

SOCIAL WORK'S ROLE IN HEALTH CARE REFORM SUMMARY

In the coming decade, the Patient Protection & Affordable Care Act of 2010(PL 111-148) is expected provide over 31 million people with access to health care insurance who previously did not have access. In the near future, the federal government will be issuing regulations for its implementation. At this time social work has an opportunity to be part of the design.

The Affordable Care Act (ACA) seeks to improve the quality of health care in several ways: 1) it provides all citizens with health insurance, which closes loopholes that kept some clients out of the health care system, 2) it reinvents primary care, and 3) it calls for “community-based multidisciplinary medical homes” that are inclusive of physical and behavioral health care needs. This is patient-centered primary care, which includes prevention and wellness as core concepts, considers the client’s family and the community in health care access and delivery. This philosophy acknowledges the existence of health care disparities across the spectrum of the social, behavioral and physical environment. In addition, ACA builds on recent efforts to achieve greater accountability and evidence-based approaches to treatment. Evidence from medical home models demonstration projects shows that the new models can improve the quality of health care while being cost effective. Social workers are specifically noted in the Act as interdisciplinary team members, to support the medical home concept (section 3502) and area health education centers (AHECs). The law names social work health care participation with persons across the life span.

Likewise California has identified its health care reform goals in its section 1115 Waiver “A Bridge to Health Care Reform.” Specifically California’s plan calls for improved care coordination for vulnerable populations, including seniors and persons with disabilities and children with special health care needs (CH&HS, November 2010, p. 2). Further the administrator for the Centers for Medicare and Medicaid Services, Dr. Donald Berwick, described and approved the FFP for workforce development in six State-funded programs and in “an additional three funded programs for persons with disabilities and programs that promote workforce development in medically underserved areas” (Berwick, 2010). Strategies to improve and expand the health care workforce are crucial to the success of health care reform in California.

Health care reform brings unique opportunities to social work. By the same token, there are several ways that social work brings unique knowledge and practice skills to health care reform implementation:

- Social work’s person-in-environment orientation and strengths-based perspective makes social work particularly well-suited to understand and explain how social, emotional, economic and physical environments affect health.
- Social workers learn about development across the life span and indeed work with all ages. Social work education takes place in community-based organizations, hospitals, schools, behavioral health programs, neighborhood centers and clinics, home health agencies, day care centers for adults and children.
- Social work practitioners have a public health tradition, which gives them a population view as well as an individual view. They are acutely aware of issues of equity and social justice. For example, given this focus, social workers learn to attend to the prevention of disease by promoting healthful environments in communities, a perspective that is very well-suited to ACA’s focus on primary care.
- Social workers already work in public human services, community clinics, public hospitals, mental health organizations that serve the most disadvantaged and can be helpful in planning for health care access expansion. Social workers are trained to work as part of a team with multiple levels of intervention ranging from participation in individual case planning to facilitate community collaboration among CBOs.

- Social work's strengths-based, person-in-environment perspectives enable us to see beyond the illness or disability to the social, behavioral and environmental determinants of health. Social workers are acutely aware of issues of equity and social justice. Social workers learn about development across the life span and work with persons of all ages.
- Social work education takes place in community-based organizations, in schools, behavioral health programs, neighborhood centers and clinics, home health agencies, day care centers for adults and children. Currently most medical education is centered on disease identification and treatment and it is delivered in inpatient medical settings by doctors, nurses and other ancillary health care personnel. Social work education, by contrast, would bring a preventative, client-involved, community support, case management model to health care delivery.
- Because social workers are trained to work with whole families and communities, we will make excellent contributions to care planning, connecting with families and assisting them to manage their care plans, and prevention plans. We will offer valuable insight to other team members about environmental factors' contributions to physical and mental health.
- Many services provided by social workers in health, behavioral health, and geriatric settings are already financially reimbursable, but are not for some other disciplines such as marriage and family counselors.
- Much of what social workers do is education and we could have multiple opportunities to educate in the area health education centers. Social workers "start where the client is" believing that finding out what the client needs to know to make informed decisions about his or her care; for example with the older Americans and their families in making decisions about palliative care. They also know how to assess the various environmental components that affect patient health.

