INVESTING IN THE SOCIAL WORK WORKFORCE

Social Work **Policy** Institute

ANSWER
Action Network for Social Work
Education and Research

ONASW
National Association of Social Workers

NASW foundation

> **REPORT FROM A THINK TANK SYMPOSIUM**
>
> Sponsored by the NASW Social Work Policy Institute
>
> In collaboration with the Action Network for Social Work
> Education and Research (ANSWER)

INVESTING IN THE SOCIAL WORK WORKFORCE

was sponsored by the NASW Foundation's Social Work Policy Institute (SWPI) and the Action

Network for Social Work Education and Research (ANSWER).

The opinions expressed in the monograph are those of the author.

Recommended Citation – Social Work Policy Institute (2011).

Investing in the Social Work Workforce. Washington, DC:

National Association of Social Workers.

TABLE OF **CONTENTS**

EXECUTIVE SUMMARY

INVESTING IN THE SOCIAL WORK WORKFORCE
THINK TANK SYMPOSIUM

Sponsored by the NASW Social Work Policy Institute
In collaboration with the Action Network for Social Work Education & Research

September 2011

> SYMPOSIUM PURPOSE

Professional social workers promote the health and well-being of individuals, families, organizations and communities. They are agents of change, working in a variety of settings and with diverse populations. Social work practice covers an array of functions including clinical, counseling, case management and care coordination; developing and administering programs; supervising staff and volunteers; creating and implementing policies; undertaking research, program planning, community development and community organizing; and providing training, education and consultation. Social workers work across the lifespan, especially serving persons who have complex health, economic and psychosocial needs, working with persons who may have physical and psychological impairments and limited incomes, and who experience discrimination and health disparities.

In recent years, there have been specialized efforts to recruit and educate the next generation of social workers and to build leadership capacity in child welfare and aging. There are also efforts to address education and advanced practice competencies in a few fields of practice or with specific populations (see for example CSWE advanced practice competencies – www.cswe.org/Centers Initiatives/CurriculumResources/CompetenciesforAdvancedPractice.aspx).

The profession, however faces workforce challenges and shortages. Yet, there are not consistent or broadly available strategies that specifically target the recruitment of the next generation of professional social workers. Nor are there comprehensive initiatives to provide training to ensure that current practitioners maintain up-to-date skills.

There are growing needs for well trained, culturally competent, and committed social workers in all fields including mental health, health care (including subspecialties like oncology, long term care and hospice), substance abuse, and education. Furthermore, the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) (ACA), the long running wars in Afghanistan and Iraq, and the changing demographics in the United States also have implications for social work workforce development.

On May 18, 2011, the Social Work Policy Institute (SWPI) of the National Association of Social Workers (NASW) Foundation, in collaboration with the Action Network for Social Work Education and Research (ANSWER), convened a think tank symposium, *Investing in the Social Work Workforce.* The symposium brought together leaders from practice, policy, research, and education, including representatives from federal agencies, national organizations, foundations, universities, insurers, and state and local service-providing agencies. The goal of the think tank symposium was to move beyond viewing workforce issues for the social work profession within specific practice silos (e.g., mental health, child welfare, oncology, chronic disease or aging) and to create an action agenda to look broadly across social work functions (e.g., clinical practice, care coordination, management and supervision) and across levels of social work education. The focus of this symposium was in keeping with NASW's commitment to working within social work and with interdisciplinary partners, and with the executive and legislative branches of government, at both the state and national levels, to promote investments in the social work profession and to promote individual, family and community well-being.

> TOPICS EXPLORED

To help meet the symposium goals the interdisciplinary group addressed:

> Social work workforce data and trends.
> Federal strategies and funding opportunities for workforce capacity building, professional education and training.
> Implications of the Centers for Medicare and Medicaid Services (CMS) social work provisions and the possibilities for social work with the increased attention to innovation, primary care, psychosocial well-being and prevention.
> Prospects for workforce investments through the implementation of the provisions of the ACA.
> Challenges and opportunities related to workforce investments and staffing issues from a service delivery perspective, including implications for funding of social work positions.
> Social work within an interdisciplinary context – both in settings where multiple providers perform similar roles – and for social workers as members of interdisciplinary care teams.
> Emerging trends in the delivery of health and social services, including refocused attention to quality care coordination and the need to address disparities in the delivery of health and social services and how these can promote opportunities for social work practice.
> Policies that can support workforce investments and capacity building and opportunities for further collaborations to continue to build capacity and competence and address workforce gaps.

> FRAMEWORK FOR ACTION

Social work organizations and social work educators have a shared goal – ensuring the development of a competent, committed social work workforce that will be employed across numerous fields of practice; that will be retained within the social work profession; and that can help to achieve positive outcomes for the clients served. The breadth of social work roles suggests the on-going need for practitioners who can demonstrate clinical, care coordination, program development, professional development, organizing, supervisory, administrative, and policy skills.

Social workers need to be able to work in interdisciplinary settings and engage with clients and communities in developing and implementing services and programs. Social workers should be ready to meet new challenges and be responsive as the needs of populations change; as policies (e.g., ACA) and funding streams change; as the job market becomes increasingly competitive; and as some fields of practice, e.g. working with disasters or working with the military and veterans, expand. Social workers also need to be engaged in life-long learning.

For many of the federal, state and local agencies that fund and implement the programs in which social workers work, recruiting, retaining and training the right workforce is a challenge to which solutions are being sought. In most instances, agencies are seeking someone that has a set of skills and experiences to do the job; and that individual might be selected from an

array of professions – social workers, psychologists, nurses, counselors, lawyers, etc. – who may all fit the employers' job descriptions. In some fields, especially in child welfare and in aging, social workers with BSW and MSW degrees may be competing for jobs against persons who have no specialized training and may have only a bachelor's degree, or less. The public, however, often assumes that all of the persons performing these functions are professional social workers.

There may be a declining number of positions in the 21st century that specifically call for hiring only a social worker to do the job. Services that do specifically recruit and employ social workers are those where federal, state or other policies define who the required staff are. Settings may specifically require a professional social worker due to states' licensing requirements or social work requirements may be in keeping with an agency's efforts to meet accreditation standards. In some instances, agencies have a preference for hiring social workers; however, it is not a requirement.

As we look to the future, the increased demand for social workers will continue to grow and will need to be responsive to the following:

> The impending retirement of a sizable cohort of today's health and human service workforce;
> The implementation of the ACA;
> The efforts to reduce the number of children in out of home care;
> The increased linkages between mental health services and primary care;

> The expanded focus on interdisciplinary/interprofessional service delivery;
> The requirements to implement tested interventions and evidence-based practices;
> The increased demand for quality consumer-centered care and care coordination;
> The focus on addressing the needs of the military and their families and the many generations of veterans;
> Growing opportunities for social workers in business and in the for-profit sector.

The think tank participants grappled with many issues that could result in enhanced efforts by the government and other funders to invest in the social work workforce; that would strengthen and enhance intra-social work and interprofessional partnerships and advocacy strategies; and that would strengthen the linkages between what social workers learn in the academy and what they do in practice. The following highlights issues that need further attention.

Influencing Social Work Education
> **Enrollments and applications to social work education programs are increasing, creating a readiness to respond to the growing need for social workers.** This is an opportunity to be responsive to the Bureau of Labor Statistics projections of the growing need for social workers. Efforts should ensure that graduates have the right skills, abilities, and experiences to effectively perform their jobs in settings where social workers are most needed.
> **Changes in practice suggest that social work curricula changes are also needed.** Educational institutions must keep current in preparing students to meet client and community needs. This may include curriculum innovations, incorporating evidence-based practice into professional education and enhancing research/practice bridges.

Influencing Service Delivery and Social Work Practice
> **Emerging practice methods may require shifts in how practice is defined and how social work communicates its expertise.** Training and professional development and advocacy will require professionals across disciplines to work together and to partner with clients and communities to ensure practice relevance and cultural congruency.
> **Interdisciplinary/interprofessional practice will be increasingly the norm in practice settings.** Strategies are needed in the academy and in practice settings to ensure that social workers are well prepared to work as part of an interdisciplinary team.

> **Use of data and research findings will increasingly be used to guide practice and policy.** Collection of data is critical as well as ensuring that front-line practitioners and supervisors be encouraged and guided to use data and research to inform practice.
> **Consistent data need to be collected and analyzed regarding the social work workforce.** Social work organizations should work with the Bureau of Health Professions and others to ensure relevant and accessible data. Since social work is a high growth field over the next decade, data are needed to support recruitment and retention efforts, including the need for faculty and researchers.

Strengthening Policy and Practice Linkages
> **Workplace supports and the work environment should facilitate quality social work practice.** Enhanced efforts needed to ensure that organizational culture and climate in health and human service settings are conducive to professional practice; that recruitment and retention is supported and that competitive salaries are offered.
> **Advocacy to address workforce issues is needed at the federal, state and local levels.** Social workers need to work with other disciplines, consumers and employers to advocate for service enhancements and workforce supports. Social work organizations should develop and implement a unified workforce advocacy agenda.
> **Influencing the executive branch of government to advocate for investing in social work is critical.** The executive branch of government

develops regulations and administrative policy guidance, issues grants and contracts, organizes workgroups and advisory groups and works to implement legislation. Influencing the executive branch requires outreach and advocacy on behalf of the social work profession to ensure that social work has a seat at the table. This is especially crucial in the implementation of the ACA and in ensuring social workers' roles in emerging fields of practice.

> CONCLUSIONS

Investing in the social work workforce will require actions by multiple players both within the social work profession and on the outside. Efforts will need to focus on *advocacy, research, professional social work education and training, and interprofessional collaboration and interdisciplinary practice*. These efforts should be targeted to and engage multiple stakeholders including:

> Social work organizations.
> Government agencies (at the local, state and national levels).
> Unions.
> Licensing boards.
> Accrediting bodies.
> Legislatures.
> National organizations representing service providers (e.g., Child Welfare League of America, Alliance for Children and Families, National

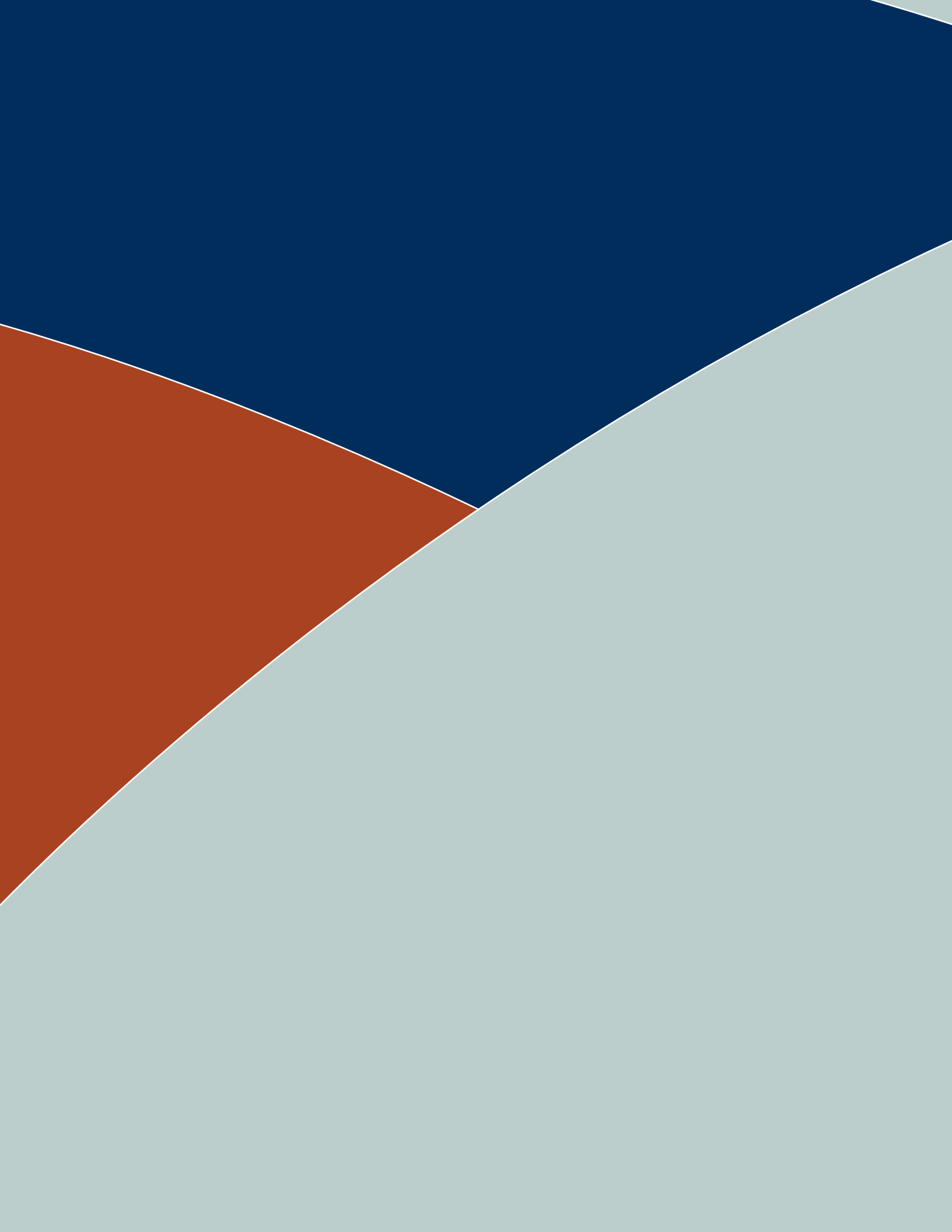Association of Area Agencies on Aging).
> Employers of social workers (e.g., Kaiser Permanente, Family Service Agencies, the Department of Veterans Affairs).
> Clinicians and practitioners.

Anticipated outcomes for implementing the action agenda will include:

> Enhanced public and policy maker understanding of the essential role of social workers.
> Strengthened inter-social work organization collaboration and attention to shared missions related to advocacy and professional development.
> Enhanced interdisciplinary training and team outcomes and advocacy across discipline-specific organizations.
> Strengthened and sustained relations with key executive branch agencies, including collection of social work workforce data and supports for social work education and professional development.
> Strengthened licensing and enhanced recognition of professional social work.
> Increased social worker salaries.
> Increased clarification of variation in skills and expectations for service outcomes for social workers with differential education and experiences.
> Improved retention of social workers in their jobs and within the profession.

> Enhanced understanding of social work roles by employers and policy makers.
> Enhanced alignment between social work education and contemporary practice needs based on demographics and growing service delivery sectors (aging, veterans, military, health disparities).
> Enhanced information about social work effectiveness.
> Attention to development and implementation of evidence-based practices.
> Expanded use of data and research to guide practice.

The goals of this think tank symposium were met. People who do not usually connect with each other connected. Following the symposium, several social work organizations came together to enhance their workforce advocacy efforts, and federal agencies and the profession have enhanced their potentials for partnerships. The agenda for the future is daunting and will require the development of sustained relationships between the profession and government and foundation representatives, as well as between social work and its interdisciplinary partners. The workforce crisis for social work is real, and creating a *safety net for a civil society* is critical. Social workers must be well positioned to meet the demands for their services from individuals, famillies, organizations and communities in need.

