have the most difficulty navigating the complex systems of care.

THE RESULTS OF A MASSACHUSETTS HOUSING FOR HEALTH PROGRAM

ESTIMATED TOTAL COST PER PERSON PRIOR TO ENTRY TO HOUSING PROGRAM: $33,190

AFTER ONE YEAR TOTAL COST FELL TO: ↓ $8,603

SAVINGS AFTER INCLUDING HOUSING AND CASE MANAGEMENT COSTS: = $9,000

The ClientTrack Care Coordination Platform

In order for care coordinators to influence the healthcare cost/value curve, they need access to powerful tools that track, monitor, and manage real outcomes. Such tools promote collaboration among all care givers and directly involve the client in care decisions. Working with cloud-based modern case management software, care coordinators have the ability to bring about real change in the way we deliver healthcare and address human service needs.

The ClientTrack Care Coordination platform is designed for the collaborative, highly integrated model of case management that has produced impressive outcomes by managing the social determinants of health conjointly with health needs. ClientTrack facilitates communication across the spectrum of case managers, housing coordinators, medical providers, human service, and behavioral health providers.

Powerful technology enables care coordinators to deliver the recommended changes necessary to transform healthcare: incorporating the social determinants of health into healthcare decisions, linking primary care and community services, and creating a seamless journey through the systems of care.

INCORPORATING THE SOCIAL DETERMINANTS OF HEALTH INTO HEALTHCARE DECISIONS

The ClientTrack platform is natively designed for today's collaborative model of care. Information across the full spectrum of the social determinants of health is collected and tracked, leading to better-informed care decisions. Providers no longer. have a limited view into their client's condition. Information collected from anypoint of care is available to all authorized users.

[2] Institute for Healthcare Improvement web site, http:// www.ihi.org/Engage/Initiatives/ TripleAim/Pages/default.aspx Accessed July 2, 201

ClientTrack is ideal for cross-discipline programs, such as housing for health programs that combine aspects of housing, primary medical care, behavioral health, and case management. ClientTrack enables users to create their own unique forms, workflows, and data collection requirements. This allows administrators to tailor the software to fit the specific needs of innovative programs that include information intake on housing, employment, education, medical health, behavioral health, family needs, and a variety of other assessment areas.

In order to incorporate the social determinants of health into healthcare decisions, the information must be readily available. ClientTrack places critical information in the hands of all care providers through a shared platform that combines elements of case management and healthcare delivery. Having information from multiple disciplines in one location facilitates incorporating the social determinants of health into all medical decisionmaking. Care providers can adjust care plans to better match client needs and care being delivered elsewhere. Providers can also identify barriers to successful medical and social outcomes and identify appropriate resources to address the full scope of client needs.

LINKING PRIMARY CARE AND COMMUNITY SERVICES

Because information from multiple programs, agencies, and departments can be accessed across the ClientTrack platform, primary care providers are connected with their counterparts on the human service side.

ClientTrack can act as the primary system of record or integrate with other data systems, including medical EHR systems, to create a holistic patient health record that links information from primary care and community services.

Case managers, care coordinators, and healthcare providers stay informed as clients progress through a plan of care. Milestones and patient outcomes can be reviewed across a multi-agency coalition who are working together to ensure acceptable outcomes. Medical and behavioral health care providers can tailor care plans to the client's specific situation, incorporating aspects of care delivered through other channels.

ClientTrack keeps all interested parties informed on the client's condition with up-to-the-minute information delivered through a powerful reporting suite. Program dashboards provide a quick, at-a-glance view of program success while in-depth data drill-down is facilitated through Data Explorer, an ad hoc query tool that combines drag-and-drop ease of use with powerful data discovery capabilities. And for more formal data needs, ClientTrack includes a library of formatted reports, covering a wide range of agency needs.

Through data integrations, cross-discipline communication, and multiple levels of analytics reporting, ClientTrack keeps all providers informed and involved across the spectrum of care delivery.

CREATING A SEAMLESS JOURNEY THROUGH THE SYSTEMS OF CARE

Navigating multiple, overlapping systems of care can be a confusing journey for clients and providers alike. ClientTrack simplifies the care system confusion by housing information from disparate data systems and facilitating collaboration across the healthcare/human services divide. Both clients and providers have powerful tools at their disposal to keep them informed on aspects of the care journey.

Care givers have a powerful suite of convenient tools at their disposal to access and input information from virtually any location. ClientTrack is a cloud-based, natively mobile application, so care coordinators can access information, verify information accuracy, input new data, and run data queries from any location using a smartphone or tablet device. Whether conducting street outreach, operating a mobile clinic, performing field services, or working in a home health setting, the full application functionality is available. Having full program capability in a handheld device helps create a seamless client experience no matter the location, day of the week, or time of day.

The ClientTrack online portal is another tool that helps smooth the journey through the healthcare system. Clients can use the convenient online portal to update their status, review and upload forms, and perform check-in functions. Care coordinators and other providers can use the online portal for data sharing and collaboration. The online portal facilitates data-sharing through a secure, easily-accessible web location that clients and providers alike can access.

Naturally, all information in ClientTrack is safeguarded with HIPAA-ready security protection to protect sensitive information while still enabling the open collaboration between medical providers, human service providers, and case managers necessary to create a seamless journey through systems of care.

CONCLUSION

While many options have been proposed for improving this country's healthcare system, programs that facilitate the convergence of health and human services show great promise. These programs typically combine case management, human services, behavioral health, and primary medical care to address the social determinants of health that adversely impact population health.

Housing for health programs are one type of community-based program that has shown great promise. These programs provide supportive housing as a means to achieve better health outcomes. Once clients are placed in supportive housing they are better able to receive the necessary level of care and better manage health conditions. These programs have been proven to deliver better health outcomes and an improved patient experience at a lower overall cost, thereby achieving the IHI Triple Aim for healthcare.

Care coordinators are the linchpin of program success. Care coordinators help clients navigate complex systems of care, ensure medical services are received at the appropriate level of care and in the appropriate amounts, and oversee system cost and results. Programs that use care coordination as part of a comprehensive program to address the social determinants of health have a successful track record of financial, social, and medical outcomes.

Just as care coordinators are an indispensable part of the improvement process, a full-featured care coordination platform is indispensable to the work of a case manager. ClientTrack delivers a care coordination platform built for the collaborative nature of innovative, cross-departmental programs that span health and human services.

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