Coordination, Integration and Collaboration:
A Clear Path for Social Work in Health Care Reform

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Presented at a Congressional Briefing on the Implications of Health Care Reform for the Social Work Profession
Washington, DC
February 16, 2011

I want to commend Congressman Towns, Members of the Congressional Social Work Caucus and everyone who joined us today for your attention to the implications of health care reform for the social work profession.

The need for change in our health care delivery system is well known, well researched, and well documented by people inside the field and out. The Affordable Care Act (ACA) creates a framework for addressing that need through innovative programs and policies that shift health care's attention from acute, disease-focused episodes to person-centered, coordinated care. We recognize the enormous opportunities afforded by the ACA to improve and expand the continuum of care to include more chronic care and focus less on acute care.

The National Coalition on Care Coordination (N3C), is a coalition of 40 national stakeholder groups representing leading aging, health care, family caregiver and social services organizations. It was founded and is co-chaired by Patricia Volland of the New York Academy of Medicine and myself through the American Society on Aging. The Coalition participated in the negotiations leading up to the passage of ACA, advocating for a focus on better care coordination for those with multiple health and social needs and a recognized role for social work in providing those services.

Social workers are ideally educated and positioned to address the challenges of health care reform's shifting focus, enhancing the quality and efficiency of health care delivery systems, particularly for the nation's most vulnerable populations.

Our current health care delivery system can be described in one word: fragmented. Older adults and others with chronic conditions receive health care in fragmented settings, from fragmented providers, funded by fragmented payment systems.

One older adult can receive care in a number of settings: home, primary care or specialty care, hospital, emergency room, and nursing home and residential care. At each of these settings, the older adult encounters multiple providers, with each provider facing challenges unique to their care setting, discipline, and therapeutic

goal. Meanwhile, each older adult experiences non-medical life circumstances that impact their ability to adhere to their medical plan of care. The often complicated health and social needs of older adults combined with a variety of settings at which they receive services demand a system-level rethinking of how care is delivered.

Paying for the services accessed in multiple settings from multiple providers adds an additional level of complexity. Many services are available for older adults, but the systems for funding and providing these services are not unified. Health care for this population is funded through Medicare, Medicaid, private health insurance, and private payment. Long term care is paid through Medicaid, private payment and long term care insurance, and a patchwork of federal, state, and local funding through the Administration on Aging and various titles of the Social Security Act. The two "systems" are internally disorganized and do not communicate well with each other—much less with the "outsiders," the beneficiaries for whom the services are intended.

This fragmentation puts vulnerable older adults and their caregivers at increased risk for declines in health and functioning, unmet psychosocial needs, unnecessary health care costs, and needless suffering. Attempting to navigate the rules, regulations, and nuances of our multi-faceted health care system can leave even the most savvy clients and caregivers exhausted, burned out, and defeated.

The Affordable Care Act provides the opportunity for a radical shift in the way we care for patients and their families because it recognizes that the *patient* should be at the center of medical care. One way the ACA will do this is to shift the priority from episodic acute care to incentivized comprehensive care across an entire continuum. Meeting this challenge requires improved coordination of care over time and across multiple settings provided by professionally educated social workers who can act as a bridge between the outdated medical model and the social model.

Social workers have a significant impact on the quality of life of patients as they participate in the health care system. Social workers are educated and trained to look at the whole person, broadly assessing how that individual, within the context of their support system, are faring medically, socially, psychologically, functionally and economically. They are aware of services in the community, know how to access them, and understand how to enhance the usefulness of these services for optimal client support in the community. Yet social workers' unique role—and a variety of functions—in meeting and improving health and welfare—is not understood and is generally overlooked and undervalued by many policymakers, and as a result, payers.

The Affordable Care Act creates several programs based on promising models for improving care in which social work should be playing a key and vital role.

Readmissions (Section 3025) and Community Based Care Transitions (Section 3026)

Programs to reduce hospital readmissions, and support transitions from hospitals to communities are key. In a 2008 study, Arbaje found an association between post discharge environmental and socioeconomic factors—such as living alone, having unmet functional needs, having limited formal education, and lacking self-management skills—and higher hospital readmissions within 60 days. In a 2009 Mathematica Report, Brown noted that care coordination must address both medical and psychosocial aspects of care to be effective.

Social work's contribution to preventing readmissions and supporting transitions from the hospital to home are evident in the outcomes of programs such as Rush University Medical Center's Enhanced Discharge Planning Program (EDPP). EDPP provides telephonic short-term post-discharge social work services to older adults at risk for adverse events after an inpatient hospital stay. This social work-based transitional care model places equal importance on psychosocial factors impacting health outcomes, particularly for our most vulnerable older adults. EDPP social workers focus on forming collaborative relationships with existing

health care and community-based providers to prevent adverse events, improving knowledge of the health care system, and promoting health and quality of life. The EDPP social worker can identify and eliminate barriers, keeping complications from becoming catastrophes.

As a result of this social work-based intervention, older adults show statistically significant increases in an understanding of their medications, decreased stress over managing their health care needs, and improved communication with their physicians post-discharge. In addition, older adults schedule and attend their follow-up medical appointments more than peers not receiving this intervention. Another remarkable finding is that fewer older adults died within thirty days of their hospital discharge in EDPP intervention group during this randomized control trial of the model.

EDPP analysis contributes to an evidence base for care coordination, strengthening the case for social work's integration into medical care and outlining a process by which it can be provided.