![Social Work Policy Institute logo — SWPi, Social Work **Policy** Institute]

INVESTING IN THE SOCIAL WORK WORKFORCE

> **REPORT FROM A THINK TANK SYMPOSIUM**

> Sponsored by the NASW Social Work Policy Institute

> In collaboration with the Action Network for Social Work Education and Research (ANSWER)

> PURPOSE

Professional social workers promote the health and well-being of individuals, families, organizations and communities. Social workers are agents of change, working in many different settings and with diverse populations. Social work practice is made up of an array of functions including clinical, counseling, case management and care coordination services; developing and administering programs; supervising staff and volunteers; creating and implementing policies; undertaking research, program planning, community development and community organizing; and providing training, education and consultation. Social workers work across the lifespan, especially serving persons who have complex health, economic and psychosocial needs, working with persons who have physical and psychological impairments, limited incomes, and who experience discrimination and health disparities.

In child welfare and aging, in recent years, there have been specialized efforts to recruit and educate the next

generation of social workers and to build leadership capacity. In other fields, however, such as mental health, health care (including subspecialties like oncology, long term care and hospice), substance abuse, and education, there are also growing needs for well trained, culturally competent, and committed social workers. However, there are not consistent or broadly available strategies that specifically target the recruitment of the next generation of professional social workers into these fields nor are there comprehensive initiatives to provide training to ensure that current practitioners maintain up-to-date skills. The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) (ACA), the long running wars in Afghanistan and Iraq, and the changing demographics in the United States also have implications for social work workforce development.

While there are some efforts to address education and practice competencies and training in a few fields of practice or with specific populations (see for example CSWE advanced practice competencies - www.cswe.org/Centers

Initiatives/CurriculumResources/ CompetenciesforAdvancedPractice.aspx), the profession faces workforce challenges and shortages related to all service sectors and populations. Thus, it is important to move beyond focusing on single practice areas and to holistically focus on investments in the social work workforce overall. This will require identification of strategies that can cut across service sectors and populations.

On May 18, 2011, the Social Work Policy Institute (SWPI) of the National Association of Social Workers (NASW) Foundation in collaboration with the Action Network for Social Work Education and Research (ANSWER) convened a think tank symposium, *Investing in the Social Work Workforce* (see Appendix 1 for the agenda). The symposium brought together leaders from practice, policy, research, and education, including representatives from federal agencies, national organizations, foundations, universities, insurers, and state and local service-providing agencies (see Appendix 2 for a list of the participants).

The Social Work Policy Institute (SWPI) is a think tank established within the NASW Foundation to strengthen social work's voice in public policy deliberations; to inform policy makers through the collection and dissemination of information on social work effectiveness; and to create a forum to examine current and future issues in health care and social service delivery. For more information visit www.socialworkpolicy.org

The ANSWER Coalition was founded in 1995 to increase advocacy on behalf of social work education, training, and research through collaboration among social work education, research, and practice organizations; social work education programs; and other interest groups. The current members of the ANSWER Coalition are the Association for Baccalaureate Social Work Program Directors (BPD), Council on Social Work Education (CSWE), Group for the Advancement of Doctoral Education (GADE), National Association of Deans and Directors of Schools of Social Work (NADD), National Association of Black Social Workers (NABSW), National Association of Social Workers (NASW), and Society for Social Work and Research (SSWR). For more information visit www.socialworkers.org/advocacy/answer/default.asp

The goal of the think tank symposium was to move beyond viewing workforce issues for the social work profession within specific practice silos (e.g., mental health, child welfare, oncology, chronic disease or aging) and to create an action agenda to look broadly across social work functions (e.g., clinical practice, care coordination, management and supervision) and across levels of education (BSW, MSW and PhD). The participants examined policy opportunities, current strategies,

and funding related to professional education, training and service enhancements across fields of practice and across population groups. Discussions focused on potential opportunities and existing challenges, especially in light of the changes included in the ACA. The resulting agenda for action identifies the need for intraprofessional, interorganizational and interdisciplinary collaborations and partnerships, as well as the need for further research, policy enhancements and communication strategies.

The focus of this symposium is in keeping with NASW's commitment to working within social work and with interdisciplinary partners, and with the executive and legislative branches of government, at both the state and national levels, to promote investments in the social work profession and to promote individual, family and community well-being.

The symposium also builds on several imperatives from the *2005 Social Work Congress* (www.socialworkers.org/congress/imperatives0605.pdf) and *2010 Social Work Congress* (www.socialworkers.org/2010congress/documents/2010Imperatives.pdf). These focus on advocacy; influencing the policy agenda; articulating the evidence-base for social work practice; promoting quality health care, aging and child welfare services; and enhancing the influence of and collaboration among national social work organizations.

> THINK TANK TOPICS EXPLORED

To help meet the symposium goals the interdisciplinary group addressed:

> Social work workforce data and trends.
> Federal strategies and funding opportunities for workforce capacity building, professional education and training.
> Implications of the Centers for Medicare and Medicaid Services (CMS) social work provisions and the possibilities for social work with the increased attention to innovation, primary care, psychosocial well-being and prevention.
> Prospects for workforce investments through the implementation of the provisions of the ACA.
> Challenges and opportunities related to workforce investments and staffing issues from a service delivery perspective, including implications for funding of social work positions.
> Social work within an interdisciplinary context – both in settings where multiple providers perform similar roles – and for social workers as members of interdisciplinary care teams.
> Emerging trends in the delivery of health and social services, including refocused attention to quality care coordination and the need to address disparities in the delivery of health and social services and how these can promote opportunities for social work practice.
> Policies that can support workforce investments and

capacity building and opportunities for further collaborations to continue to build capacity and competence and address workforce gaps.

Through the deliberations and discussions of the diverse group of stakeholders, the symposium's participants grappled with questions such as:

> How do we best identify, document, distill and disseminate the evidence base for social work practice across fields of practice, including identification of how social work interventions affect individual, family, organizational, system and societal outcomes?

> What areas of social work practice and interventions need further research and better collection and analysis of data to build the evidence?

> How can comparative effectiveness research support social work workforce investments?

> What workforce investments are needed to best address health disparities and the differential outcomes for populations that experience disparities?

> How can the differential roles that social workers perform within and across systems best be articulated and supported? For example, differential roles of behavioral health provider, care coordinator, and interdisciplinary medical team member in health care; or child welfare roles of clinician and care coordinator.

> What are the linkages that can be strengthened among all levels of social work education and service providers in order to promote practice excellence and enhance consumer and community outcomes?

> What are emerging areas of practice and what policy and program strategies are needed to build the necessary capacity?

> What roles should social work education programs play in the professional development of health and social service providers; and what are the necessary investments to ensure a qualified workforce across fields of practice?

> What current models for professional development and training might be adapted and adopted by other fields of practice?

> What stakeholders should work together to move these agendas forward?

The symposium kicked off with invited presentations related to trends in the social work workforce overall; the current strategies and future needs for child welfare workforce development; health professions training opportunities, and the implications for workforce development due to health care reform and federal health care financing strategies. Two invited respondents drew from their own work to comment on the presentations and to address workforce challenges in community-based health and human services programs and in addressing transitions of care (see Appendix 3 for speakers' biographies). Two think tank participants were also specifically asked to briefly highlight the federal and foundation supported social work workforce investments in aging and health disparities in which they are involved.

> THE SOCIAL WORK WORKFORCE: SHIFTING THE CONTEXT

To underpin the day's discussions, Dr. Tracy Whitaker, Director of NASW's Center for Workforce Studies and Social Work Practice provided an overview of the social work labor force and some of the opportunities and challenges it faces. To better understand the social work labor force, in 2004 the National Association of Social Workers undertook a national benchmark study of 10,000 licensed social workers, with support from Atlantic Philanthropies, the John A. Hartford Foundation, the Annie E. Casey

Foundation and the Robert Wood Johnson Foundation. NASW launched this study because there were insufficient data specifically related to the social work profession and no other reliable and detailed source of data existed.

The study found that mental health is the most common practice area for all licensed practitioners at 37 percent, with Child Welfare/Family and Health each having about 13 percent of licensed social workers. Approximately 9 percent of social workers work in the field of aging. Those social workers in long term care and child serving organizations are most likely to have caseloads larger than 50 clients. Child welfare/family work is most likely to take place in the public sector and aging work is most likely to take place in the private/ non-profit sector. Persons with a bachelor's degree in social work (BSW) who work in aging are more likely to work in nursing homes, case management and social service agencies and spend less time providing direct client services than do those who have a Master's degree in social work (MSW). Child Welfare/Family settings are common areas of practice for those entering the social work profession; however, many of these social workers leave this area of practice or leave the profession altogether, due to stress and the lack of supervision and workplace supports.

The NASW study identified an impending shortage of social workers due to several factors including:

> The need to replace retiring workers due to the age of the workforce;

> Difficulties retaining the current workforce due to workplace and service delivery challenges;

> Concerns about recruiting the next generation of social workers due to high levels of student loan debt coupled with expectations of low salaries for social work positions (Whitaker, Weismiller & Clark, 2006).[1]

According to the Bureau of Labor Statistics (BLS, 2010), the social work profession is projected to grow faster than the average between 2008 and 2018 and the current behavioral health care workforce is deemed to be inadequate to provide services to all persons in need. The growth in the health care industry means that jobs are being added, and this has helped to make the social work profession somewhat "recession proof." In December 2010, US News.com (Baden, 2010) identified medical and public health social work as one of the best careers of 2011. Although there may be jobs in social work, the profession is identified as one of the worst paying for those with a college degree, and is seen in particular as a stressful job that pays badly. The National Council for Community Behavioral Healthcare in 2011 reported that behavioral health care workers earn less than fast food workers and that salaries have not kept up with inflation (Mental Health Weekly, 2011).

Unlike the nursing shortage, the impending shortage of social workers has not been identified as an "emergency." Policy

---

[1] For more information about this landmark study, including specialty reports in several practice sectors visit http://workforce.socialworkers.org.

makers, foundations, nursing organizations and educational institutions have all responded to the nursing workforce emergency, creating strategies to recruit new nurses into the field, to raise salaries, to retain nurses in clinical care, to improve working conditions, and to address the nursing faculty shortage. In addition, the public is aware of this shortage through savvy public service announcements seen during football games and through other visible media strategies.

By contrast, news of an impending social worker shortage did not seem to drive more attention to shoring up the social work profession, but rather, seemed to divert attention to other professions, disciplines and workers that might be able to fill the gaps created by a lack of a professional social work workforce.

In long term care, for example, a 2006 report by the U.S. Department of Health and Human Services (HHS) estimated that there is a need for 110,000 professional social workers in long term care by 2050. However, the report stated that although social workers' "theoretical framework may be unique, social workers in long-term care settings perform tasks, including assessment, psychosocial support, active treatment,

and case management, that may also be performed by other disciplines" (HHS, 2006).

Dr. Whitaker asserted that that those pursuing a social work career receive conflicting messages such as "You will have a job," and "You will be fulfilled," but, "You will be underpaid." Perhaps the lack of public and policy maker attention to social work is because the profession is identified with the *recipients* of social work services, rather than with the *beneficiaries* of social work services. The recipients of social workers' services– persons who depend on the social safety net–often evoke vulnerability, sadness, and sometimes fear, in the general public.

However, social workers keep members of the society connected, protect the standards of a civil society, and establish a minimum floor of what and how to meet the needs of society's most vulnerable individuals, families and communities. **It is perhaps the frame as the *safety net for a civil society* that will create a mandate to invest in the social work workforce.**

> FEDERAL FUNDING TO INVEST IN SOCIAL WORK: OPPORTUNITIES AND EXEMPLARS

Shifting from Dr. Whitaker's remarks, the think tank then explored two examples of federal investments in workforce development that can benefit the social work profession. Workforce investments are linked to populations that have a high need for services and where service innovations are being implemented. From the Department of Health and Human Services (HHS), Clare Anderson of the Administration

on Children, Youth and Families (ACYF) and Diana Espinosa of the Bureau of Health Professions (BHPr) in the Health Resources and Services Administration (HRSA) provided information about their agencies current and potential investments in social work.

Developing the Health Professions Workforce
HRSA's mission includes improving access to health care services for people who are uninsured, isolated or medically vulnerable. There is great synergy between HRSA's overall mission and the populations served by social workers across the United States. All of HRSA's programs – the National Health Services Corps, Community Health Centers, Bureau of Maternal and Child Health, Ryan White HIV/AIDS Program, Title IV Block Grants and Healthy Start, (www.hrsa.hhs.gov), for example, involve social workers as direct care providers, as well as administrators, consultants, trainers and technical advisors.

The HRSA presentation focused on the priorities of the BHPr including the relevant provisions of the ACA and opportunities for social work. The mission of the BHPr is to increase the population's access to health care by providing national leadership in the development, distribution and retention of a diverse, culturally competent health workforce that can adapt to the population's changing health care needs and provide the highest quality of care for all. BHPr efforts include training of primary care providers, workforce pipeline development, diversity, continuing education, scholarships, loans, and loan repayment programs. The legislative authority for BHPr can be found in the Title III, Title VII and Title VIII of the Public Health Service Act as amended by the ACA. Strategies for training the direct care health care workforce are

also now part of BHPr's priorities. More information can be found at the BHPr website, http://bhpr.hrsa.gov/.

The major focus areas for the BHPr for Fiscal Year 2012 include:

> Improving primary care workforce supply, capacity and distribution through stronger education and training opportunities.
> Developing new team-based models of care based on interprofessional training.
> Reducing health disparities by increasing workforce diversity.
> Enhancing geriatric training and expertise, including both professional and paraprofessional education.
> Continuing development of the National Center for Health Workforce Analysis to improve data collection to inform stakeholders on health workforce issues.
> Collecting and reporting meaningful performance measures and conducting evaluations to assess program performance.

The passage of the ACA has implications for the health care workforce including the programs administered by the BHPr. ACA updates and reauthorizes programs to support:

> Workforce supply, including primary care, oral health and interdisciplinary activities (including social work).
> Workforce distribution, including training opportunities in rural and underserved settings.
> Workforce diversity, including recruitment, retention and faculty development.

Specific investments funded through the ACA include an array of expansions in health care training. Although some are specific to nursing, physicians, physician assistants, public health and health aides; no provisions are specific just to social work. The investments include:

> Primary care residency expansion
> Advanced nursing education expansion
> Expansion of physician assistant training
> Teaching health centers – for graduate medical education (for medicine and dentistry in community settings)
> Nurse managed health clinics
> State health care workforce development
> Public health training centers
> Personal and home care aide state training programs.

Examples of the BHPr's strategy to grow the primary care workforce includes providing opportunities for interprofessional primary care training; enhancing the clinical training of physician assistant programs; improving the medical school clinical experience; retaining internal medicine residents in primary care; innovating in pre-medical education, and expanding advanced practice nursing training capacity.

