Community in Primary Care Model
NASW – Michigan Chapter

Achieving better health, better health care, and reducing costs by integrating community supports into Michigan’s primary care system.
The National Association of Social Workers (NASW) - Michigan Chapter views social workers and community health workers as key contributors to the health care system by linking community to existing health and social service delivery systems, resulting in improved health outcomes and reduced costs for vulnerable populations. In 2014, NASW - Michigan released, “Better Health, Better Health Care, and Reduced Costs: Integrating Community Supports into Michigan’s Health Care Systems,” which provides the foundation for the Community in Primary Care (CPC) model with the goal of a pilot project, followed by statewide implementation.

The CPC model is designed to operationalize primary care as an integrated community-based system of health and human service delivery that utilizes the specialized skill set of social workers and community health workers to address the social determinants of health. While much can be accomplished through retooling the existing delivery system, achieving the Triple Aim of better health, better health care, and lower costs will require transformational change.

CPC works to achieve the Triple Aim by putting social workers inside of the primary care clinic, working directly with physicians and as part of the interdisciplinary team, to address the social determinants of health. Community health workers work side by side with patients helping them to navigate systems and carry out the care plan developed by the social worker. The CPC model takes primary care beyond the traditional four walls of the office and into the community to overcome barriers to better health. While working with the community health worker, social worker, nurse, clinical provider, and other team members, the patient is connected to services that address physical, social, and environmental aspects of their health.

The CPC model is not about substituting or replacing medical care positions with social support personnel; instead, it is about re-envisioning the functionality of care team members to serve the patient as a whole person through the continuum of primary care service delivery. A new, re-oriented system must address social determinants of health through a primary care workforce – including social workers and community health workers – that bridge existing systems of care and impacts the health of the whole person at the community level.

BACKGROUND

Medical care by itself cannot address the disparate health outcomes impacted by social determinants. Shortfalls in health care account for about 10 percent of early deaths, while genes, social circumstances, and behavioral and environmental factors account for the remaining 90 percent. The goal of the CPC model is to address these other factors. CPC brings a renewed emphasis on primary care as a comprehensive health and social service delivery structure that reaches beyond the clinical setting. By connecting neighborhoods, homes, community and social resources, physician offices, clinics, and hospitals, CPC will improve health, reduce disparities in population health, and help control the costs of care.

THE CPC WORKFORCE

The CPC allows for rethinking who is on the health care team delivering primary care services and support and does not require new training. A core principle of patient-centered, community-based health care delivery for vulnerable populations is whole person care. This requires a retooled workforce that integrates social workers and community health workers into an interdisciplinary team that can include registered nurses, nurse practitioners, physician’s assistants, physicians, disease-specific coaches, psychologists, psychiatrists, and other health professionals to address the needs of an individual.
These professionals are then able to practice at the top of their credentialing to address health issues and social needs. By reorienting primary care in the context of the community, providers can begin to serve patients on a continuum of care that serves the needs of patients beyond the four walls of the doctor’s office. This model also provides a potential solution to the continued shortage of primary care physicians.

**Social Workers**

Social workers in primary care settings and as members of interdisciplinary teams have been shown to decrease depression and anxiety among patients, improve the overall quality of life for patients with advanced cancer, increase social activities of chronically ill seniors, and reduce mortality in older adults. With CPC, social workers provide on-site direct services as needed, brief crisis intervention, case management, and lead the community health worker team. Social work is a profession devoted to helping people function the best they can in their environment. The phrase ‘in their environment’ points to a distinguishing characteristic of social work—one that sets it apart from other helping professions. Social workers empower clients to deal not only with how they feel about a situation but also with what they can do about it.

**Community Health Workers**

Because of the connection to their communities, the role of community health workers in CPC is to serve as liaisons or links between community members and health and social service systems, improving the quality and cultural competency of service delivery. Community health workers can support patient efforts to comply with medical advice, use their prescriptions appropriately, and operationalize positive health changes. In Michigan, community health workers have helped community residents successfully manage chronic disease, reduce depression, develop healthier lifestyles, improve maternal and child health, improve rates of preventative screenings, and improve access to, and use of, health care services. Community health workers are primed to connect patients in the community to patient-centered care.

