CHaSCI
Center for Health and Social Care Integration

The National Center
for Complex Health & Social Needs
An initiative of the Camden Coalition

TELE-SOCIAL CARE:

IMPLICATIONS & STRATEGIES

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Social determinants of health are increasingly being recognized as important for health care to pay attention to.

These conditions in which we live and age can be protective and associated with positive outcomes (e.g., having stable housing or supportive social connections), or they can be detrimental to one's health and wellbeing. In the latter case, social determinants are known as *health-related social risk factors*, and when experienced at the individual level, as *social needs*.

Social care – a broad term that refers to activities that prevent and address health-related social risk factors and social needs – is a core component of caring for people's health.

It includes activities such as providing navigation around community resources, engaging individuals at risk for isolation and loneliness, or providing comprehensive care management that is attuned to social and mental health needs and their impact on one's wellbeing, health, and ability to follow one's medical care plan. There are an increasing number of resources to support best practices in social care provision, including core competencies for frontline complex care providers.

As part of the transition to telehealth prompted by the COVID-19 pandemic, many health care institutions are also transitioning their social care activities to tele-social care.

This brief highlights strategies and implications for delivery of social care activities via telephonic or virtual video-based platforms, with a focus on care management. It is informed primarily by the experience of social work and nurse care managers at the *Camden Coalition of Healthcare Providers* (Camden, NJ) and *Rush University Medical Center* (Chicago, IL).

This brief complements other previously-developed materials on telehealth and social needs, such as the *Center for Care Innovation's* toolkit on Telemedicine for Health Equity and the *CDC Clinician Outreach and Communication Activity's* Telehealth & Health Equity webinar.

Table of contents

Implications of tele-social care: Benefits and drawbacks

Benefits

- May increase access to care for people who are busy (e.g., caregivers, people who work full time) or by decreasing barriers to accessing care (e.g., make it easier for people who live far away from clinic).
- Efficient: inexpensive to deliver, less time traveling to in-person visits.
- If using video platform, adds extra benefit of having visual cues on one's home environment vs. meeting in the clinic.
- Some sense of intimacy from telephonic discussions; people may disclose things that feel harder to say in person.

Drawbacks

- May decrease access to care for those who have limited access to cell / internet service, limited access to devices, or limited proficiency in using them.
- Can be hard to assess complexity of care needs.
- Can feel hard to build rapport or get to point of individuals feeling comfortable disclosing sensitive topics if you haven't met in person.
- Some people multi-task in conversation with you and may be less engaged/present.
- Less visibility of your intervention with the care team if provided off-site or not documented within EHR.
- Privacy and security concerns with some communication channels.

Considerations for program planning & administration

There are several considerations and strategies program leaders can use for planning and administering tele-social care programs:

Build local partnerships and programs to address evolving needs and support self-management of health.

- The pandemic has exacerbated issues such as resource needs, anxieties, social isolation, loneliness, and ability to follow one's medical plan of care. Make sure your program is doing as much as it can to directly provide relevant resources and telephonic and virtual programming, and/or to build partnerships with community-based organizations that can address such needs.

Be thoughtful about caseload expectations for care managers and navigators.

- Many institutions are experiencing pressure to gain efficiencies or increasing referrals corresponding with increasing social needs.
- Be clear with your team on expectations for caseload management and build in some flexibility for complex cases that may not be able to be "terminated" within your timeframe.
- Use longitudinal care management to maintain relationships, even if you have shorter interventions each time someone is referred.

Strategically identify patients to focus on.

- For instance, proactive tele-social care with patients who have not recently engaged with care can help increase access to care for isolated individuals. Or, proactive tele-social care with patients identified as rising risk due to previous diagnoses and social risks may help avoid exacerbation of illnesses, as people may have a harder time managing their chronic conditions due to economic and access-to-care challenges.
- Certain patient populations may be eligible for specific visit types or benefits (e.g., certain payers reimbursing for telephonic check-ins, or grant funding supporting digital literacy navigation for older adults).