Examples of the BHPr strategy to promote interdisciplinary work includes a February 2011 HRSA sponsored meeting in partnership with the Josiah Macy Foundation, Robert Wood Johnson Foundation and the Interprofessional Education Collaborative (www.aacom.org/InfoFor/educators/ipe/Pages/default.aspx) www.aacom.org/InfoFor/educators/ipe/Pages/default.aspx), to promote interprofessional competencies in education, practice, training and certification programs. Six disciplines were included in this effort - medicine, nursing, public health, osteopathic medicine, pharmacy and dentistry – but not social work. Based on the core competencies (www.aacom.org/InfoFor/educators/ipe/Documents/CCrpt05-10-11.pdf) the next steps include a planned collaborative demonstration project (included in the FY 2012 budget request).

In addition, in 2010 HRSA convened its four advisory committees together – the Council on Graduate Medical Education, the Committee on Training in Primary Care Medicine and Dentistry, the National Council on Nurse Education and Practice, and the Advisory Committee on Interdisciplinary, Community-based Linkages (ACICBL). The focus was on identifying interprofessional team competencies. The ACICBL met 3 times in 2010 each time focusing on preparing the healthcare workforce to address health behavior change. The ACICBL vice-chair is currently a social work educator and social workers have often been appointed to this panel and other HRSA advisory groups. Notes of all of the advisory committee meetings can be found at www.hrsa.gov/advisorycommittees/bhpradvisory/acicbl/Meetings/index.html.

Accredited social work education programs can partner with BHPr grantees in the interdisciplinary Area Health Education Centers (AHEC) and State Healthcare Workforce Development. Health profession graduates from disadvantaged backgrounds, who serve as faculty at an eligible health

professions college or university (including social work) for a minimum of two years, may also be eligible for the Faculty Loan Repayment Program, administered under the Bureau of Clinician Recruitment and Service (www.hrsa.gov/about/organization/bureaus/bcrs/index.html).

To better address diversity in the health care workforce, BHPr programs are integrated and designed to develop a diverse workforce that will provide access to care for all Americans. Targeted efforts include building a pipeline of diverse, qualified applicants; funding institutions successful in placing graduates in underserved areas and having a diverse student mix; and providing financial assistance and training to students likely to work in underserved areas. Accredited schools and programs of social work are eligible for BHPRs' Scholarships for Disadvantaged Student Program, the Health Careers Opportunity Program and the Centers of Excellence.

In regard to geriatric interdisciplinary training efforts, BHPr funds geriatric education centers (GEC), geriatric training for physicians, dentists and behavioral and mental health professionals (including social work);

and geriatric academic career awards.. Social workers are part of GECs and social work is also eligible for the geriatric academic career award. Social workers are also eligible for the one year re-training program. Funding is requested for FY 2012 for the new Geriatric Incentive Awards Program and the Mental and Behavioral Health Education and Training Grant Program. While these programs are authorized, their funding levels are contingent on Congressional Appropriations for fiscal year 2012.

Another major effort supported through ACA is the development of the National Center for Health Workforce Analysis (http://bhpr.hrsa.gov/healthworkforce/). The goals of this new center are to inform national and state policy making in regard to the health care workforce; to promote the supply and distribution of well-prepared health workers; and to become the most trusted source of data on the health workforce. Activities of the center include strengthening national, state and professional association capacity for data collection and analysis, developing a standard minimum data set for health professions (social workers will be included in the planned state health profession reports); and collaborating with the health workforce research community.

To assist interested social work education programs in applying for BHPr funding, a representative from the BHPr has presented at recent Annual Program Meetings (APM) of the Council on Social Work Education (www.cswe.org/File.aspx?id=44126). Additional information about the HRSA BHPr programs can be found at http://bhpr.hrsa.gov/index.html.

Preparing the Child Welfare Workforce: What will it take to Reach the Next 25 Percent?
Over the past two decades the Children's Bureau, one of two bureaus's in the Administration on Children, Youth and Families (ACYF) has developed an extensive training and technical assistance network (www.acf.hhs.gov/programs/cb/tta/cbttan.pdf). The network consists of:

> An array of targeted National Resource Centers and Training and Technical Assistance (T/TA) Institutes including the National Child Welfare Workforce Institute (NCWWI).
> Several Quality Improvement Centers.
> Five Implementation Centers.
> The Child Welfare Information Gateway (www.childwelfare.gov).
> The National Data Archive on Child Abuse and Neglect.
> Partnering with the Substance Abuse and Mental Health Services Administration (SAMHSA).
>> The National Center on Substance Abuse and Child Welfare (partnering with SAMHSA).
>> The National Technical Assistance Center for Children's Mental Health.
>> The National Technical Assistance and Evaluation Center for Child Welfare Systems of Care Grantees.

Begun in 2008, the NCWWI is a key part of the T/TA network. It is an innovative strategy of the Children's Bureau, which has made investments in workforce training and professional education, especially in social work, since the mid-1960s.

NCWWI is a collaboration among nine universities and the National Indian Child Welfare Association. Its goals are to:

> Derive promising practices in workforce development.

> Deliver child welfare leadership training for middle managers and supervisors.
> Facilitate BSW and MSW traineeships, engage national peer networks.
> Support strategic dissemination of effective and promising leadership and workforce practices.
> Advance knowledge through collaboration and evaluation.

The Children's Bureau's investments through NCWWI include traineeship award projects with 12 social work education programs particularly targeting child welfare services to under-represented populations and attracting diverse students to child welfare careers. In addition to NCWWI's traineeships, the Children's Bureau also funds five Comprehensive Workforce Projects that also offer traineeships. These Projects are being evaluated through NCWWI and participate on NCWWI's national advisory board. (For more information on the two major funding streams, Title IV-E and Title IV-B Section 426 that can support social work education, see Appendix 4.)

NCWWI offers two leadership academies, the Leadership Academy for Supervisors (an on-line training with peer support) and the Leadership Academy for Middle Managers (LAMM), a residential leadership development effort. The Leadership Competency Model focuses on *Leading Change, Leading in Context, Leading People and Leading for Results.* For more information about NCWWI's programs see www.ncwwi.org and *Supervision: The Safety Net for Front-Line Child Welfare Practice* (www.socialworkpolicy.org/news-events/supervision-the-safety-net-for-front-line-child-welfare-practice.html). NCWWI is

an effort by the Children's Bureau to more comprehensively address child welfare workforce concerns and needs through a five-year cooperative agreement, rather than the direct administration of traineeship grants, which had been the long-standing practice of the Children's Bureau. Schools and departments of social work are most commonly the recipient of these targeted investments.

Policy implications for child welfare outcomes. Beyond the T/TA strategies underway, the Children's Bureau also took a comprehensive examination of the outcomes for all children and families who are being served by the child welfare systems across the nation. In the 1980s and early 1990s the number of children in out of home care rose, doubling in size. Between 1996 and 2009, the number of children in out of home care decreased by 25 percent. This reduction is due in part to the reforms included in the Adoption and Safe Families Act (ASFA) of 1997 (P.L. 105-89). The goals were to move children more quickly into permanent placements rather than languishing in foster care; and to change the experiences of children who enter the child welfare system, by focusing on safety, permanency and well-being. In 2008, child welfare reforms continued with the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) passed as a complement to ASFA, with an effort to extend care up to age 21, to expand guardianship placements, to promote educational stability for children in foster care, to enhance transitions for youth aging out of care, and to empower tribes to administer their own IV-E dollars.

In looking to the future, the Children's Bureau is now considering, what system

transformation will be required to decrease the out of home care population by an additional 25 percent; and what will be required of the child welfare workforce to accomplish this. In looking at the children served by the system it is important to consider that:

> Young children entering child welfare have high levels of development risk
> Youth involved with child welfare face social-emotional, behavioral and cognitive challenges
> The behavioral sequelae of trauma manifest over time.
> Maltreatment has a distinct fingerprint on the mental health of young people
> Mental health disorder prevalence is high among children who have been in foster care.

Thus, the objectives for workforce development to meet this agenda should include:

> Focusing on improving child and family functioning and well-being by addressing social-emotional, behavioral, and mental health needs of children coming into contact with child welfare. This includes understanding common disorders and issues that children with a history of trauma face.
> Emphasizing child and family outcomes and promoting data and outcomes driven decision-making.
> Using workforce development as an implementation tool for evidence-based practices and the targeting of effective interventions to improve functioning and well-being. This will require capacity in selecting, adapting and implementing evidence-based practices.

> Substantive collaboration with mental health, physical health, education and other systems.

However to meet these objectives for workforce development will be challenging. The challenges include:

> Lack of availability of child and adolescent psychiatrists. The President's New Freedom on Commission on Mental Health (2003) identified the need for 30,000 additional child psychiatrist to address child behavioral health issues in the US – five times the number practicing at the time.
> A disconnect in the role of caseworkers who provide primary services to children and families in child welfare. They do not typically focus in on addressing the social, emotional and behavioral health needs of children, but rather provide general case management.
> High rates of worker turnover in child welfare, with common reasons including overwhelming workload, minimal support and a lack of expertise.
> A mismatch between job demands and available resources (autonomy, supervisory support, etc.) in child welfare leads to higher unmet

expectations, especially among practitioners early in their careers.

Therefore, transformation will be required of the child welfare workforce to provide more clinical practice within agencies, to use data and outcome driven decision making, to target and implement evidence-based practices, and to work collaboratively with other systems that also have a stake and input in affecting the lives of those served by the child welfare system.

Office of Minority Health Supports Deans' Health Disparities Initiative
At the symposium, in addition to the formal presentations from the BHPr and the ACYF, James Herbert Williams, President of the National Association of Deans and Directors of Schools of Social Work (NADD) and Dean at the School of Social Work at the University of Denver, provided brief information about a project, "Mobilizing social work as a resource for eliminating health disparities: Proposal for a Health Disparities Curriculum Infusion Project." NADD is undertaking this effort with support from the HHS Office of Minority Health (OMH). The project is an outgrowth of a NADD workgroup's outreach and on-going communications with OMH. The initiative both highlights the importance of the social work profession in addressing health disparities and asserts that there are gaps in the social work curricula in regard to teaching about health disparities. The contract that NADD received is being staffed through Arizona State University. It will develop health disparities competencies (in collaboration with CSWE and identify resources for infusing health disparities content into the curriculum. Other advanced competencies can be found at www.cswe.org/CentersInitiatives/Curriculum Resources/CompetenciesforAdvanced Practice.aspx.

Foundation Invests in Social Work: A Unique Commitment to Aging
For more than a decade, the John A. Hartford Foundation has implemented a Geriatric Social Work Initiative (GSWI) that collaborates with social work education programs to prepare aging-savvy social workers and improve the care and well-being of older adults and their families. The GSWI is a collection of several programs that focus on cultivation of leaders; developing excellent training opportunities in real world settings; and, in infusing gerontological competence into the social work curricula (www.cswe.org/CentersInitiatives/ GeroEdCenter/AboutGero Ed.aspx).

Nora O'Brien-Suric, Senior Program Officer at the Foundation, specifically highlighted the Hartford Partnership Program for Aging Education (HPPAE), which is developing high-quality models of, and disseminating new knowledge about, aging-rich field education at schools of social work and community agencies across the country. The HPPAE program, supporting field education opportunities for MSW includes a recent collaboration with the Department of Veterans Affairs. More information about HPPAE can be found at http://hartford partnership.org and general information about the overall GSWI can be found at www.gswi.org.

> ## SOCIAL WORK, CMS AND HEALTH CARE REFORM – OPPORTUNITIES AND ACCOUNTABILITY

The Centers for Medicare and Medicaid Services (CMS) plays an important role in the diverse ways that social work practice is defined and reimbursed in different health care settings (see APPENDIX 7) and also has

a major role to play in implementation of the Patient Protection and Affordable Care Act (ACA). Drawing on his experiences at CMS and as a health care consultant working on rate-setting and regulation for health care services, Allen Dobson, president of Dobson|DaVanzo, provided a broad look at health care reform and its components, payment for services and the potential implications for social work.

The goals of the ACA are to both expand coverage and to control health care costs. These might initially be perceived as conflicting goals. With the goal of driving down medical costs over the long term, the ACA includes strategies targeted toward payment reforms. This includes bundling acute hospital and post-acute care along with physician services as well as pay-for-performance, shared savings and value-based purchasing. In addition, the health care reform efforts promote patient care coordination through affiliating providers together. This is intended to be accomplished through Accountable Care Organizations (ACOs) and medical homes. The expectation is that better coordination among health care providers will improve quality and reduce unnecessary utilization. The goal is to decouple payment from the volume and intensity of services that are currently encouraged by the fee-for-service (FSS) payment model. Payment reform efforts are especially targeted to populations that are high utilizers of health care, building on the results of a few well-tested models of care coordination.

Transitions of Care Models
Two frequently cited, well-tested and replicated, effective models to improve outcomes in transitions of care are:

> The Transitional Care Model is an evidence-based in-hospital planning and home follow-up program for chronically ill high-risk older adults (http://innovativecaremodels.com/care_models/21/overview).

> The Care Transition Intervention model includes a "transition coach" to ensure continuity of care (www.caretransitions.org/overview.asp).

For information on the National Transitions of Care Coalition's (NTOCC) resources for professionals see Appendix 5.

The payment reform elements of the ACA include the establishment of the Center for Medicare and Medicaid Innovation (CMI) at CMS (www.cms.gov/CMSLeadership/34_Office_CMMI.asp) with a $10 billion budget between 2011 and 2019, CMI will test innovative payment and service delivery models targeting reduced program expenditures while preserving or enhancing quality of care. To accomplish its mission CMI is working on developing templates for evaluation and a core set of quality measures. CMI is designing and implementing projects with the goals of the ACA and evaluation outcomes in mind. It will undertake continuous, real-time evaluations, including improved data, information exchanges and pre-post research designs. The work of CMI will be aligned with reforms such as health information technology (HIT), the Patient-Centered Outcomes Research Institute (http://pcori.org/), and other demonstration projects.

Payment bundling is another effort growing out of the ACA. The objectives of payment system reform are to make it easier to understand, simple to administer, coherent clinically, accurate in payments, offering appropriate provider incentives, and provide adequate payment to providers to assure beneficiary access and ensure that Medicare is a value-based insurer. CMS has long used payment system reform to provide incentives to increase efficiency in health care delivery. Thus far, government-supported research on episode-based payments and post-acute bundling have found that "episode-based payment reforms may work far more effectively, if they are coupled with initiatives and incentives that pay more when reductions in the rates of some types of episodes (such as surgeries for chronic diseases or hospitalizations for heart disease) actually occur" (McClellan, 2010). The ACA contains a provision for bundling acute care hospital and post-acute care payments for an episode. The ultimate goals of a bundled payment are to provide care in the most cost-effective setting with less reliance on fee-for-service payments; to reduce hospital readmissions; and to drive quality improvement through enhanced coordination of care (e.g., ACOs).