ACA recognizes that many professions must become involved with the design and implementation of the health care system. In order to implement and sustain the ACA's goals of healthy people, there needs to be a solid infrastructure of quality interdisciplinary pre-degree and continuing education, and leadership, including social work. Social work education in California has developed a coordinated public sector-academic partnership among the California State Department of Social Services, the counties, California State Universities; and the University of California to provide training, undergraduate and master's level education necessary for the development of a skilled workforce. This established resource is available to help with health care infrastructure development.

SOCIAL WORK'S ROLE IN HEALTH CARE REFORM UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

On March 29, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PL 111-148) (ACA) into law, marking the beginning of major reforms that will

- provide nearly universal access to health insurance coverage,
- increase access to affordable health care for millions of US citizens, and will
- transform the way that health care is delivered in the United States.

There are opportunities for social workers to play a leading role in the delivery of care. The purpose of this paper is to delineate these opportunities and roles.

We begin by explaining the major changes in health care established by the ACA and by summarizing related legislation that has informed the ACA. Then, we discuss the results of recent demonstration projects which provide evidence of the cost effectiveness of new healthcare service delivery models. We emphasize the potential for social work in implementation of the new models. Next, ethnic and racial healthcare disparities are examined which suggest that even with health insurance, healthcare access and quality inequities remain among disadvantaged groups. We then turn to a detailed explanation of the potential roles for social workers under the ACA. Current policies that support the implementation of health care reform will be discussed, including California's Section 1115 waiver, "A Bridge to Health Care Reform". Finally what social work brings to health care reform and several contributions that social work could make to health care reform's success are discussed. Possible funding sources for development and evaluation of new educational models are provided in the appendix.

The Patient Protection & Affordable Care Act: Major Changes in Health Care Delivery

In the coming decade, through the provisions of the ACA over 31 million previously uninsured people are expected to be able to access health care insurance. It is expected that a significant proportion of this population will have chronic and serious physical and behavioral health disorders. At the same time, the law will redirect the system that has primarily focused on treatment of and aftercare for existing diseases to focus on primary care and prevention.

The ACA seeks to improve the quality of health care by providing for nearly universal health insurance mostly through the private sector and by reinventing primary care, calling for “community-based multidisciplinary medical homes” that are inclusive of the full spectrum of physical and behavioral health care needs, from wellness to end-of-life care. This is client-centered primary care. It involves the client’s family and community in health care. It is prevention-focused which leads to a consideration of health care disparities across the spectrum of the social, behavioral and physical environment. In addition, the ACA calls for greater accountability and evidence-based approaches to treatment: it goes without saying that evaluation is a major part of health care reform. Social work is specifically noted in the establishment of interdisciplinary teams to support the medical home concept (section 3502) and as a component of area health education centers (AHECs). The law also names health care social work participation with persons across the life span (children and youth, families and geriatrics).

The Medical Home Model

The medical home concept builds on many years of model demonstration projects. From approximately 1999 - 2006, the Human Resource Services Administration (HRSA) provided start-up and expansion funding to strengthen patient-centered primary care including building in prevention and behavioral health services into their array of services. California’s most familiar example is Kaiser Permanente Health Care, providing comprehensive care to its insured populations across the lifespan. Its current advertising campaign “Thrive” conveys the central role of primary prevention in overall health and wellness. In California, many community clinics serving disadvantaged populations with limited or no insurance have integrated behavioral health providers (typically LCSWs and licensed psychologists) into their medical teams with HRSA funding and technical support. Despite policy and practice challenges, community clinics are finding that integrated health care is cost-effective and very responsive to consumer needs. The guidelines for Mental Health Services Act (MHSA—aka Prop 63) Prevention and Early Intervention funding have accelerated changes in county behavioral health systems by encouraging the establishment of contracts between mental health services and community clinics, the first “door” that people with mild to moderate mental health symptoms usually enter seeking services. In all of these settings – Kaiser, community clinics, and behavioral health services – social workers provide prevention education, engagement, brief treatment, case management and discharge planning services as well as playing influential leadership roles.