Intervention depth and duration may need to be adjusted for telephonic delivery.

- Depending on your intervention protocol, it may not be ideal for telephonic delivery.
- For instance, recognize that assessments that were once completed in person may be too long or not appropriate to carry out telephonically, and adapt accordingly.

Pay attention to staff well-being.

- Telephonic engagement may create tension and anxiety for staff compared with face-to-face interactions, in addition to other stressors that individuals are experiencing during the pandemic in their personal lives and stressors from organizational pressures.
- Provide regular clinical supervision or structures for peer consultation.

Have regular touchpoints as a team.

- Maintain team comraderie via regular touchpoints, e.g., 15-minute daily huddles, to plan for the day's work, troubleshoot programmatic barriers, share successes, and share personal updates.

Maintain effectiveness via quality assurance and improvement efforts.

- Quality assurance processes such as call monitoring or documentation review can gauge depth and fidelity to clinical intervention.

Tips for frontline providers: Preparing for successful interactions

There are a number of strategies that frontline tele-social care providers can utilize to improve their success, starting with intentional preparation:

Include both formal and informal touchpoints in your intervention.	• Assessment calls are one formal part of most intervention protocols. • Brief update / check-in calls can maintain rapport and gauge progress.
Anticipate and mitigate privacy concerns for both parties.	• Are you confirming with the individual that they are in a quiet, private space to discuss sensitive topics if necessary? • Are you ensuring their protected health information is secure and out of reach of anyone else in your household?
Plan ahead and be explicit when working with interpreters.	• Tell them who you are hoping to reach and what to do if someone else answers the phone. • Provide them with information about what to say in a voicemail.
Leverage a variety of communication mechanisms.	• Ideally, programs can supplement majority telephonic engagement with in-person or virtual video interactions, or with text reminders.
Try to use your work phone whenever possible.	• Due to the prevalence of spam calls, individuals may not answer an unknown number. • Specialized telecommunications services can personalize your caller-ID to look like you're calling from your office phone.
Protect your personal cell phone number.	• Dialing *67 or using Google Voice is a helpful way to protect you and your cell phone number (if it's approved by your organization's compliance policy), but the individual you're calling won't know the institution you're affiliated with.
Translate self-awareness to telephonic interactions.	• Before and during an interaction, ask yourself, what am I bringing to this interaction and how does that affect my ability to engage with this individual?

Have a plan for crisis management.	• Be prepared to initiate a 3-way phone call with 911, a mental health crisis line, or mental health clinician on your team. • With individuals anticipated to be at high risk due to chart review or reason for referral, line up a colleague prior to call to be on alert for real-time consultation or involvement. • If you are concerned, identify location at beginning of the call and ask exploratory questions to understand supports in a non-punitive way, *e.g., "Is there anyone there with you who can support you right now? We want to make sure you are safe", or "Great that your mom is downstairs; in case we get disconnected, would you mind sharing her phone number with me?"*
Have clear call and voicemail protocols.	• Be clear on how many call attempts you'll make, whether to leave voicemails, and what number they can reach you at. • Follow typical best practices regarding not leaving details other than your contact information in the voicemail.
Encourage warm handoffs as much as possible.	• Communicate with referring providers regularly and encourage them to explicitly discuss with the patient the reason they are referring and what to expect for follow-up. • Ideally, the provider will give the individual your contact information, so make sure they have your correct card, flyer, or contact information.
Anticipate technology issues.	• Do a dry run through with a colleague before using a video platform. • Think about how to adapt the normal protocols and how to talk with someone through technology issues or what the Plan B is if a call/interaction cuts out (calling back, etc.). • Think about and plan for issues or confusion that may arise from a telephonic consultation with no visual information.
If you are engaging with individuals via a video platform, offer additional guidance on how to access it.	• Some sites use volunteers or "digital navigators" to assist with telehealth appointments. • Rush Generations, which runs several health workshops and support groups, created older-adult-friendly Zoom and Facebook access guides for its participants.