Accountable Care Organizations (ACOs) are an additional ACA initiative to improve health care service delivery and deal with health care costs. The three part objective of ACOs, (as published by CMS in the Notice of Proposed Rulemaking (NPRM), *Federal Register*, April 7, 2011[2]) are:

1) better care for individuals,
2) better care for populations, and

---

[2] 42 CFR Part 425 Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice, http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf.

3) lower growth in expenditures (including Medicare and other payers).

ACOs are intended to be primary care centric, with beneficiaries assigned to ACOs based on contacts with their primary care physician. The ACO would be a group of providers (including hospitals) that will be jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth, which will be rewarded through a shared savings program. As written, the NPRM focuses on the delivery of primary care services and says nothing specifically about social work services, although achieving the ACO goals of reduced re-hospitalization and improved care coordination can be accomplished through involvement of social workers. It will be important for all types of providers to demonstrate their value to be part of the ACO team and demonstrate how they can improve quality and reduce overall ACO expenditures commensurate with payments to social workers. (See Appendix 6 for a copy of NASW's written comments to CMS in response to the NPRM on ACOs).

The expectation of a Medicare ACO is that it would be serve at least 5,000 beneficiaries; that the primary care

physicians must be exclusive to that ACO; and at least 50 percent of the primary care physicians would need to be users of Electronic Health Records within a certain timeframe. Participants in an ACO would be different types of physicians and other primary care providers, hospitals, specialists and other health care delivery entities (e.g. long term care facilities, rehabilitation facilities, hospice programs). They would be expected to work together to manage and coordinate care for Medicare beneficiaries. It is hoped that payment bundling and the development of ACOs will be aligned with each other and not develop on separate tracks. In order to bundle payments several issues must be resolved. First, the payment amounts need to be defined. This includes determining how the bundle is defined; how the bundled payment amounts are set; how the bundles are risk-adjusted; what other payment adjustments might be needed (e.g. wage adjustment); and what payment transition methods will be used. Secondly, it needs to be decided who will be paid directly. For example, will individual professional providers be paid or will the focus be on payment to facilities; how will payments be distributed within the bundle; how will join ventures with other management models be paid, and how will payment be determined in situations of care coordination across geographic regions.

As the planning for payment bundling moves forward, it also needs to be determined what incentives there will be for physicians and facilities to participate; what will determine individual care quality and volume, and how will coordination of care quality and volume be determined across providers? The implications of bundling include changes in management

structures, capacity, cost-saving, quality, outcomes, and workforce, among other issues. Since the initial payment bundles will be hospital and post-acute care oriented, physicians may be added, but other providers are less likely to be added to the bundle over the near term.

Social work services could be considered to be part of the bundle, but they are not currently recognized. It will be important for social work to focus on the "value" of its services and how the bundles will be risk-adjusted. The vulnerable populations that social workers serve in health care, e.g., the frail elderly and persons with other complex and chronic diseases, are the cases for which risk adjustment is most important.

Since there are currently differential CMS qualifications and definitions of social work services across practice settings this can be a stumbling block in including social workers in the payment bundle. This is especially of concern because of the variations, with a clinical social worker with an MSW and experience required in home health care to social work requirements in skilled nursing facilities where federal regulations do not even require a BSW degree at a minimum (see Appendix 7).

> IMPROVING HEALTH OUTCOMES: THE VALUE OF THE PATIENT-CENTERED INTERDISCIPLINARY TEAM

NASW works closely with the Case Management Society of America (CMSA), especially on the National Transitions of Care Coalition (NTOCC)

(www.ntocc.org) that has been led since 2006 by CMSA. Cheri Latimer, Executive Director of CMSA served as a respondent during the think tank symposium, drawing from her interdisciplinary health care experiences and her practice, professional and advocacy partnerships with social workers. Some of the key themes that she addressed included:

> Patient-centered care must be more than just a statement, but become a reality in practice.
> In considering contemporary health care delivery, it is not about one discipline but rather the team, and team members should be included in the planning of care from the beginning.
> Medically complex patients require more diverse care provision and there need to be revisions of how care is conceptualized, moving from "episodic care" to a "continuum of care."
> Consumers expect services from a team of experts, and different disciplines bring complementary but differential expertise, perspectives and knowledge to the team.
> Nursing-social work case management partnerships will become more common in the future as the differential expertise of each is valued.
> Social work needs to be able to articulate what it does and what other disciplines say they value in social work.
> It is critically important for the team to be sit down together to decide how to best serve the client.
> A view to the future would be health care delivery that is consumer-directed in how it is planned and provided. Health care

professionals across disciplines and consumers need to coalesce together to achieve these goals.
> As we look to health care reform and the development of ACOs, medical home and payment bundling, the goal is to move beyond just enhanced managed care; but to truly break down some of the silos of care we currently have.
> CMSA and NASW have worked together with other stakeholders to develop an array of tools and resources for consumers, policy makers and professionals. Information on the links to the *Tools for Health Professionals* can be found in Appendix 5.

> INVESTING IN THE SOCIAL WORK WORKFORCE: A VIEW FROM THE FRONT-LINE

Moving from the national perspective, Uma Ahluwalia, Director of the Department of Health and Human Services for Montgomery County, MD provided a local government perspective on workforce issues and workforce investments. The Department of Health and Human Services incorporates a continuum of programs including Aging and Disability Services; Behavioral Health and Crisis Services; Children, Youth and Family Services; Public Health Services; Special Needs Housing and the Office of Community Affairs. The demographics of the county are changing. With one million residents, 50.6 percent of the residents are ethnic minorities, so that cultural competency for all who work in the county is extremely important.

Different groups utilize services in different ways and this must be considered when developing and implementing programs, including for the growing population of suburban poor.

In carrying out health and social service programs, the county needs to examine individual, system and population outcomes, with attention to safety and well-being as overarching goals in the more than 80 programs under the Department's purview. This has to be coupled with developing the technology and data gathering mechanisms to promote integration among practice settings and programs and to also be in keeping with HIPAA confidentiality requirements. The county is working to build a framework to create an integrated data system that would address collaborative practice, privacy and HIPAA, but also share information on a need to know basis.

For social workers that work in these 80 programs, there are many different skills and expertise required, including clinical skills to work with different populations and to address different types of problems, to skills in community development, planning, administration, data analysis and social research. Changes that will be occurring in the workplace, including the high number of staff eligible for retirement, require that the workforce be nimble, flexible and responsive. Attributes that will be desirable include:

> Ability to embrace technological modernization.
> Ability and desire to embrace a leadership role.
> Desire to create energy, and to demonstrate pride and excitement to be part of the social work profession.

- Ability to manage with data and to be more business oriented without losing facility for empathy and compassion.
- Ability to work in a multi-disciplinary environment.
- Ability to create a more integrated practice framework across practice settings and systems, including integration of human services and health.
- Responsive to changing economic, demographic and political realities
- Ability to capitalize on opportunities to partner and work across the public and private sectors and to reach out to the business community.
- Ability to incorporate new knowledge and evidence-based practices.
- Ability to be an advocate and engage with advocacy organizations and professional associations.

As service delivery changes, as available funding becomes scarcer, and as expectations of and demand for skilled social workers increases, it is important to reflect on what roles social work education programs, and professional organizations should fulfill. What are their roles and responsibilities to educate the next generation for the workplace of the future, as well as to retool current workers for new realities?

> CHARTING AN ADVOCACY AGENDA: A VIEW FROM NASW AND CSWE

Congressional Social Work Caucus Brings New Focus on Social Work to Capitol Hill

The visibility of the important work done by social workers took a substantial leap forward on Capitol Hill with the launch of the Congressional Social Work Caucus (CSWC) in 2011. Chaired by Congressman Edolphus "Ed" Towns (D-NY 10), the purpose of the CSWC is to create a platform on the Hill representing the interests of over 600,000 social workers throughout the United States. It will serve as an informal, bipartisan group of Members of Congress dedicated to maintaining and strengthening social work services in the United States. It will educate national legislators and their staffs on issues that challenge the social work profession. The objectives of the Congressional Social Work Congress are to:

- Initiate and support legislation to address the unique challenges and opportunities for professional social workers.
- Monitor and evaluate programs and legislation designed to assist and support individuals, families, and communities at all income levels who are coping with economic, social, and health problems, particularly those with limited resources.
- Provide Congressional staff members with educational tools and resources directed toward improving the social work profession and the people social workers serve.
- Assist in the education and

awareness efforts on the breadth and scope of the social work profession.

The CSWC will accomplish its goals and objectives through regular briefings on the Hill, statements in the media, convening experts on specific issues, engaging social work practitioners, schools, and scholars, fostering interdisciplinary cooperation with relevant disciplines, and by working with various stakeholders in local government and communities. Congressman Towns has already hosted briefings on the Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act as well as the impact of health care reform on the social work profession and prevention, treatment, and services research funding in the National Institutes of Mental Health Budget. Information on the briefings can be found at http://socialwork reinvestment.org/2011/caucus.html.

NASW and the members of the ANSWER Coalition will continue to work closely with the CSWC to advance its goals and legislative priorities. The CSWC website can be found at http://socialworkcaucus-towns.house.gov. As of September 2011 there are 57 members of the Congressional Social Work Caucus (see Appendix 8).

Strengthening the Social Work Workforce: A Legislative Viewpoint from NASW

The *Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act (SWRA)* (H.R. 1106/S. 584) was first introduced in February 2008 and has been reintroduced in the 111th and 112th Congress. The lead sponsors are social workers Edolphus Towns (D-NY) in the House of Representatives and

Barbara Mikulski (D-MD) in the Senate. Asua Ofosu, NASW's Manager of Government Relations provided an overview of the Act, its origins within the overall Social Work Reinvestment Initiative as well as an update on its current status, along with information on the newly created Congressional Social Work Caucus (CSWC).

THE SOCIAL WORK REINVESTMENT INITIATIVE

The goal of the Social Work Reinvestment Initiative is to secure federal and state investments in professional social work to enhance societal well-being. The strategies focus on recruiting new social workers, retaining current social workers, retraining experienced social workers and reinvesting in the profession of social work. The Reinvestment Initiative is led by NASW and ANSWER. For more information visit www.socialworkreinvestment.org.

NASW worked with members of Congress to introduce SWRA as an outgrowth of NASW's long-standing legislative and executive branch advocacy. As concerns about the challenges facing the social work labor force loomed large, the profession became increasingly concerned about its own future. Many of the challenges expressed in Dr. Whitaker's presentation led to the pursuit of legislation that could accomplish multiple goals regarding the recruitment, retention, and workforce development for social workers.

The key components of SWRA include:

> The creation of a *Social Work Reinvestment Commission* to provide a comprehensive analysis of current trends within the practice, academic and professional social work communities.

> The development of grant programs related to *Workplace Improvements, Research, Community-Based Centers of Excellence and Education and Training*.
> The creation of a *National Coordinating Center.*

For more information about the Height/Young Social Work Reinvestment Act see Appendix 9 and visit http://socialworkreinvestment.org/SWRI/default.html.

In addition to SWRA there are several other pieces of legislation introduced in the 112th Congress that would have the potential to specifically address social work workforce issues.

> *Strengthen Social Work Workforce Act* (S. 42) would ensure that social work students or social work schools are eligible for grants for training projects in geriatrics and to establish a social work training program. It was introduced by Sen. Daniel Inouye (D-HI) on January 25, 2011.
> *National Office of Social Work Research Act* (S. 41) would create a national office of social work research within the National Institutes of Health. It was introduced by Sen. Daniel Inouye (D-HI) on January 25, 2011.

As previously mentioned, the ACA includes opportunities for social work such as:

> The creation of the National Healthcare Workforce Commission (www.gao.gov/press/nhcwc_2010sep30.html).
> State health care workforce development grants
> Education and training grants:

Geriatrics, mental and behavioral health

In regard to the implementation of ACA, NASW has been very active. In addition to meetings with high level HHS officials, and participating in taskforces implementing requirements of the ACA, NASW submitted comments on numerous requests for information and proposed rules and nominated social workers for the several commissions and workgroups that emerged from ACA. Although there is no social worker appointed to the Health Care Workforce Commission (despite nominations being sent forward), the social work community has reached out to several members of the Commission to request that the social work profession's roles and challenges be considered throughout the Commission's deliberations.

In addition to these specific legislative and executive branch activities, NASW participates in more than 100 coalitions, many of which focus on practice and provider issues including workforce development as well as promotion of social justice. Targets for advocacy include Congress, and the executive branch, including the White House. For more information on NASW's government relations activities and advocacy agenda, visit www.socialworkers.org, subscribe to the monthly MemberLink and to the advocacy listserv (http://capwiz.com/socialworkers/mlm/signup/).

It should also be noted that reports from entities such as the Institute of Medicine (IOM) help to frame recommendations and suggest policy enhancements. A few recent reports that specifically are social work relevant

include *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, The Mental Health Workforce and Geriatric Populations* (Coming Soon), and *Retooling for an Aging America: Building the Healthcare Workforce.* Their recommendations can help to shape policy priorities. IOM reports and information on IOM committees and workshops can be found at www.iom.edu.

Investing in the Social Work Workforce: An Advocacy Agenda for Social Work Education

In 2008, the Council on Social Work Education (CSWE) launched a new Public Policy Initiative (PPI) and engaged Lewis-Burke Associates LLC as their government relations representatives. Wendy Naus serves as Government Relations Consultant and provided an overview of CSWE's public policy agenda and priorities.

The goal of the PPI is to *enhance social work education and the profession through thoughtful public policy that is focused on providing the very best education, training and financial assistance for social workers*

(www.cswe.org/CentersInitiatives/PublicPolicyInitiative13785.aspx)*.* The audiences for the initiative include the United States Congress, federal agencies and other organizations throughout the social work, health care, and higher education communities. The initiative is guided by (but not limited to) four fundamental areas of focus: 1) Debt load and loan forgiveness; 2) Higher education and accreditation policy; 3) Skilled and diverse workforce; and 4) Ally building.

In addition to working with members of Congress to enact thoughtful policies that enhance social work education and the profession, CSWE engages with executive branch agency officials on the implementation of policy. Outreach to the Department of Health and Human Services has focused on enhancing opportunities for social workers around training, care coordination, cultural competency, research, and addressing health disparities, among other topics. CSWE works closely with the Department of Education, especially around implementation of the *Higher Education Act*, accreditation policy, student aid, and community college articulation. CSWE engages with the Department of Veterans Affairs, focusing on topics such as scholarship and loan repayment opportunities, meeting the needs of military families, and the development of competencies for social work programs. Over the last several years CSWE has taken its priorities to the White House, most recently engaging with the Obama Administration offices on topics dealing with military families, health care and education initiatives.

