CPCPracticeSpotlight65

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Social Worker Contributes to Collaborative, Team-based Care Management

Stillwater Medical Physicians Clinic, Stillwater, Oklahoma; single-site group; 9 providers; 10,484 patients

Feb. 19, 2016

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care and Population Health
- 1.3: Risk-Stratified Care Management
- 1.5 Coordination of Care Across the Medical Neighborhood

CPC Change Driver 2: Use of Enhanced Accountable Payment

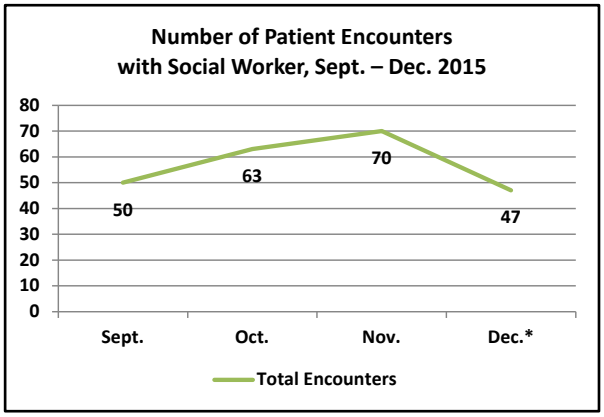
- 2.1 Strategic Use of Practice Revenue

CPC Change Driver 3: Continuous Improvement Driven by Data

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In 2015, the care managers at **Stillwater Medical Physicians Clinic** worked with providers to determine the patients who physicians thought could have benefited from the assistance of an in-office social worker. After reviewing the data, they decided that adding a social worker would round out the care management team's expertise and ability to address patients' non-clinical needs. With the support of all nine providers, leadership approved the new position.

Innovation: When recruiting for the new social worker position, finding someone who would fit well and contribute to a cohesive care team was important, shares **Elizabeth Wilbourn, RN, care manager lead**. The hiring process included peer interviews and meeting the care management team. **Tonya Ingram, MSW,** started in July 2015, working in the clinic on Mondays, Wednesdays and Fridays from 8 a.m. to 3 p.m.



*This graph shows the number of patient contacts Ingram has had with her three-day-a-week schedule in the clinic. *Note: Ingram was out of office part of December.*

Broadening care – Having a social worker on the care management team enables Stillwater to provide non-nurse driven services that the care managers struggled to manage. Ingram connects patients to community resources, such as food banks, housekeeping and meal delivery, counseling and support groups, and caregiver respite. Her training lets her address some behavioral health issues, such as using motivational interviewing to encourage patients to seek help for substance abuse. Ingram assists patients with filling out various applications, and she follows up on resources that patients are referred to, such as assisted living and prescription financial assistance. She helps overcome any roadblocks patients experience accessing these resources. Further, she conducts home visits, often in conjunction with a care manager. Stillwater is also exploring how to add Ingram's social work expertise to the depression screening process for helping patients with positive PHQ-9s but who don't have a current behavioral health diagnosis.

Much of the assistance that Ingram gives patients focuses on connecting them with resources they need before issues develop into medical emergencies. For example, Ingram worked with a patient who had behavioral health concerns and who could not use the community clinic. He was also unable to keep employment and was uninsured, which prevented him from getting the medications he needed. Ingram intervened with the community clinic and worked with them so she could pick up the maintenance medications on his behalf, and then she personally delivered the medication to him. Ingram also coordinates community resources to help lower-income patients fill basic needs that are hindering their ability to self-manage their health. For example, a low-income patient with chronic conditions was struggling to pay for food and medications. Ingram helped the patient apply for disability, food stamps and Medicaid assistance. Taking care of basic needs lowered stress for the patient and helped her focus on her health.

Creating a team – When she joined the clinic, Ingram was actively involved in developing the process for how her role as social worker would integrate into the care management workflow. Through conversations about the goals for her position and the current care management workflow, they added referrals to her as an option for care managers when they identify a patient who needs assistance or resources that a social worker can best provide. Sometimes these referrals result in immediate action, such as Ingram joining a patient visit to address an emergent issue. Other times, Ingram follows up with a phone call or by scheduling an appointment with the patient. In the beginning, Ingram was working with patients already under care management who needed additional resources. However, as providers witnessed the resources Ingram can provide patients, they began directly referring patients to Ingram when they identify a one-time need that does not require ongoing care management for the patient. Physicians give Ingram's business card to patients and encourage them to call her, or providers can create a message in the EHR asking Ingram to follow up with a patient.

Additionally, Ingram maintains a library of resources at her desk that care managers can access when she's not there. If she knows a patient is coming when she will be out of office, Ingram prepares a packet of resource information for the care manager to go through with and give the patient. Ingram also networks with the hospital social worker to learn about and share new resources and updated information.

Tracking – Ingram tracks the number of patient contacts she has, as well as resources and follow-up for each patient. Data includes a running total of patient encounters, as well as the number of new patients she works with each month.

Takeaways: A social worker's expertise can complement the clinical expertise of the care managers, enabling the team to provide person-centered care that addresses patients' non-clinical needs that are affecting patients' health priorities or access to care. Having Ingram in-office allows the care management team to seamlessly provide support and connections with community resources and to promptly address emergent issues.

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