**COST SAVINGS AND IMPACT**

Studies have shown social worker participation on interdisciplinary primary care teams save an average of $90 per patient. Social workers offset costs by maximizing medical staff time and increasing efficiency of systems as well as improving timeliness and effectiveness of patient discharge.

Community health worker interventions have demonstrated significant return on investment results, ranging from $2.28 to $5.56 of savings for every $1.00 invested. These interventions have worked with patients in various social situations and in multiple systems of care, pointing to the need to connect patients to people and resources on a continuum of care, not just within a singular system.

Although data is limited, it is expected that the combination of social workers and community health workers in a team-based health intervention approach to primary care will further reduce cost and have a substantial impact on health outcomes. It is the intent of a CPC model pilot to demonstrate these outcomes.

**WHY NOW?**

With too few primary care practitioners, the Affordable Care Act requirements taking effect, and with patient-centered initiatives on the rise, now is the time to incorporate social workers and community health workers into the structure of
primary care, extending the reach and efficiency of primary care into homes and communities. Social workers and community health workers build relationships with patients that assist care teams in the establishment of a connection point between home and clinical office.

Access to physician office visits has not been enough to improve their health. The following case is an example of someone who would benefit greatly from the CPC model and demonstrates the complexities of patients facing chronic health conditions:

“LS is a 75 year old male who first came to the clinic for a hospital follow-up after being found to have acute exacerbation of COPD and pneumonia. He is an illiterate man who moved to Michigan from Tennessee and who had been trying to manage his health issues on his own without much success. Our first meeting [patient and physician] immediately made it clear to me that he is a patient that will require a lot of hand holding and guidance due to his inability to thoroughly comprehend his disease processes.

LS was only hospitalized about twice a year between 2006 and 2012, when it became apparent that he also had Diabetes, Congestive heart failure, coronary artery disease, chronic pain and chronic kidney disease stage 3. He visited the Emergency Department (ED) at least 20 times in 2012, resulting in 15 admissions. We always saw him within 1 week of discharge but somehow could not manage his fluid and respiratory status enough to be able to keep him out of the hospital.

We started requiring him to be seen on a biweekly basis and then extended that to a monthly basis starting in late 2012 and this achieved the goal of decreasing his re-hospitalization rate. He had 5 ED visits in 2013 and no admissions. During his monthly visits, we talked to him about his disease processes and educated him and the effects of his lifestyle choices on them.

He married his longtime girlfriend in mid 2014 and, since then, he has had more ED visits and admissions. When pressed for information it became clear that this is partly due to lack of funds to have proper nutrition, heat in his house, and general financial distress due to losing his wife’s social security check when they married.” –provided by Mid-Michigan Physicians Group

The CPC model could have a significant impact on this patient. Upon request by the physician, the social worker would meet with LS in the primary care location, establish a relationship, and develop a treatment plan. The treatment plan would then be carried out, with the assistance of a community health worker, in the familiarity of LS’ community. This ensures the multidisciplinary team of physician, nurse, specialists, etc. can accurately assess the needs of the patient with consideration of the social determinants of health. By having a community health worker within the community, working with the patient, important information is gained and can be incorporated into the treatment process.

CONCLUSION

The existing system of primary care in Michigan fails to deliver services where people are located. The above case example illustrates how the current system does not employ a workforce that can reach people impacted by the social determinants of health. With CPC, services function as an integrated system, connecting the primary care office with the patient and community.

Michigan, through this model, has the opportunity to achieve the Triple Aim by:

- operationalizing primary care as an integrated community-based system of health and human service delivery;
- defining the workforce providing services for vulnerable populations to include social workers and community health workers;
- and by making the case for a sustainable payment policy that reimburses community support professionals for their contributions to the health and social service delivery team through payment mechanisms such as Medicare, Medicaid, and private insurance.