As a result of the PPI, federal policy makers have increased awareness of social work education and key contacts have been established and strengthened across the federal government and with other organizations and stakeholders. Specific successes of the PPI are related to proposed policies to implement the *Higher Education Opportunity Act of 2008* related to accreditation policy, for profit institutions of higher education, federal student aid and community colleges. Also, as noted in the earlier section on the Bureau of Health Professions' programs, as a result of health care reform, several programs provide eligibility for social workers. It was especially noted that in the BHPr program to train behavioral and mental health professionals, priority for eligibility for the grants is given to those social work programs accredited by CSWE. In regard to the VA Health Professionals Educational Assistance Scholarship Program, in the 111th Congress language was included to broaden eligibility to reinstate the social work scholarships that existed in the 1990s. It is anticipated that this will be implemented in Fall 2011 or Spring 2012. Lewis-Burke prepared an overview of the relevant provisions of the ACA for social work education that is available at www.cswe.org/File.aspx?id=48334.

CSWE keeps educators and students informed of its public policy efforts through its monthly Public Policy Monthly Review, and its webpage (www.cswe.org/CentersInitiatives/PublicPolicyInitiative13785.aspx).

DEVELOPING A FRAMEWORK FOR ACTION

Social work organizations and social work educators have a shared goal – ensuring the development of a competent, committed social work workforce that will be employed across numerous fields of practice; that will be retained within the social work profession; and that can help to achieve positive outcomes for the clients served. The breadth of social work roles suggests the on-going need for practitioners who can demonstrate clinical expertise and care coordination, program development, professional development, organizing, supervisory, administrative, and policy skills.

Social workers need to be able to work in interdisciplinary settings and engage with clients and communities in developing and implementing services and programs. Social workers should be ready to meet new challenges and be responsive as the needs of populations change; as policies (e.g., ACA) and funding streams change, as the job market becomes increasingly competitive; and as some fields of practice, (e.g. working with disasters or working with the military and veterans) expand. Social workers also need to be engaged in life-long learning.

For many of the federal, state and local agencies that fund and implement the programs in which social workers work, recruiting, retaining and training the right workforce is a challenge to which solutions are being sought. In most instances, agencies are seeking employees that have a set of skills and experiences to do the job; and these individuals might be selected from an array of professions – social workers, psychologists, nurses, counselors,

lawyers, and others – who may all fit the employers' job descriptions. In some fields, especially in child welfare and in aging, social workers with BSW and MSW degrees may be competing for jobs against persons who have no specialized training and may have only a bachelor's degree, or less. The public, however, often assumes that all of the persons performing these functions are professional social workers.

There may be a declining number of positions in the 21st century that specifically call for hiring only a social worker to do the job. Services that do specifically recruit and employ social workers are those where federal, state or other policies define who are required staff or members of an interdisciplinary team, (e.g., end-stage renal disease facilities, rural health centers, inpatient psychiatric hospitals or hospice). Settings may specifically require a professional social worker due to states' licensing requirements (go to www.aswb.org); social work qualifications that are defined in law or administrative policy; or an agency's efforts to meet accreditation standards of the Joint Commission or the Council on Accreditation or other accrediting body. In some instances, the front-line position may not require a social work degree, but it may be required for the supervisory position. This can create problem in implementing a career ladder for experienced workers to move into supervisory positions, if social workers are not recruited to the front-line.

Some agencies have a preference for hiring social workers as they consider social workers to have the most relevant preparation; however it is not a

requirement. As noted earlier, in situations where a social work degree may be required or preferred, there are variations regarding the social worker's educational level and the type of experiences and skills that are required or preferred. This can vary as well due to geographic region, as MSW level social workers might be scarcer in more rural areas and are well concentrated in cities like New York, Boston and Chicago where there are many programs graduating new MSWs each year.

For the Bureau of Health Professions, many disciplines including social work, or multiple disciplines working together, are eligible to apply for training grant funding. For the programs of the Children's Bureau, schools of social work are most frequently engaged in the workforce development initiatives. Social work is the lead in many other Children's Bureau grants and cooperative agreements as well. This is due to the long-standing history and body of research that connects social work and child welfare, the leadership by social workers in this field of practice, as well as the targeted legislative and executive branch advocacy by NASW and by the ANSWER coalition (SWPI, 2010; Zlotnik, 2009).

As we look to the future, the increased demand for social workers will continue to grow and will need to be responsive to the following:

> The impending retirement of a sizable cohort of today's health and human service workforce;

- The implementation of the ACA;
- The efforts to reduce the number of children in out of home care;
- The increased linkages between mental health services and primary care;
- The expanded focus on interdisciplinary/interprofessional service delivery;
- The requirements to implement tested interventions and evidence-based practices;
- The increased demand for quality consumer-centered care and care coordination;
- The focus on addressing the needs of the military and their families and the many generations of veterans;
- Growing opportunities for social workers in business and in the for profit sector.

The demand for social workers needs to be coupled with the creation of an adequate supply of social workers with the skills and competencies to meet the needs of the marketplace. Through large and small group discussions, the think tank participants grappled with many issues that could result in enhanced efforts by the government and other funders to invest in the social work workforce; that would strengthen and enhance intra-social work and interprofessional partnerships and advocacy strategies; and that

would strengthen the linkages between what social workers learn in the academy and what they do in practice. The following highlights the issues and the questions that need further exploration.

> INFLUENCING SOCIAL WORK EDUCATION

Enrollments and applications to social work education programs are increasing, creating a readiness to respond to the growing need for social workers. Social work, like several other applied professions are viewed as counter-recessional. Applications and enrollments for social work education rise in tight economic times. This is an opportunity to be responsive to the Bureau of Labor Statistics projections of the growing need for social workers. However, there are also questions:

- Will the graduates have the right skills, abilities, and experiences to effectively perform their jobs in the settings where social workers are needed?
- With availability of field placements in flux, is there mismatch between accessible field placements and the jobs available after degree completion?
- It is critical to have field placements in macro settings available so that students can be prepared and mentored to pursue careers in government agencies and be involved in planning and policy activities. What strategies can be pursued? How might these students be more competitive in federal programs to recruit the next generation of leaders?

Changes in practice suggest that social work curricula changes are also needed. Educational institutions may not always keep current in preparing students to meet the needs of the communities and clients in need. Questions that get raised include:

- What are the roles that deans/ directors of social work education programs can take to ensure that there is innovation in curriculum in schools of social work so that there is not a disconnect between what is offered in education and the populations to serve and the interventions that are used in practice?
- Are we making sure that information on evidence-based practice is reaching social work faculty?
- Are strategies to translate research into practice being utilized?

EXAMPLES OF EVIDENCE-BASED PRACTICE RESOURCES IN SOCIAL WORK

REACH-SW - A Curriculum Tool to Infuse Evidence-Based Practice and Research across the Social Work Curriculum was developed with support from the National Institute of Mental Health (NIMH) (www.danya.com/reach)

Partnerships to Integrate Evidence-Based Practice across Social Work Education and Research – Includes a Report from a Social Work Symposium sponsored by NIMH and Links to Resources about Social Work and Evidence-Based Practice (www.social workpolicy.org/publications/evidence-based -practice- publications.html).

SHIFT PROJECT FOR ADOLESCENT SUICIDE PREVENTION – NASW developed a toolkit to provide a step-by-step, online resource to make the shift to evidence-based programs (EBPs) in your practice, agency or community (www.socialworkers.org/ practice/adolescent_ health/shift).

- What opportunities exist to build research/practice bridges in social work – to encourage clinician-researchers and to embrace the teaching hospital type of model that exists in medicine?
- What role can dual degree programs play in improving workforce marketability?
- While dual degree programs are attractive, how do we also ensure that those with dual degrees maintain their social work identification?
- How can social work education programs track graduates and call on them to mentor both faculty and students regarding the reality of contemporary social work practice?
- How can education and training innovations in evidence-based practice or military social work, for example, best be disseminated to the field?
- What opportunities might be available in the business community for social work students and how can social work education best engage business leaders in pursuing such opportunities?

> INFLUENCING SERVICE DELIVERY AND SOCIAL WORK PRACTICE

Emerging practice methods may require shifts in how practice is defined and how social work communicates its expertise.
The ACA and other efforts to better meet the needs of those who are most at risk and most vulnerable as well as the demographics of aging and the needs of the military and veterans provide important opportunities for social work. Questions to address include:

- What training and professional development strategies are needed to ensure that practitioners have the necessary evidence-base to provide services, especially as the use of evidence to inform practice is increasingly written into policy?
- With the increased focus on care coordination, how will care coordination be defined and what will be the critical roles and functions required for quality care coordination? How can materials and tools developed through NTOCC, for example, best be disseminated?
- Although case management and care coordination are not the sole domain of social workers, how can social work best articulate its roles and functions as care coordinators in diverse practice settings?
- How will several disciplines share leadership in the new visions for health care delivery?
- Although the medical model and role of physicians is strong in the ACA, accomplishing the ACA goals will require psychosocial interventions. How will we ensure that social work is at the table in developing the necessary interventions and outcome measures, especially in addressing health disparities and health literacy, and meeting the needs of those with complex health and social needs?
- How will professionals work together with the client/patient/consumer to develop and implement the appropriate plan of care, as greater emphasis is placed on person-centered care and the need

to build on strengths and protective factors?

Interdisciplinary/interprofessional practice will be increasingly the norm in practice settings.
Despite at least 40 years of interdisciplinary service delivery and training there are still discussions about social workers and other disciplines being unprepared to work in an interdisciplinary setting. This raises the questions:

- What strategies are needed in the academy and in practice settings to ensure that social workers are well prepared to work in such settings? Are there examples of success?
- Can social work effectively articulate its particular roles and its knowledge and skills in an interdisciplinary setting?
- Can we develop consistent and agreed upon definitions of interdisciplinary and/or interprofessional practice that are shared across disciplines and settings?
- How do we ensure that social workers are part of the health care interdisciplinary team; especially when some interdisciplinary initiatives may merely be inter-medical which is different from interdisciplinary?
- What research and data can support the appropriate understanding of role differentiations?
- How do we create interdisciplinary training in the academy that can translate into interdisciplinary practice at the community level?
- What needs to be done to ensure continued relationships among national organizations

from different disciplines and to encourage their efforts related to enhancing interdisciplinary practice?

Interprofessional Resources Exist
In the 1990s, social work educators explored interprofessional practice within the health care domain as well as across social work, health and education. *Myths and Opportunities: The Examination and Impact of Discipline-Specific Accreditation on Interprofessional Education* was a collaborative project undertaken by the CSWE with support from the Annie E. Casey Foundation. The principles and competencies for interprofessional education and practice articulated in that project have stood the test of time and can be found in Appendix 10.

Use of data and research findings will increasingly be used to guide practice and policy.
Some of the critical issues discussed by the think tank participants relating to practice and client data include the following:

> How can the data available be more client-centric, so that different agencies can access the same information, to be better informed of client needs and to have greater

coordination in providing the necessary services?
> How can different local agencies work together to develop uniform data systems?
> How can data entry of client information be streamlined so that it can be done easily, while out in the field?
> How can front-line practitioners and supervisors be encouraged and guided to use data and research to inform practice?
> How can community-based participatory research methods be used to ensure involvement of consumers, community-members and practitioners in developing and implementing useable and relevant research?

Availability of data regarding the social work profession is essential.
Questions include:

> What is the most consistent and available source of information on data on the social work workforce?
> What role will the new Bureau of Health Professions (BHPr) National Center for Workforce Analysis play in gathering and analyzing social work workforce data?
> How can information on the social work workforce be gathered together and be easily accessible, to use with federal, state and local policy makers?
> How might data gathered by individual schools on alumni be used to create a data bank of social work practice information?

Workplace supports and the work environment should facilitate quality social work practice.
Concerns are continually raised about the organizational culture and climate in some health and human service settings, especially as funding is tight, workers are laid off, class action lawsuits are filed, and caseloads rise. To address these environmental issues the following questions are raised:

> What roles do unions play to provide a venue for management and staff to work together to address workforce challenges and to improve workplace conditions?
> How do the many changes and shifts happening in organizations (e.g., leadership changes, funding cutbacks) impact worker retention and service outcomes? How can the case be made to policy makers to address these issues?
> What strategies for investments in the social work profession need to be taken to address both public and private sector settings for practice?
> How can members of interdisciplinary teams work together across disciplines to provide the necessary continuum of care and to identify how the diverse roles of the interdisciplinary team are necessary to achieve quality care outcomes?

Increasing social work salaries should become a top priority.
Concerns continue to be raised about the perennial low salaries of social workers. This is not only true for practice, but is true in academia where

social work faculty salaries are low as well. According to Barth (2003), one of the factors that keep social work salaries low is what economists would describe as social workers' "taste" for the profession. Questions include:

> How can this "taste" for the work be coupled with better advocacy by social workers themselves and social work organizations, collectively, to advocate raising social work salaries?

> How can advocacy work with other disciplines and provider organizations help make the case for higher social work salaries, especially when doing similar jobs as professionals with other degrees?

> What role can schools of social work play in preparing students to market themselves and their social work skills to employers?

> Many of the highest earning social workers are not necessarily in positions with a social work title, as they may be a Chief Executive Officer of a large organization or a Vice President of a hospital, for example. How can we encourage all professional social workers to use their professional credentials and continue to identify their expertise as a social worker, no matter what their role and job function?

Social Work Labor Market: A First Look
"Fragmentary evidence suggests that this market (for social work) is highly segmented by education; that many people who do not have social work degrees work in social work jobs, at least at the lower levels; that people who want to be social workers have such a strong commitment to the career of social work that relative wages make relatively little difference to their career decisions; and that employers often hire applicants without degrees for social work jobs. These factors tend to depress wages for social workers."
Economist Michael C. Barth, *Social Work*, January, 2003, 48(1):9-19.

Advocacy to address workforce issues is needed at the federal, state and local levels.
Workforce shortages exist across professions, suggesting that increased efforts are needed to address workforce gaps and workforce competency in collaborative ways. Questions include:

> How can interdisciplinary workforce advocacy efforts best be facilitated so that policy makers see the strength in the groups working together toward common goals?

> How can unique needs of specific professions be acknowledged and supported when working in interdisciplinary coalitions and in coalitions of provider associations and professional associations together?

> How can consumer/professional advocacy partnerships coalesce to advocate for service delivery enhancements?

> How can the business community and other stakeholders be engaged in advocacy for the health and human services workforce?

> How can social workers' best engage employers in advocacy for workforce improvements?

Addressing workforce policy issues in the profession can best be realized through collaboration among social work organizations. Questions include:

> What new actions can the ANSWER coalition take to advocate for the Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act, including engaging national organizations of providers (e.g., Alliance for Children and Families, National Association of County Behavioral Health and Developmental Disability Directors, National Council for Community Behavioral Healthcare, National Assembly, Child Welfare League of America) whose members are major employers of social workers?

> How can the work of the ANSWER coalition best be enhanced to ensure inter-organizational communication, planning and priority setting among social work organizations?

> How can advocacy among social work organizations best be facilitated to identify a common advocacy agenda and join together to ensure that there is strength in numbers?

> What are the data needs for effective advocacy and how can a repository of comprehensive social work workforce data best be created and maintained; how can these data be made accessible to stakeholders when it is needed?