Tips for frontline providers: Strategies for effective social care interactions

There are a number of strategies that those who provide tele-social care can utilize to improve engagement and impact when interacting directly with individuals:

Set expectations.	• Be upfront about the anticipated length of your interaction and what content will be discussed.
Reinforce connection with trusted / referring group.	• Clearly state upfront how you got the individual's contact information (referring group), how you work with the trusted organization / provider, and your connection with the local community.
Break the ice.	• Acknowledge challenges and awkwardness of telephonic or video interactions up front.
Foster empowerment.	• Ask for the individual's permission to get started. • Invite and answer any questions throughout.
Ask how people prefer to receive information.	• Ask if they prefer handouts and paperwork via mail or email. • Ask if they also want information delivered verbally either over the phone or via video. • Ask if they'd like a trusted individual to join your discussion.
Leave space for relationship building.	• Caseload pressure or awkwardness over the phone may make it tempting to rush through and check off boxes vs. focusing on relationship-building, which is more important now than ever. • Take your time. Building relationships is incredibly important and we may be the only person the patient has been in contact with in some time. • Use of informal touchpoints is critical to explore ambivalence, validate emotions, check on progress with a goal, and mitigate against social isolation.
Read people's "sound" language.	• Listen for tone, hesitation, distraction – these are valuable cues that can replace body language cues. • Be okay with silence and resist jumping in to fill the void. • Take note of what you are not hearing the patient say (use in replacement of in-person body language cues), ***e.g.,*** *"I suggested something and you paused for a bit."*

Connect individuals with resources and programming to address social needs.	• Resource navigation, troubleshooting ambivalence, and connection with social support or health education programming may be part of your program's typical intervention protocol. • Make sure to assess individuals' and families' needs and follow your intervention protocol, paying particular attention to social needs, anxieties, isolation, and loneliness, which have all been exacerbated by the pandemic.
Leverage three-way calls with benefit providers such as social security, Medicare, or Medicaid.	• Many benefit providers will not speak to social care providers without the individual's permission. • Calling together can address this while also modeling how the individual can call on their own in the future.
End call with a summary.	• At end of each call, summarize what you discussed. • Recap next steps / when to expect next call.

Tips for frontline providers: Useful follow-up practices

Post-interaction documentation and follow up are important to maintaining cohesive and timely ongoing care:

Make sure to document.	• Please remember to keep careful notes and to allow yourself extra time to document between tele-visits.
Timely follow-up communications.	• Follow up using whatever format is preferred by the individual: call, message within your Electronic Health Record (EHR), postal mail, text message, etc.
It's okay to call back.	• If you forget to touch on something during your call, it's okay to call back for more information! This is one benefit of tele-social care.
Leverage informal touchpoints.	• Use regular, informal touchpoints to reinforce action steps.

Looking ahead: Sustainability and research needs

Sustainability avenues for health and social care integration activities are challenging in general, and those challenges persist within tele-social care activities. Most tele-social care programs rely on grant funding, which does not enable consistent funding across time or equal access across geographies. The move toward value-based and capitated payments has opened the door for many health systems, clinics, and community-based organizations to provide social care as a way to improve health, reduce unnecessary utilization, and improve quality outcomes.

However, the return-on-investment of specific health and social care integration activities remains hard to identify.

More often than not, multiple interventions are provided at once, making it hard to pinpoint the value-add of a given component (e.g., care management that connects individuals with emergency utility support while also helping troubleshoot challenges with securing medications, connecting with chronic disease self-management education, and providing them with stress-management strategies). Data on total cost of care outside of a particular health system is hard to secure, and the "wrong-pockets problem" is widespread. Moreover, for complex health issues to be mitigated, we also need societal-level issues such as a lack of affordable housing to be addressed in order to fundamentally change what enables populations' health and wellbeing.