Medical Home Demonstration Projects: Initial Results Demonstrate Quality Improvement and Cost Effectiveness

California has several current and completed demonstration projects for the medical home model. California's Health Care Coverage Initiative coordinated a 3-year, 10-county demonstration project which offered a medical home model to the low-income adult recipients. Different counties had varying levels of care coordination and case management available to patients, which some defined simply as arranging referrals and follow-up rather than care-coordination teams. However, based on the initial outcomes the recommendations included providing more case management services on site, and optimizing communication between physicians and other team members (Pourat et al, 2009).

The *Frequent Users of Health Services Initiative* in California represents another example. This six-year project sponsored by The California Endowment and the California HealthCare Foundation, integrated permanent housing services, case management, and health care. Participating counties included: Alameda, LA, Orange, Sacramento, Santa Clara, Santa Cruz, Sonoma, and Tulare. The Initiative led to a 61% decrease in emergency room visits, and a 62% decrease in inpatient hospital days over two years of client participation. Of the participants, two thirds had chronic previously-undiagnosed medical conditions, more than 50% had substance abuse disorders, and about one third had a diagnosed mental disorder; almost half were homeless, and more than a third had three or more of these risk factors. Because of this co-morbidity, mental health professionals were crucial to the coordinated care models. Addressing homelessness and co-morbidity will be a critical role for social workers, and will be increasingly important in medical homes, particularly in urban areas

Nationally, there are multiple examples of success to draw upon. Large-scale studies have not yet been conducted on the cost-effective outcomes of the demonstration projects. However, data is available on several of the model projects: The Community Care of North Carolina (CCNC) has reportedly saved \$160 million per year, mostly through a 23% reduction in emergency and outpatient visits, and an 11% reduction pharmacy visits in their ten years of operation in 1300 community-based sites (Grumbach et al 2009). Similarly, the Geisinger Health System in Pennsylvania reported a 20% reduction in hospital admissions, and system-wide savings for 7% in medical costs. (Paulus et al., 2008; Pourat et al., 2009). Johns Hopkins' Bloomberg School of Public Health's Guided Care Person-Centered Medical Home recently reported a 24% reduction in hospital inpatient days, 15% fewer visits to the ER, and a 37% decrease in days spent in skilled nursing care (Grumbach et al., 2009; Grumbach & Grundy, 2010).

Initial lessons from the first national effort at coordinating demonstration projects were published last year (Nutting et al., 2009). The findings chronicle the major lessons from 36 demonstration projects. They highlight the need for outreach and integration with the local communities, and also the risk of “change fatigue” among medical staff. Though the article does not mention social workers, we would seem to possess the specific skills needed to assist, and perhaps facilitate the process of community integration, and also to cope with this “change” fatigue and assist teams in the transformation process. Social workers will be members of coordinated care team in the multiple settings that will become medical homes in the coming years: community centers, schools, community clinics, mental health clinics, traditional hospitals, and other locations throughout the community. They will assist with direct service provision, and coordination of care, working on interdisciplinary teams to implement this model.

Ethnic/Racial Disparities in Access to Coverage and Care

Inequities in access to and quality of care among ethnic groups are long-standing problems that may continue to present obstacles to care, even with equitable insurance coverage. Results of several studies have shown that many ethnic and racial minorities do not receive the same quality of care or access to services as whites, even when they possess the same insurance coverage. Policy and practice decisions grounded in social justice principles are necessary to ensure that health reform does not miss any opportunities to reduce, if not eliminate, structural racism as a factor in health outcomes for ethnic minorities. Social workers need to become aware of these disparities and play a role in the medical homes, and in communities, advocating for equitable care for ethnic and racial minorities.

The Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (IOM 2002), based on published research from over 100 studies nationwide, concluded that “ethnically diverse populations do not receive the same kinds of tests, treatments or pain medications as whites suffering from the same diseases. Evidence suggests these disparities in health care are associated with higher death rates from such illnesses as heart disease, cancer and HIV infection.” For example, in one Southern California study 55% of Hispanic patients received no pain medication for long bone fractures compared to 26% of white patients (Todd, Samaroo and Hoffman, 1993);

Multiple studies suggest that African Americans are hospitalized with more severe conditions and treated less aggressively than whites. In an era of health-care reform, such differences require more than universal insurance coverage to be overcome. (Ball and Elixhauser, 1996). In another national

study, African Americans suffering from chronic kidney disease were much less likely than whites to have been referred to a transplant center for evaluation, to have been placed on a transplant waiting list, or to have received a transplant within 18 months after starting dialysis (Ayanian, Cleary, Weissman & Epstein, 1999); among diabetic and non-diabetic Medicare patients who underwent amputation or leg-sparing surgery, African Americans were 58% more likely to undergo amputation procedures than angioplasty or lower extremity revascularization (Guadagnoli, Ayanian, Gibbons, McNeil & LoGerfo, 1995).

A primary value of professional social work is social justice (NASW Code of Ethics). Social work education has designed several programs to increase the number of underrepresented faculty and students and to include content about oppression and social justice in all sections of the social work curriculum. Since health care reform's goal is to expand access to and quality of health care to all Americans, social workers are especially well-educated and focused on navigating the obstacles that may affect the success of this goal.

Contributing Public Policy Decisions

In addition to the Patient Protection and Affordable Care Act, other public policies support and contribute to its implementation. These policies will affect the implementation of the ACA and the work of social workers in the coming years.

Mental Health Parity Act. The Federal Wellstone-Domenici Mental Health Parity and Addiction Equity Act, effective January 1, 2010 required that group health insurance plans covering 50+ employees and providing both physical and mental health/substance use benefits had to eliminate inequity among the benefits (e.g. limits on mental health outpatient treatment that were more restrictive than limits on physical health outpatient treatment). It did not include Medicare or Medicaid patients. ACA incorporates all of the Wellstone-Domenici requirements, and expands them to cover everyone who is eligible under ACA. This serves to increase economic access for people with mental illness or substance use conditions who formerly had restrictions on the services covered by insurance through their employers or Medicare/Medicaid, and presumably will increase the demand for services as well.

The 1989 Omnibus Reconciliation Act (OBRA). The *Early and Periodic Screening Diagnosis and Treatment Program (EPSDT)* was intended to screen pre-school children for developmental problems, to diagnose and treat these problems. EPSDT has been in existence since 1967, but it has never been fully implemented for a number of reasons (Sardell & Johnson, 1998). In 1989 OBRA mandated states

expand eligibility to cover all pregnant women and children up through the age of six and to provide the medically necessary treatment even if these treatments were not covered for other Medicaid recipients.

Children in foster care are known to be at risk for health and disability problems and often need long term care. Social work education in this area can include skills in brokering resources such as EPSDT services for children in foster care even though they do not work directly in a health care or medical care center. However social workers need to have the skill to bridge the institutional environments of health care and foster care, something not readily transparent to welfare departments or school social workers.

1115 Medicaid Waiver for California "A Bridge to Health Care Reform". In November 2010 the Federal government approved a five-year Medicaid waiver for California. The state will receive approximately \$10 billion in federal funds to invest in the health delivery system and support the state's preparation for and transition to the requirements of federal health care reform by 2014 (CH&HS, December 2010). These investments are also designed to help slow the rate of growth in health care costs within the Medi-Cal program. The waiver is expected to:

- Health care insurance reform: Expand coverage to more uninsured adults through a "community norm change." (CH&HS December 2010, p.1): The waiver increases and expands health care coverage to as many as 500,000 low-income uninsured residents by taking advantage of the Coverage Expansion and Enrollment Demonstration (CEED) offered in the ACA. Eligible adults enrolled in a CEED project will be enrolled in a medical home and receive a core set of services, including inpatient and outpatient services, prescription drugs, mental health, substance use and other medically necessary services.
- Improve care coordination for vulnerable populations: The waiver authorizes mandatory enrollment of seniors and persons with disabilities into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes.
- Promote wellness and prevention for communities to transform communities and improve the population's health status: along with this effort, the waiver seeks to expand the health care workforce and rethink care delivery to assure access to health care services.
- Support uncompensated care costs: The waiver expands the Safety Net Care Pool (SNCP) that is part of the state's existing waiver, to provide additional resources to support both safety net hospitals' uncompensated care costs and other critical state programs that are paid for through the SNCP.