We have also joined with many home and community based agencies to create the Illinois Transitional Care Consortium where hospitals are both reaching out to the

community and the community is reaching into the hospital to bridge the silos and create a coordinated continuum of care.

Similar innovations are seen in other health care reform efforts.

Independence at Home (Section 3024)

The Affordable Care Act influences more than inpatient hospitalizations. It extends into the home through primary care based programs such as the Independence at Home Medical Practice Pilot Program. This program tests a payment incentive and service delivery model that utilizes home-based primary care teams to reduce expenditures and improve health outcomes in the provision of items and services. Coordinated care will be imperative to make this pilot a success, and thus social work is imperative as well.

Patient Centered Medical Homes and Interdisciplinary Community Health Teams (Section 3502)

The Patient Centered Medical Home is an approach to providing comprehensive primary care that involves partnerships between patients and a team of physicians and other professionals to address patient needs. One of the keys to this is a team approach while keeping the patient and family at the center. Through ACA, Interdisciplinary Community Health Teams (3502) will be established to support medical homes.

Social workers should be a key player on these community health teams. Social workers bring advanced assessment skills to identify each patient and caregiver's unique environmental and psychosocial needs, values, and preferences. These non-medical factors often go unattended in primary care settings, but they have a significant impact health outcomes and quality of life.

The inclusion of social workers as part of the community health team will bring heightened awareness of these non-medical factors to improve the overall quality of care provided in this setting. The presence of a social worker to intervene around these non-medical barriers will also allow other members of the interdisciplinary community health team to focus on their specific areas of expertise. Moreover, the profession's ecological framework guides us to assess within the context of environment and to intervene on both individual and systemic levels. As a result, patients and caregivers will be better supported and more able to navigate the complexities of the health care system with the social workers' assistance.

Chronic care coordination, discharge planning, and mental health referrals will all be parts of this important Patient-Centered Medical Home. The nature of these challenges, and the suitability of social work skills to meet these challenges,

accentuate the need to recognize and support the vital role that social workers can and do play in this coordinated preventative model.

Accountable Care Organizations (Section 3022)

Section 3022 of the Affordable Care Act extends beyond individual primary care offices to create a network of multiple health care professionals from different disciplines and practice areas. These Accountable Care Organizations (ACOs) will be created in response to increasing agreement on the need for local accountability for quality and cost across the continuum of care. High quality of care, especially for those with serious and chronic conditions, will require coordination and engagement across settings and specialties.

As part of this program, ACOs must demonstrate their adherence to patient-centeredness criteria. Patient and caregiver assessments, individualized care plans, care across transitions and chronic care management for high-volume or high-cost chronic diseases will all be part of these criteria. These important tasks are perfectly aligned with social work skills and knowledge, and processes have already been created for delivering these services. Social work involvement in programs to assist with patient activation like the evidence-based Chronic Disease Self-Management Program and the related Diabetes Self-Management Program can help ACOs meet their requirements.

CMS Innovations Center

The time for change has come. The programs above acknowledge that fact, as does the CMS Innovations Center, a cornerstone of the Affordable Care Act. This Center is charged with rapid testing and evaluation of new delivery models designed to foster patient-centered care, improve quality and slow the rate of Medicare cost growth. The Center will evaluate coordination, patient-centered care, and team-based approaches, with an eye toward less bureaucracy and greater quality. The examination of social work's role within these care coordination activities and interdisciplinary teams should be a priority for the Innovations Center.

Opportunities to Expand the Number of Specially-Trained Social Workers

The ACA provides numerous opportunities for health care workforce development**.** The Social Work Leadership Institute (SWLI)of the New York Academy of Medicine, has as its primary focus addressing the current shortage of social workers who work with older adults, could be a great partner with the federal government in ensuring that there are adequate numbers of appropriately-trained social workers with specializations in geriatrics and increasing competencies among social workers caring for older adults. We recommend that the field of social work be recognized and included on the National Health Care Workforce

Commission and that social work training is supported by grants provided to states under the State Health Care Workforce Development Grants.

As a result of The Institute of Medicine's critical report "Retooling for An Aging America: Building the Healthcare Workforce", the Eldercare Workforce Alliance (EWA) was established. A group of 25 national organizations, joined together to address the immediate and future workforce crisis in caring for an aging America.

Both groups applaud the new, innovative models of care emerging from health care reform because they have a great potential to entice social workers to work with older adults and thus expand badly-needed capacity in this area.

Establishing a Role for Social Work in an Appropriately-funded Continuum of Health Care

Social work's contributions are evident in hospitals and communities across the nation. They can be seen in well-supported older adults and caregivers in every one of our neighborhoods. And while the valuable contributions social work could make to the implementation of the Affordable Care Act have been established, the roles have not been made explicit. Social workers, with their skills, education, and perspective, could be and should be integral in patient and caregiver assessments, care planning, prevention and wellness programs, and patient and caregiver education and activation.

Roles for social workers, however, need to be thoughtfully and sustainably developed. Social workers are a critical component of health care, but provision of social work services cannot be an unfunded mandate. The profession's contributions to health care's bottom line, such as reductions in unnecessary health care utilization and promotion of wellness, need to be financially acknowledged through the funding of new health care positions for social workers.

Social workers have the power and potential to build and influence the creation of an ideal health care delivery system – a collaborative system of care based on a continuum of services that is both integrated and coordinated, cuts across the payment silos, and has the older adult and the family at the center.

Thank you!