As a result, many healthcare leaders remain skeptical of the business case for them investing in individual social care integration initiatives.

In many cases, when they do invest operational funds in social care initiatives, it is viewed as a pilot or is only available for a small portion of the population, is not fully effectively integrated within the EHR, and does not receive the attention needed to gain medical provider buy-in. Mergers between health systems or organizational consolidation also threaten the sustainability of social care integration supported by operational funds. Finally, social care investments are often not carried out in alignment with community-based providers who generally have expertise and service lines already built, and who rely on philanthropic grants or underfunded government resources in order to support the communities they serve.

For health systems still operating within a fee-for-service billing environment, public and private payers may or may not reimburse for social care integration activities, or the operationalization of billing for those codes may be too prohibitive to be useful.

For instance, Medicare reimburses for Chronic Care Management, which is billable by physicians, nurse practitioners, and physician's assistants, but services provided by "clinical staff" can count toward the billable services. This includes phone calls to ensure individuals have the resources and support needed to manage their chronic conditions. However, obstacles to full utilization of these codes to support social care initiatives include documentation burdens on the billing provider, a lack of clarity from Medicare on who counts as "clinical staff," and the billable services being subject to cost sharing with patients rather than recognized as a preventive service.

Another example from Medicare is the Health and Behavior Assessment and Intervention code set, which recognizes care that supports emotional and psychosocial concerns that arise because of a medical condition. Many social care interventions would be appropriate for these billable services; however, the codes are only billable by psychologists and psychiatrists, which have significantly smaller workforces than social workers, and thus many beneficiaries cannot access those services.

The distinctions between different fee-for-service billing codes can fragment care, create burdens for documentation, and serve as a barrier for providing person-centered care that builds on relationships.

For instance, if part of a tele-social care interaction with an individual is troubleshooting access to home-delivered meals to follow their heart failure care plan, and another part is coordinating with a physical therapist and securing caregiver respite after an unrelated recent fall and hospitalization, some time from that interaction would be eligible for Chronic Care Management while other time would be more appropriate for Transitional Care Management. Social care integration programs need to identify processes within their EHR for tracking and billing these respective services, and secure revenue from the billing clinic leadership to support their team's ongoing efforts.

It's worth noting that some states reimburse community health workers directly for their work, rather than reimbursement going through a medical provider. However, these opportunities are often narrow and not consistently available, as they are only available via State Plan Amendments and waivers upon approval by the federal government.

Finally, significant implementation research is needed to identify the impact of diverse tele-social care initiatives, and of social care integration more broadly.

As noted in the National Academies of Sciences, Engineering, and Medicine study, telephonic social care integration initiatives such as the Bridge Model of transitional care have demonstrated successful outcomes such as increasing post-hospitalization follow-up visits and improving patient outcomes. However, additional outcomes and implementation research is needed to address sustainability concerns as described above and to hone interventions to maximize return-on-investment and benefit for those populations who can benefit most from social care.

About the Center for Health and Social Care Integration

The Center for Health and Social Care Integration (CHaSCI) is an applied think-tank housed at Rush University Medical Center, an academic medical center on the near West Side of Chicago, IL. CHaSCI works to reduce inequitable outcomes in health and well-being in Chicago and across the country by advancing practices and policies that break down barriers to health in order to create a system that addresses the unique health and social needs of individuals and those who care for them — while also moving upstream to minimize those needs and inequitable outcomes in the first place.

CHaSCI advances our mission by providing direct training, technical assistance, and educational opportunities, as well as by facilitating diverse working groups to advance systems change needed to integrate care and reduce inequitable outcomes.

About the Camden Coalition of Healthcare Providers

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and wellbeing. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals in Camden and regionally.

The National Center for Complex Health and Social Needs (National Center), an initiative of the Camden Coalition, connects complex care practitioners with each other and supports the field with tools and resources that move complex care forward. The National Center's founding sponsors are the Atlantic Philanthropies, the Robert Wood Johnson Foundation, and AARP.