> What actions can be taken to better standardize licensing and reciprocity across states, especially in adjoining states and for people who are providing telehealth and working through national entities (e.g., Department of Defense, Department of Veterans Affairs, U.S. Public Health Service)?

> How can the public education campaign be expanded in its information and outreach to employers, the business community and policy makers?

National Social Work Public Education Campaign

The National Social Work Public Education Campaign is a multi-year outreach effort led by the National Association of Social Workers to educate key stakeholders, including American citizens, the media, policy makers, employers and social workers about the importance of this profession. The goals of the public education campaign are to (a) increase awareness and respect for the social work profession; (b) educate the public on the depth and breadth of social work practice; (c) expand perceptions of who can benefit from social work services; (d) attract young people to the profession; and (e) improve employment opportunities for professional social workers. For more information, visit: www.naswfoundation.org/image Campaign/default.asp.

Influencing the executive branch of government to advocate for investing in social work is critical.

The executive branch of government develops regulations and administrative policy guidance, issues grants and contracts, organizes workgroups and advisory groups and works to implement legislation. Influencing the executive branch requires outreach and advocacy on behalf of the social work profession to ensure that social work has a seat at the table. Questions include:

> How can we best encourage social work experts who are engaged by executive branch agencies due to their expertise to make sure that they identify as a social worker, so that the agency and other stakeholders can become more familiar with the breadth of knowledge and experience of social workers?
> What strategies can social work organizations undertake to ensure that social workers are nominated for key posts on advisory boards and workgroups? What process might be used to track such appointments so that NASW might know when social workers are serving on such committees?
> How might social workers within government agencies coalesce, in order to maintain their social work identity? For example in the late 1980s a Federal Social Work Consortium was created.
> How can NASW and the social work community broaden their connections with federal agencies beyond the Department of Health & Human Services and the Department of Veterans Affairs, to other agencies that support and fund programs that can and do employ social workers (e.g. the Department of Defense, the Department of Housing and Urban Development, the Department of Justice, the Department of Education)?
> Since social work has been identified as a high growth field over the next decade, what strategies need to be undertaken, not only to recruit and retain the social work practitioners, but to also support the education of social work faculty and social work researchers?

Targeted social work involvement with ACA implementation is crucial.

Numerous efforts are underway to implement the many provisions of the ACA, focusing on workforce development, implementing evidence-based practices and new service models, defining eligibility and identifying process and outcome measures. Of particular focus are those persons who are the costliest in the health care system, and who are usually those patients that social workers are highly likely to encounter. These efforts should involve individual social work researchers and practitioners as well as input from national social work organizations, and the coalitions with which social work engages. Questions include:

> What opportunities for social work research and practice need to be pursued to ensure that social work is "at the table" in the implementation of the ACA?
> What outreach should social work organizations undertake to develop relationships with key government officials and leaders in other organizations and think tanks to ensure that the social work perspective is included in efforts related to, for example, workforce development, service delivery programs, evidence- based practices, research on psychosocial outcomes, underway as part of the implementation of the ACA?
> What efforts should take place to enhance social work connections with the CMS Innovations?

CONCLUSIONS

Investing in the social work workforce will require actions by multiple players both within the social work profession and on the outside. (Figure 1 provides a conceptualization of priority actions and goals of the necessary action agenda.) Efforts will need to focus on advocacy, research, professional social work education and training, and interprofessional collaboration and interdisciplinary practice. These efforts should be targeted to and engage multiple stakeholders including:

> Social work organizations.
> Government agencies (at the local, state and national levels).
> Unions.
> Licensing boards.
> Accrediting bodies.
> Legislatures.
> National organizations representing service providers (e.g., Child Welfare League of America, Alliance for Children and Families, National Association of Area Agencies on Aging).

> Employers of social workers (e.g., Kaiser Permanente, Family Service Agencies, the Department of Veterans Affairs).
> Clinicians and Practitioners.

Anticipated outcomes for implementing the action agenda will include:

> Enhanced public and policy maker understanding of the essential role of social workers.
> Strengthened inter-social work organization collaboration and

FIGURE 1: ACTION AGENDA

Investing in the Social Work Workforce
ACTION AGENDA

attention to shared missions related to advocacy and professional development.

> Enhanced interdisciplinary training and team outcomes and cross-discipline organizations advocacy

> Strengthened and sustained relations with key executive branch agencies, including collection of social work workforce data and supports for social work education and professional development.

> Strengthened licensing and enhanced recognition of professional social work.

> Increased social worker salaries.

> Increased clarification of differential skills and expected service outcomes for social workers with differential education and experiences.

> Improved retention of social workers in their jobs and within the profession.

> Enhanced understanding of social work roles by employers and policy makers.

> Enhanced alignment between social work education and contemporary practice needs based on demographics and growing service delivery sectors (aging, veterans, military, health disparities).

> Enhanced information on social work effectiveness.

> Attention to development and implementation of evidence-based practices.

> Expanded use of data and research to guide practice.

The goals of this think tank symposium were met. People who do not usually connect with each other connected. Following the symposium, several social work organizations came together to enhance their workforce advocacy

efforts, and federal agencies and the profession have enhanced their potentials for partnerships. The agenda for the future is daunting and will require the development of sustained relationships between the profession and government and foundation representatives, as well as between social work and its interdisciplinary partners. The workforce crisis for social work is real, and creating a *safety net for a civil society* is critical. Social workers must be well positioned to meet the demands for their services from individuals, famillies, organizations and communities in need.

REFERENCES

Baden, B. (2010, December 6). Best careers 2011: Medical and public health social worker. *U.S. News and World Report.* [Online]. Retrieved from http://money.usnews.com/money/careers/articles/2010/12/06/best-careers-2011-medical-and-public-health-social-worker.

Barth, M.C. (2003). Social work labor market: a first look. *Social Work*, 48(1):9-19.

Bureau of Labor Statistics. (2010). *Occupational outlook handbook, 2001-2011 edition, social workers.* Retrieved from www.bls.gov/oco/ocos060.htm#outlook.

HHS. (2006). T*he Supply and Demand of Professional Social Workers Providing Long-Term Care Services: Report to Congress*. Retrieved from http://aspe.hhs.gov/daltcp/reports/2006/swsupply.pdf.

Institute for the Advancement of Social Work Research. (2008). Strengthening University/Agency Research Partnerships to Enhance Child Welfare Outcomes: A Toolkit for Building Research Partnerships. Retrieved from www.socialworkpolicy.org/wp-content/uploads/2007/06/9-IASWR-CW-Research-Partners.pdf.

Institute for the Advancement of Social Work Research. (2007). Partnerships to Integrate Evidence-Based Mental Health Practices into Social Work Education and Research. Retrieved from www.socialworkpolicy.org/documents/EvidenceBasedPracticeFinal.pdf

McClellan, M., et al. (2010). A national strategy to put accountable care into practice. *Health Affairs*, 29(5): 982-990.

President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Retrieved from http://store.samhsa.gov/shin/content/SMA03-3831/SMA03-3831.pdf.

National Council for Community Behavioral Healthcare. (2011, April 11). National Council: BH Salaries fail to keep pace with inflation. *Mental Health Weekly, 21,(15)*, pp. 4-5.

SWPI. (2010). *High Caseloads: How do they Impact Health and Human Services.* Retrieved from www.socialworkpolicy.org/research/high-caseloads-how-do-they-impact-delivery-of-health-and-human-services.html.

Zlotnik, J.L. (2009). Social Work and Child Welfare: A National Debate. Fauri Lecture presented at the University of Michigan School of Social Work, October 27, 2009. Retrieved from ssw.umich.edu/events/fauri/FauriLecture_ChildWelfare.pdf.

1 > INVESTING IN THE SOCIAL WORK WORKFORCE

AGENDA

Wednesday, May 18, 2011
A Think Tank Symposium Sponsored by the NASW Social Work Policy
Institute in collaboration with ANSWER

NASW National Office: 750 First Street, NE, Suite 700, Washington, DC

REGISTRATION & CONTINENTAL BREAKFAST

WELCOME & INTRODUCTIONS
THINK TANK PURPOSE & OUTCOMES
Joan Levy Zlotnik, Director,
   Social Work Policy Institute

Elizabeth J. Clark, Executive Director,
   National Association of Social Workers

THE SOCIAL WORK WORKFORCE: SHIFTING THE CONTEXT
Tracy Whitaker, Director, NASW Center for
   Workforce Studies and Social Work Practice

FEDERAL OPPORTUNITIES FOR WORKFORCE CAPACITY BUILDING, PROFESSIONAL DEVELOPMENT & TRAINING
Developing the Health Professions Workforce
Diana Espinosa, Deputy Administrator, Bureau of
   Health Professions, U.S. Department of Health
   and Human Services

Preparing the Child Welfare Workforce to Meet the Unique Needs of Children and Families
Clare Anderson, Deputy Commissioner,
   Administration on Children, Youth and Families
   U.S. Department of Health and Human Services

SOCIAL WORK, CMS AND HEALTH CARE REFORM – NEW OPPORTUNITIES & ACCOUNTABILITY
Allen Dobson, President, Dobson ╎ DaVanzo

RESPONSE PANEL & DISCUSSION
Cheri Latimer, Executive Director, Case Management
   Society of America

Uma Ahluwalia, Director, Health and Human
   Services for Montgomery County

WORKING GROUPS

LUNCH SERVED

REPORT BACK FROM WORKING GROUPS

CHARTING AN ADVOCACY AGENDA
Investing in the Social Work Workforce: An Advocacy Agenda for Social Work Education
Wendy Naus, Government Relations Consultant,
   Council on Social Work Education
   Lewis- Burke Associates

Strengthening the Social Work Workforce: A Legislative Viewpoint
Asua Ofosu, Manager, Government Relations
   National Association of Social Workers

GROUP ACTION PLANNING

WRAP-UP & NEXT STEPS

ADJOURN

2 > PARTICIPANTS

Uma Ahluwalia, MSW
Director
Health and Human Services for
   Montgomery County

Clare Anderson, MSW, LICSW
Deputy Commissioner
Administration on Children, Youth and
   Families
US Department of Health and Human
   Services

Robert Arnold, MPS
Director
National Association of Social Workers
   Foundation

Tricia Bent-Goodley, PhD, MSW, LICSW
National Policy Advisor
National Association of Black Social
   Workers (NABSW)
Professor
School of Social Work
Howard University

Katharine Briar-Lawson, PhD, MSW
Dean and Professor
School of Social Welfare
University at Albany

Reinaldo Cardona, MSSW, LCSW
Executive Director
NASW New York State Chapter

Elizabeth Clark, PhD, ACSW, MPH
Executive Director
National Association of Social Workers

Mirean Coleman, MSW, LICSW, CT
Senior Practice Associate
Social Work Practice
National Association of Social Workers

Stacy Collins, MSW
Senior Practice Associate
Social Work Practice
National Association of Social Workers

Joseph Colosi, C-ASWCM, LSW
Senior Project Manager
Medicare Care Management Operations
AETNA

Llewelyn Cornelius, PhD, LCSW
Professor
School of Social Work
University of Maryland

Joan DaVanzo, PhD, MSW
Chief Executive Officer
Dobson | DaVanzo

Bonita Davis, BA
Executive Assistant
National Association of Social Workers
   Foundation

Donna DeAngelis, MA, LICSW, ACSW
Executive Director
Association of Social Work Boards

Judith Dekle, LCSW, ACSW
Family Programs Liaison
Psychological Health Strategic Operations
   Force Health Protection and Readiness
   Office,
Assistant Secretary of Defense, Health
   Affairs/TMA

Peter Delany, PhD, LCSW-C
RADM, U.S. Public Health Service
Director, Center for Behavioral Health
   Statistics and Quality
Substance Abuse and Mental Health
   Services Administration

Allen Dobson, PhD
President
Dobson | DaVanzo

Diana Espinosa, MPP
Deputy Administrator
Bureau of Health Professions
US Department of Health and Human
   Services

Adrienne Farrar, PhD, MSW
Representative
Society for Social Work Leadership in
   Health Care

Marilyn Flynn, PhD, MSW
Dean and Professor
School of Social Work
University of Southern California

Margaret Glos, BS
Management Analysis
National Center for Health Workforce
   Analysis
Health Resources and Services
   Administration

Vicki Hansen, LMSW-AP, ACSW
Executive Director
NASW Texas Chapter

Isadora Hare, MSW, LCSW
Public Health Analyst
Adolescent Health Branch
Health Resources and Services
   Administration

Sunny Harris Rome, MSW, JD
Associate Professor
Department of Social Work
George Mason University

Chris Herman, MSW, LICSW
Senior Practice Associate
Social Work Practice
National Association of Social Workers

Elizabeth Hoffler, ACSW
Special Assistant to the Executive Director
National Association of Social Workers

Karen Hopkins, PhD, MSW
Associate Professor
Co-Chair, Management and Community
   Organization Concentration (MACO)
School of Social Work
University of Maryland

Sharon Issurdatt, LCSW, ACSW, DCSW
Senior Practice Associate
Social Work Practice
National Association of Social Workers

Carla Jacobs, BS
Government Relations Consultant, CSWE
Lewis-Burke Associates

Mildred Joyner, MSW, LCSW, BCD
President, Council on Social Work
   Education
Professor, Director/Chairperson
Undergraduate Social Work
   Department
West Chester University

Cheri Latimer, RN, BSN
Executive Director
Case Management Society of America

Polina Makievsky, MPP
Chief Operating Officer
Alliance for Children and Families

Sherri Morgan, JD, MSW
Associate Counsel
LDF & Ethics and Professional Review
National Association of Social Workers

Wendy Naus, BA
Government Relations Consultant, CSWE
Lewis-Burke Associates

Nora O'Brien-Suric, PhD
Senior Program Officer
The John A Hartford Foundation

Asua Ofosu, JD
Manager
Government Relations
National Association of Social Workers

Cecilia Perry, MA, JD
Public Policy Analyst
American Federation of State, County and
    Municipal Employees (AFSCME)

Ashton Theodore Randle, BS
Director
Government Relations
Case Management Society of America

Jerry Satterwhite, MSSW, LCSW, ACSW
Congressional Liaison
Association of VA Social Workers

John Sciamanna, MSW
Director
Children's Policy and Government Affairs
American Humane Association

Cheryl Sharp, MSW, ALWF, CPSST
Coordinator
Community Intergration & Wellness
The National Council for Community
    Behavoioral Healthcare

Allison Smith, BA, BSN, RN
Vice President
Strategic Initiatives
C-Change

Cudore Snell, DSW
Dean and Associate Professor
School of Social Work
Howard University

Barabara Solt, PhD, LICSW
Social Work Consultant

Danielle Spears, BS
Executive Assistant to the Executive Director
National Association of Social Workers

Linda Spears, BA
Vice President, Policy & Public Affairs
Child Welfare League of America

Evelyn Tomaszewski, MSW
Senior Policy Advisor
Human Rights & International Affairs
National Association of Social Workers

Roxana Torrico Meruvia, MSW
Senior Practice Associate
Social Work Practice
National Association of Social Workers

Rita Vandivort-Warren, MSW, ACSW
Public Health Analyst
Substance Abuse and Mental Health
    Services Administration

Ashley Varner, MSW, MBA, LCSW-C
Representative
Association of Oncology Social Work

Randi Walters, MSW, PhD
Child Welfare Program Specialist
Children's Bureau

Michelle Washko, PhD
Specialist in Aging Policy
US Administration on Aging
US Department of Health and Human
    Services

Jennifer Watt, BS
Assistant Director
National Association of Social Workers
    Foundation

Rita Webb, MS
Senior Practice Associate
Social Work Practice
National Association of Social Workers

Tracy Whitaker, DSW
Director
NASW Center for Workforce Studies and
    Social Work Practice
National Association of Social Workers

James Herbert Williams, PhD, MSW
Dean and Professor
University of Denver

Melvin Wilson, MSW
Manager
Center for Workforce Studies
National Association of Social Workers

Gail Woods Waller, MS
Director
Communications
National Association of Social Workers

Joan Levy Zlotnik, PhD, ACSW
Director
Social Work Policy Institute
National Association of Social Workers
    Foundation

3 > SPEAKER BIOGRAPHICAL SKETCHES

Uma S. Ahluwalia, MSW
Director, Montgomery County Department of Health and Human Services

Uma Ahluwalia is currently the Director of a fully-integrated Health and Human Services Department in Montgomery County. The department is the largest agency in Montgomery County Government and includes Aging and Disability Services; Behavioral Health and Crisis Services; Children, Youth and Family Services; Public Health Services; and Special Needs Housing. Ahluwalia holds a Masters in Social Work from the University of Delhi in India and a Post Graduate Degree in Health Services Administration from George Washington University. She has over 20 years of experience in the field in various frontline and executive management capacities.