Promote public hospital delivery system transformation: The waiver implements a series of improvements to public hospital delivery systems to strengthen their infrastructure, prepare them for full implementation of reform and test strategies to slow the rate of growth in health care costs throughout the state.

Care Coordination

Given the re-invention of primary care via the establishment of client-centered medical homes, good working relationships among different professionals are required, and care coordination is vital for the success of health care reform. The National Commission on Care Coordination defines it in the following way: Care coordination “is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care” (2009, pp.1).

There is a consensus among providers that integrated care teams made of physicians, nurses, mental health professionals, and case managers are a component of care coordination (Brown, 2009; Bronheimer & Terry-Millet 2009). One source recommends that care teams are composed of one doctor, at least one MA, a full time RN, an administrative assistant to assist with case management, and behavioral health staff integrated into team, but become primary for some patients when appropriate (Gottlieb et al, 2008). Care coordination is a cornerstone of the medical home model, and this integrated coordination of care will become the norm for health care provision under the ACA.

Care Management is Included in Care Coordination

“Care management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving patients’ health status and reducing the need for medical services. The goals of care management are to improve patients’ functional health status, enhance coordination of care, eliminate duplication of services, and reduce the need for expensive medical services” (Robert Wood Johnson Foundation, 2009). The Robert Wood Johnson distinguishes between case management and care management, and sees care management as a longer-term and ongoing service conducted by a professional with clinical training and focused on quality improvement, and cost effective measures. No matter what terminology is selected, this set of tasks is a critical component of effective health reform, and one where social work must play a central role.

An Example of Care Coordination: Home-based Care for Senior Citizens

A study of home-based palliative care for patients with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and cancer published in 2005 found that patients enrolled in home-based interdisciplinary palliative care were more likely to die at home, and that cost reductions were significant for patients across all of these diseases (Enguidanos, et al., 2005). The study notes that “Seven key domains in improving end of life care in intensive settings were identified by a national consensus panel (Clarke, E. et al., 2003). These domains include patient/family decision-making, communication, continuity of care, emotional and practical support, symptom management and comfort care, spiritual support, and emotional and organizational support for clinicians.” Current health care social workers are involved managing and coordinating most of these domains. These roles are keys to the success of care management and coordination of services.

Social Work’s Role in Health Care Reform

The following are some of the ways that social work can partner with other health disciplines to promote health among the American people:

- Social workers are trained to work as part of a team. This makes them crucial members of coordinated care teams, and ideal “care managers”. Social workers need to become vocal regarding their strengths in this area, and advocate for opportunities to take on the care manager role.
- Social workers’ roles with the primary care team range from participation in case planning conferences to facilitating community collaboration among CBOs.
- Social work’s person-in-environment orientation and strengths-based perspective enable us to see beyond the illness or disability to the social, behavioral and environmental determinants of health. This will make social workers valuable members of teams in medical homes in community settings, and in assisting to assess clients’ needs and strengths in ways that enhance prevention and overall wellbeing.
- Social work is particularly well-suited to understand and explain how the social environment affects health. Social workers learn about development across the life span and indeed work with persons of all ages. Social work education takes place in community-based organizations, in schools, behavioral health programs, neighborhood centers and clinics, home health agencies, day care centers for adults and children. Social workers already work in public human services

that serve the most disadvantaged. Therefore, social workers are already comfortable in, and have ties to, the locations that will become medical homes for millions of people.