Clare Anderson, LICSW
Deputy Commissioner
Administration on Children, Youth & Families
U.S. Department of Health and Human Services

Clare Anderson is the Deputy Commissioner at the Administration on Children, Youth and Families. She obtained her Masters of Social Work, with an emphasis in children, youth and families, from the University of Alabama. Prior to joining ACYF, Clare was a Senior Associate at the Center for the Study of Social Policy, where she promoted better outcomes for children, youth and families through community engagement and child welfare system transformation. Clare provided technical assistance through a federally funded Child Welfare Implementation Center to sites implementing Community Partnerships for Protecting Children and the Annie E. Casey Foundation's *Family to Family* initiative. She also conducted monitoring of and provided support to jurisdictions under Court-order to improve their child welfare systems. Clare also worked as a direct practice social worker as a member of the Freddie Mac Foundation Child and Adolescent Protection Center at Children's National Medical

Center in Washington, DC. She also was a consultant to and clinical director at the Baptist Home for Children and Families (now the National Center for Children and Families) in Bethesda, MD and was on the clinical faculty at the Georgetown University Medical Center, Department of Psychiatry's child and adolescent services.

Allen Dobson, PhD
President, Dobson | DaVanzo

Allen Dobson, PhD, is a health economist and President of Dobson | DaVanzo. Before he co-founded the firm, Dr. Dobson spent eighteen years with The Lewin Group where he was Senior Vice President and directed the Health Care Finance Group. Prior to work at The Lewin Group, Dr. Dobson served as Director in the Office of Research at CMS (then the Health Care Financing Administration) when the Medicare Inpatient Prospective Payment System (PPS) was being developed and implemented. Dr. Dobson has studied Medicare's various PPSs (e.g., acute care hospitals, long term care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, and ambulatory surgery centers) for over twenty five years and has directed numerous efforts to model the impact of Medicare and Medicaid payment policies on health care providers using a variety of statistical and econometric methodologies. He has extensively analyzed Medicare Resource Based Relative Value System (RBRVS) physician payment and worked for ten years for CMS advising on the methodology for determining physician practice expenses under RBRVS. Additionally, he regularly leads efforts to model CMS rulemaking analyses for numerous provider groups in support of the clients' public comments and responses to the notices of proposed rulemaking (NPRM). All of Dr. Dobson's work is grounded in the use of complex data systems and validated methodology.

Diana Espinosa, MPP
Deputy Administrator, Bureau of Health Professionals U.S. Department of Health and Human Services Health Resources and Services Administration

Diana Espinosa is the Deputy Associate Administrator for the Bureau of Health Professions at the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS). The Bureau of Health Professions provides national leadership in the development, distribution and retention of a diverse, culturally competent health workforce that provides high-quality care for all Americans. Prior to joining HRSA, Ms. Espinosa served as the U.S. Office and Management and Budget's (OMB) Deputy Assistant Director for Management where she led implementation of government-wide efforts to strengthen the management and improve program performance. Ms. Espinosa also served as the Chief of OMB's Health and Human Services Branch where she led the analysis of budget, management, and policy issues relating to the U.S. Department of Health and Human Services. Ms. Espinosa has a Master of Public Policy and a Bachelor of Arts in Social Anthropology from the University of Michigan.

Cheri Lattimer, RN, BSN
CMI President
Executive Director Case Management Society of America (CMSA) Coalition Director, National Transitions of Care Coalition (NTOCC)

Cheri Lattimer is the CEO and President of Consulting Management Innovators (CMI), providing outsourcing and advisory services to the care management and health care industries. She services as the Executive Director for the Case Management Society of America, the Executive Director for the Case Management Foundation and is the Coalition Director for the National Transitions of Care Coalition. Her leadership in quality improvement, case management, care coordination and transitions of care is known on the national and international landscape. In 2009 she was asked to deliver the Anna Reynvaan Lecture at the University of Amsterdam. Ms. Lattimer spoke to over 900

nurses from the Netherlands and Belgium on Integrated Nursing Health Management of the Complex Patient. She has been quoted in several publications including the Healthcare Executive, Dorland's Case In Point, Professional Case Management Professional and Seniority. She was a contributor and reviewer for the CMSA Core Curriculum for Case Management and The Integrated Case Management Manual Assisting Complex Patients Regain Physical and Mental Health. She serves on several National Boards and Committees; URAC, Roundtable on Critical Care Policy, National Family Caregivers Association, CMS Caregiver Workgroup and participates on several of the Society of Hospital Medicine Advisory Committees; Diabetes, Hospital Collaborative Care & Better Outcomes for Older Adults through Safe Transitions.

Wendy A. Naus, BA Lewis-Burke Associates, LLC

Wendy Naus is a senior policy associate at Lewis-Burke Associates LLC. Her public policy expertise extends to a broad range of issues, including social and health policy, research and education. Ms. Naus works closely with clients in the development and implementation of their public policy agendas. She has led the federal advocacy efforts of the Council on Social Work Education (CSWE) since 2008. Her work for CSWE has focused largely on increasing training and financial support

opportunities, such as loan forgiveness, for social workers. She is also working to raise the visibility of social work in the minds of policy makers in Congress and throughout the Executive agencies. Prior to joining Lewis-Burke in 2004, Ms. Naus worked for the Buffalo News Washington Bureau. She holds a Bachelor of Arts with honors in both political science and urban studies from Canisius College in Buffalo, New York.

Asua Ofosu, JD
Manager, Government Relations, National Association of Social Workers

Asua Ofosu is the Manager, Government Relations for the National Association of Social Workers (NASW). Ms. Ofosu began her tenure at NASW in 2006 as the NASW health lobbyist and handles a variety of health issues ranging from health disparities, genetics, HIV/AIDS, aging, and cancer. She serves as the GR representative to the Social Work Reinvestment Initiative and focuses on social work safety and social work research issue areas. In addition to her work at NASW, Ms. Ofosu spends many hours volunteering for women, health and children organizations. Ms. Ofosu is a member of Alpha Kappa Alpha Sorority, Inc. and a board member of Witney's Lights, a domestic violence awareness and education non-profit organization. Ms. Ofosu, a former Hill staffer, holds a JD from Widener University and BS in psychology from Delaware State University.

Tracy Whitaker, DSW, ACSW
Director, NASW Center for Workforce Studies and Social Work Practice

Tracy Whitaker, DSW, ACSW is the Director of the Center for Workforce Studies & Social Work Practice at the National Association of Social Workers (NASW). She is responsible for developing a national repository for consolidated and comprehensive social work labor force information; identifying trends in the social work labor force that will support or diminish the adequacy of the social work workforce; collaborative agenda-setting with allied organizations and coalitions; and developing information for social workers that improves social work practice. Dr. Whitaker directed the 2004 national benchmark study of licensed social workers and was the lead author of five reports emanating from that study. She also led the first compensation and benefits study of the social work profession in 2009 and has conducted multiple studies of the NASW membership. Dr. Whitaker is the lead author of *Workforce Trends Affecting the Profession, 2009* and *The Results are In: What Social Workers Say About Social Work,* both published by the NASW Press. Dr. Whitaker received a BA in Political Science, an MSW and a DSW from Howard University. She also holds certification from NASW's Academy of Certified Social Workers.

4 > FEDERAL CHILD WELFARE TRAINING PROGRAMS SUPPORTING SOCIAL WORKERS – THE U.S. CHILDREN'S BUREAU IN THE ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

> **TITLE IV-B SECTION 426 RESEARCH,TRAINING, OR DEMONSTRATION PROJECTS – CREATED IN 1962**

>> **SEC. 426.** (c) CHILD WELFARE TRAINEESHIPS ($7 million appropriations).–The Secretary may approve an application for a grant to a public or nonprofit institution for higher learning to provide traineeships with stipends under section 426(a)(1)(C) only if the application- (1) provides assurances that each individual who receives a stipend with such traineeship (in this section referred to as a "recipient") will enter into an agreement with the institution under which the recipient agrees (A) to participate in training at a public or private nonprofit child welfare agency on a regular basis (as determined by the Secretary) for the period of the traineeship; (B) to be employed for a period of years equivalent to the period of the traineeship, in a public or private nonprofit child welfare agency in any State, within a period of time (determined by the Secretary in accordance with regulations) after completing the postsecondary education for which the traineeship was awarded;

> **TITLE IV-E OF THE CHILD WELFARE AND ADOPTION ASSISTANCE ACT OF 1980 (P.L. 96-272)**

>> **TITLE IV-E** includes a provision for entitlement funding that provides 75 percent federal matching funds to states for short or long term training of child welfare workers. Long term training may include university degree education for "personnel employed or preparing for employment by the State agency or by the local agency administering the (Title IV-E) plan" (Section 474A, P.L. 96-272). Approximately 40 states use Title IV-E dollars for degree education for BSW and MSW social work students.

For information on Children's Bureau's training efforts visit the website of the National Child Welfare Workforce Institute www.ncwwi.org and http://louisville.edu/kent/projects/iv-e.

www.ntocc.org/Home/HealthCareProfessionals/WWS_HCP_About.aspx

NTOCC has created information to help healthcare professionals understand how poor transitions impact care delivery and how you can help improve transitions in your facility. Join NTOCC as an individual subscriber or ask for your company to join as an Associate Member to be notified as new tools become available.

Patient Bill of Rights During Transitions of Care
Transitions of care (or care transitions) take place each time a patient goes from one health care provider or health care setting to another. Problems often happen during these transitions because information is not communicated. Patients and their family have the right to care transitions that are safe and well coordinated. This guide can help patients get the information and services they need and deserve each step of the way.

> Available Versions:
> Full Patient Bill of Rights
> Summary Patient Bill of Rights

My Medicine List
This is a list of important recommended information about a patient's medications. The data elements indicate the prescriptions that patients have been prescribed and are currently taking along with information about their over-the-counter medications, vitamins, and nutritional supplements. The goal of the personal medicine list is to help patients improve their understanding of their current medicine regimens including why they need to take the medication and for how long.

> Additional Languages:
> Español / Spanish
> Français / French

Taking Care of My Health Care
Taking Care of MY Health Care has been a much anticipated consumer tool. The tool was developed by the NTOCC Tools and Resources Work Group. It has been through numerous reviews with the group, by social workers, and a literacy review. The NTOCC Advisory Task Force approved it on September 16, 2008 at their meeting in

Washington DC. This tool was developed as a guide for patients and their caregivers to use so they can be better prepared when they see a health care professional on what kind of information and questions they need to ask. NTOCC's goal was to keep it simple; as a guide, to open the lines of communication and at the minimum to provide them with a convenient, simple format to have an updated list of their medication and what the next step in their care would be.

> Additional Languages:
> Español / Spanish
> Français / French

Transitions of Care Checklist
This list provides a detailed description of effective patient transfer between practice settings. Implementing this process developed by NTOCC can help to ensure that patients and their critical medical information are transferred safely, timely, and efficiently.

How to Implement and Evaluate a Plan:
> Executive Summary
> Improving on Transitions of Care: How to Implement and Evaluate a Plan
> > Module: Hospital to Home
> > Module: Emergency Department to Home

The Executive Summary outlines for you the concepts, process and how to use the guidebook titled Improving on Transitions of Care: How to Implement and Evaluate a Plan. In using the guidebook each transition point is treated as an exchange. Each exchange is where communication occurs and where evaluation may occur.

Improving Transitions of Care with Health Information Technology

NTOCC believes that for Health Information Technology (HIT) to make a difference in transitions of care, the technology must address several critical steps. The components include standardized processes, good communication, required performance measures, established accountability, and strong care coordination. Without addressing each step, the promise of HIT's affect on overall transition of care improvement will not be realized.

Because there is little guidance on how to use HIT in ways that specifically improve transitions of care, this paper builds upon NTOCC's overall recommendations for improving transitions of care and the national agenda as it relates to HIT, and identifies problems and considerations as they relate to NTOCC's overall goals.

Issue Briefs: Improving Transitions of Care

This issue brief organizes the findings and considerations of the "Vision of the National Transitions of Care Coalition."

Cultural Competence: Essential Ingredient for Successful Transitions of Care

Health care professionals increasingly recognize the crucial role that culture plays in the health care of a client or patient and the need to deliver services in a culturally competent manner. Cultural competence is essential to successful, client-/patient-centered transitions of care. This tool provides information about culture and cultural competence, as well as strategies and resources to enhance professionals' capacity to deliver culturally competent services during transitions of care.

Medication Reconciliation Essential Data Specifications

These consensus elements will help health care professionals collect, transmit and receive critical medication information needed when patients move from one practice setting or level of care to another. The use of these elements in the reconciliation process required by the Joint Commission could help reduce medication errors.

Transitions of Care Measures

At present, there is a large evidence base that demonstrates the existence of serious quality problems for patients undergoing transitions across sites of care. While currently there are transitions of care measures on the structure, process, and outcomes of care that are useful, measure gaps still exist. This report by the NTOCC Measures Work Group summarizes an environmental scan of existing measures that are applicable to care transitions and highlights the Work Group's recommendations. Included is the Care coordination Hub, a conceptual model defining seven key elements for effective transitions of care.

Included is the Care Coordination Hub, a conceptual model defining seven key elements for effective transitions of care.

Policy Paper

This detailed concept paper outlines steps to be considered by the healthcare industry and policy makers to improve transition performance.