- Social work practitioners have an individual and a population focus. Social workers are acutely aware of issues of equity and social justice. For example given this focus, social workers learn to attend to the prevention of disease by promoting healthful environments in communities. This focus is very well-suited to ACA's focus on primary care and wellness. Because we are trained to work with whole families and communities, we will make excellent contributions to care planning, connecting with families and assisting them to manage their care plans, and prevention plans. We will offer valuable insight to other team members about environmental factors' contributions to physical and mental health.
- Many services provided by social workers in health, behavioral health, and geriatric settings are already financially reimbursable, but are not for some other disciplines such as marriage and family counselors.
- Much of what social workers do is to educate and inform. We could have multiple roles in the area health education centers (AHECs).
- Social workers "start where the client is" believing that finding out what the client needs to know to make informed decisions about his or her care; for example with older Americans and their families in making decisions about palliative care (Enguiadanos, Cherin, & Brumley 2005).
- Currently most medical and the majority of nursing education is centered on disease identification and treatment and it is delivered in hospitals for doctors, nurses and other ancillary health care personnel. This creates a mismatch of knowledge and skills needed for community based practice. Social work, by contrast, is centered on the strengths-based model using a person-in-environment orientation.

The Patient Protection and Affordable Care Act goes a long way toward universalizing access to health insurance and refocusing health care service delivery by strengthening primary care. However, access to health insurance by itself does not ensure access to quality health care. At this time the ACA affords social workers the opportunity to be involved with the design and implementation of a reformed health care system. In order to implement and sustain the ACA's goals of healthy people, there needs to be a solid infrastructure of quality interdisciplinary pre-degree and continuing education, and leadership to ensure the quality of workforce preparation. At this time the ACA affords social workers the unique opportunity to be involved with the design and implementation of the reformed health care system.

Appendix

Funding for Social Work Workforce Development & Education through ACA

ACA updates and reauthorizes grant programs through Health Resources Service Agency (HRSA)-supported education and training activities. There are several opportunities for social work to participate in the workforce development provisions of the Act. The Act provides \$250 million to expand programs for education and training, but many are unfunded this fiscal year (authorized but not appropriated). Many of the programs include social work education, although HRSA does not currently explicitly include social work as one of its careers. Potential program opportunities for CalSWEC follow.

Area Health Education Centers: AHECs must offer multidisciplinary training for students. Although only medical schools and nursing schools are eligible to apply for funding, schools of social work may subcontract with a grantee interested in interdisciplinary training.

Geriatric Programs

- Geriatric Educational Centers Program. Schools of social work are included among eligible disciplines. (Funded for 2010-11)
- Geriatric Fellowship Program. Short-term intensive courses for faculty to upgrade and maintain skills for this specialized field. (Funded for 2010-11)
- Geriatric Academic Career Awards. ACA expands this program to include social work. It requires 75% of total time to be dedicated to teaching and educational skills development for the field of gerontology.
- Geriatric Career Incentive Awards. For advanced practitioners in gerontology. (Not funded in 2010-11)

National Health Services Corps

- Scholarship Program. Competitive program that pays tuition and fees and provides a stipend for living expenses to medical, psychology, social work, or nursing students.

- **Loan Repayment Program.** Allows up to \$60,000/year for licensed or registered graduates working in hard-to-retain positions in health /behavioral health shortage areas. California's program is under the auspices of the California Office of State Health Planning and Development, and the Mental Health Loan Assumption Program is augmented with MHSA funds by the Department of Mental Health.

Centers of Excellence Programs: These programs are to assist designated health/behavioral health professional schools, including schools of social work, to recruit and retain students from diverse backgrounds. 50% of these funds are designated for Historically Black Schools and Universities.

Mental Health and Behavioral Health Education and Training Grants: When available, these grants will be made to higher education institutions to support the recruitment and education of students from undergraduate to master's and doctoral degrees. There will be \$8 million authorized for expenditure between FY2010-2013 for training social work students, \$12 million for psychology, \$10 million for training in professional child and adolescent mental health, and \$5 million for training paraprofessionals in child and adolescent mental health.

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