June 6, 2011

Donald Berwick, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1345–P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Proposed Rule on Medicare Shared Savings Program and Accountable Care Organizations; CMS–1345–P

Dear Dr. Berwick:
On behalf of the 145,000 members of the National Association of Social Workers (NASW), I am pleased to submit our comments on the Notice of Proposed Rule Making for the Medicare Shared Savings Program and Accountable Care Organizations (ACOs).

NASW is a strong supporter of the 2010 Affordable Care Act. We support the concept of ACOs because shared accountability for beneficiary health will address both gaps in quality and unnecessary costs caused by fragmented and poorly coordinated care. Moreover, shared savings will support activities that improve care and lower health care costs–namely, care coordination services–which are not currently reimbursed under the Medicare fee-for-service program. We offer, for your consideration, the following recommendations to strengthen the Shared Savings Program.

Meeting the Core Objectives of the Shared Savings Program
NASW supports the three core objectives of the Shared Savings Program: better care for individuals, better health for populations, and lower growth in health care expenditures. We believe these goals cannot be achieved, however, without *the participation of a broader array of providers in the ACO health care team.* In particular, we recommend greater specificity regarding the types of psychosocial supports and services that ACOs must provide. In the absence of such requirements, ACOs may fail to address the social determinants of health and the roles access and adherence play in individual and population health outcomes.

Inclusion of professional social workers as ACO participants
The proposed rule limits ACO participants to doctors of medicine or osteopathy, physician assistants, nurse practitioners, and clinical nurse specialists [§425.4(1)(2)]. The Agency for Healthcare Research and Quality (AHRQ) suggests that the ACO model is based on the interdisciplinary team model of the primary care medical home. According to AHRQ (2010, 2011a), a medical home provides comprehensive, team-based care that meets the majority of each patient's physical and mental health care, including prevention and wellness, acute care, and chronic care. AHRQ notes that the medical home team for most patients in a primary care practice might include nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, **social workers**, care coordinators, and others.

NASW strongly recommends that professional social workers be included as ACO participants. Social workers play key roles in interdisciplinary care teams across a broad array of health care settings and as such, constitute essential members of ACOs. **Social workers are also the only health care professionals devoted exclusively to addressing the psychosocial needs of Medicare beneficiaries and family caregivers**. In its 2008 report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, the Institute of Medicine (IOM) defined psychosocial health services as "psychological and social services and

interventions that enable patients, their families, and health care providers to optimize biomedical health care and to manage the psychological/behavioral and social aspects of illness and its consequences, so as to promote better health" (p. 9).

Equally importantly, the presence of social workers on the medical home team extends the reach of the physician and nursing staff–allowing all team members to practice at the top of their licenses.

Roles and qualifications of professional social workers participating in ACOs

Professional social workers fulfill distinct but complementary roles in health care. **Clinical social workers** work in behavioral and mental health settings, including as independent practitioners. **Medical social workers** work in settings such as hospitals, primary care, long-term care, hospice and palliative care, and rehabilitation.

Clinical Social Workers: Mental and behavioral health care should be a strong component of ACO services. More than 240,000 clinical social workers in the United States diagnose and treat mental illness (Substance Abuse and Mental Health Services Administration, 2010). Of that number, more than 37,000 clinical social workers are currently Medicare providers. NASW recommends the inclusion of clinical social workers in all ACO programs providing mental and behavioral health services. A *clinical social worker* is an individual who possesses a master's or doctor's degree in social work; has performed at least two years of supervised clinical social work; and is either licensed or certified as a clinical social worker by the State in which the services are performed; or, in the case of an individual in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic (CMS, 2009). (Since 2009, all states license social workers at the clinical level.)

For decades, clinical social workers have been recognized for their expertise in providing services to Medicare beneficiaries who experience emotional, behavioral, psychological, and social problems related to health and mental health conditions. NASW recommends the expansion of Medicare-reimbursed clinical social work services to include the prevention, assessment, and treatment of mental, emotional, and behavioral disturbances as fee-for-service providers. This change would accurately reflect the services clinical social workers currently provide to Medicare beneficiaries. The expansion of the Medicare definition of clinical social work services would also promote greater continuity across the health care continuum. NASW supports the fee-for-service model currently used within the Medicare payment system for clinical social workers participating in ACOs. At present, clinical social workers are the only group of non-physician practitioners who are paid 75 percent of the physician fee schedule. NASW recommends reimbursement of clinical social workers at 85 percent of the physician fee schedule, in keeping with reimbursement rates for other non-physician practitioners.

Medical Social Workers: Medical social workers perform multiple roles within interdisciplinary health care teams: case management and care coordination, medically related social services, patient and family education, discharge planning, advance care planning, and community outreach and engagement. Consistent with NASW's Standards for Social Work Practice in Health Care Settings (2005), medical social workers participating in ACOs should have a social work degree from a school accredited by the Council on Social Work Education. Social workers functioning in leadership roles within ACOs, such as managers or directors, should be licensed at the advanced practice level and be able to provide supervision for licensure (NASW, 2005).

Benefits of social work involvement in ACO-type programs

As indicated below, social work involvement in ACO-type projects have shown positive trends in a number of performance measures:
> Reduction in 30-day hospital readmissions
> Delays in permanent nursing home placement
> Reductions in avoidable emergency room visits
> Improved access to primary care providers
> Improved adherence to treatment plans

For your reference, we have provided examples of a few of these programs below.

Care Management Program: An Initiative to Reduce Unnecessary Emergency Department Utilization

This program addresses the needs of the most frequent users of emergency departments and hospitals in Camden, New Jersey. These individuals lack consistent primary care and often have complex medical, psychiatric, and substance abuse disorders, compounded by an array of social concerns. A team consisting of a social worker, medical assistant, and nurse practitioner helps program participants address a variety of social, environmental, and health conditions. The team also facilitates participant access and on-going involvement in a medical home (Camden Coalition of Healthcare Providers, 2011).

Enhanced Discharge Planning Program (Rush University Medical Center)

In the Rush University Enhanced Discharge Planning Program, social workers work with older adults and family caregivers following discharge from the hospital. Social workers help patients avoid adverse events, encourage follow-up with primary care providers, and connect patients and caregivers to community-based resources. Data from the project show statistically significant increases in older adults' understanding of their medications, decreased stress over managing their health care needs, and improved communication with their physicians post-discharge (American Hospital Association, 2010).

Project SAFe: University of Southern California, Los Angeles, CA

Project SAFe (Screening Adherence Follow-Up Program) is a system of patient navigation counseling and case management designed to help low-income, ethnic-minority women overcome barriers to timely breast cancer screening and follow-up after receiving an abnormal mammogram. The service involves a structured interactive telephone assessment of screening-adherence risk (barriers), health counseling, and follow-up services, including patient tracking, appointment reminders, and referral to community resources. Low-income, ethnic-minority women are more likely than other women to delay or miss follow-up appointments after receiving an abnormal mammogram. This disparity can be attributed to barriers such as cultural norms, language, low health literacy, lack of insurance, irregular sources of medical care, uncoordinated treatment services, and psychological distress. Patient navigation counseling and case management that is sensitive to the challenges faced by low-income, ethnic-minority women may improve adherence to recommendations for regular screening and treatment follow-up after an abnormal mammogram (Ell, 2007).

Geriatric Resources for Assessment and Care of Elders

The GRACE (Geriatric Resources for Assessment and Care of Elders) medical home project includes a nurse practitioner–social worker care coordination team, which works closely with primary care physicians and a geriatrician. The program, situated at an urban system of community clinics affiliated with the Indiana University School of Medicine, enrolls low-income older adults with multiple diagnoses. Data from the project show decreased use of the emergency department and lower hospitalization rates among seniors receiving the GRACE intervention, compared with those in control groups (Counsell et al., 2007).

Commonwealth Care Alliance

Serving older adults and medically fragile individuals on Medicaid, the Commonwealth Care Alliance (CCA) uses nurse practitioner-led teams in 25 community-based medical practices. These teams, which include social workers, assume primary responsibility for the ambulatory care needs of patients assigned to each practice. Teams provide intake and assessment, ongoing care coordination, and in-home assistance with activities of daily living. The physicians on the team, on the other hand, focus on inpatient care. According to the Commonwealth Fund, the number of hospital days per year per CCA member who is dually eligible for Medicare and Medicaid was 2.0, compared to 3.6 days per dually eligible patient enrolled in the Medicare fee-for-service program. The study also found the percentage of nursing home–certifiable patients

permanently placed in the nursing home per year was 8.5 percent, compared with the overall Massachusetts rate of 12 percent (Commonwealth Fund, 2010).

Processes to Promote Evidence-based Medicine, Patient Engagement, Quality Reporting, and Coordination of Care
Evidence-based medicine
The Affordable Care Act states that ACOs need to have processes to promote the use of evidence-based medicine. NASW recommends that CMS broaden this term to evidence-based medicine *and practices*, because it is critical that ACOs implement evidence-based psychosocial interventions not generally included as *medicine*. ACOs should incorporate the following definition for both evidence-based medicine and evidence-based practice: "bringing together the best available research evidence, with practitioner knowledge and values and patient/client preferences" (Social Work Policy Institute, 2010, p. 10). The following databases may be valuable to ACOs in identifying evidence-based psychosocial interventions and care coordination programs:

> Evidence Database on Aging Care, maintained by the Social Work Leadership Institute at the New York Academy of Medicine: www.searchedac.org/
> The Guide to Community Preventive Services, maintained by the Centers for Disease Control & Prevention (CDC): www.thecommunityguide.org
> National Registry of Evidence-Based Programs, maintained by the Substance Abuse and Mental Health Services Administration: www.nrepp.samhsa.gov
> Research-tested Intervention Programs, maintained by the National Cancer Institute: http://rtips.cancer.gov/rtips/index.do

Care coordination and case management
The National Transitions of Care Coalition (NTOCC) recommends increased use of case management and professional care coordination as essential to improving communication of health care information (NTOCC, 2010b). Although the proposed rule focuses heavily on care coordination and case management, CMS provides no clear definition of either term. Effective care coordination and case management must address not only communication among primary care providers and physician specialists but also the psychosocial needs of beneficiaries and family caregivers (Herman, 2009).

The proposed rule proposes telehealth, remote monitoring, and enabling technologies as tools for care coordination. Although these tools may monitor changes in health status, they cannot replace the role person-centered care coordination and case management play in ACOs. Case management is not a "free" service, as indicated on page 19547 of the propose rule. Rather, case management and coordination constitute essential services that must be included in the cost of care.

NTOCC's Transitions of Care Compendium (2011a) provides a wealth of information about strategies and programs to improve transitional care. The compendium, which is listed on the webpage for CMS's Community Based Care Transition Program, would be a useful resource for ACOs.

Quality and cost metrics
NASW supports the proposed use of quality measures in ACOs and views measures as an important avenue in the provision of effective health care services. NASW recommends additional measures in the area of mental health, cancer and hospice and palliative care. Participation in the measure approval/endorsement process is restricted because of the National Quality Forum's expensive annual membership dues. NASW recommends an approval/endorsement process that would be opened to all interdisciplinary health providers through their professional organizations, regardless of each organization's ability to pay membership dues.

Patient-centeredness criteria [§425.5 (d)(15)(ii)]
NASW strongly recommends inclusion of all nine proposed criteria and proposes addition of a new criterion. Our specific comments follow.

1) Beneficiary experience of care survey. NASW concurs with CMS that use of one survey is important to ensure consistency across ACOs and to facilitate measurement over time. The Consumer Assessment of Health Care Providers and Systems (CAHPS) Clinician and Group survey addresses many areas fundamental to patient-centered care. On the other hand, the survey items focus solely on doctors and support staff. This limitation makes the survey inapplicable not only to services provided by non-physician primary care providers (physician assistants, nurse practitioners, and clinical nurse specialists) but also to services provided by other health care professionals, such as social workers. NASW proposes a simple but significant modification to CAHPS: Replace *doctor* with *health care provider* throughout the survey. This change would ensure applicability of the survey across ACO providers.

2) Patient involvement in ACO governance. NASW supports CMS's proposal to include at least one ACO beneficiary in the governing body of each ACO. We also support inclusion of a beneficiary advisory panel or committee. The panel should not replace beneficiary participation in the governing body, however. As CMS notes in the proposed rule, without voting power the influence of a consumer representative would be extremely limited. At the same time, the input of the advisory panel would enable a broader group of beneficiaries to influence the focus and processes of the Shared Savings Program. Ideally, the voting representative would participate not only in the governing body but also in the advisory panel.

3) Diversity and population needs evaluation/health planning. Medicare beneficiaries vary in age, race, ethnicity, biological sex, gender identity, sexual orientation, geographic region, socioeconomic status, and physical, mental, and cognitive ability. The literature identifies health care disparities related to each of these cultural factors (AHRQ, 2011b; Centers for Disease Control and Prevention & Merck Foundation, 2008; IOM, 2011). Given this context, NASW affirms CMS's proposed incentives for rural health clinics and federally qualified health centers to participate in the ACO program (§425.7(c)(4); 425.7(c)(7); 425.7(d)(2); 425.7(d)(6)). We also support CMS's proposal to establish partnerships between ACOs and state or local health departments.

We encourage CMS to discourage avoidance of high-risk beneficiaries and exacerbation of health disparities by requiring ACOs to take the following steps:
> Add people from medically underserved racial and ethnic groups and individuals with low incomes to the list of at-risk beneficiaries (§425.(4)) and consider these characteristics when adjusting for per capita Medicare expenditures
> Collect and report quality data related to race, ethnicity, and income
> Monitor degree of ACO nonparticipation among health care providers for beneficiaries from medically underserved racial and ethnic groups

NASW also supports integration of the *National Standards on Culturally and Linguistically Appropriate Services* (CLAS) (U.S. Department of Health & Human Services, 2007) in ACO practice. Social workers are well prepared to provide culturally and linguistically appropriate services:
> Content addressing cultural diversity, human rights, and social and economic justice constitutes a core component of the social work curriculum (Council on Social Work Education, 2008).
> The NASW standards (2001) and indicators (2007) for cultural competence in social work practice guide social workers in developing and maintaining cultural competence—an ethical responsibility outlined in the Association's *Code of Ethics* (2008). (The Association's standards and indicators also form the basis for the National Transitions of Care Coalition's cultural competence tool for interdisciplinary health care teams [2010a]).
> The NASW standards for social work practice in health care settings (2005) specify that social workers need the knowledge and skills to identify and address health disparities.
> NASW's HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project (NASW, n.d.-a) strives to

promote culturally competent practice skills with individuals, families, and communities affected by HIV/AIDS. The Project is supported through a five-year contract with the Center for Mental Health Services of SAMHSA.

4) High-risk individuals, individualized care plans, and integration of community resources. Comprehensive biopsychosocial assessment and care planning guide social work practice in health care settings (NASW, 2005) and are included in the accreditation standards of both the Commission on Accreditation of Rehabilitation Facilities (CARF) (2010) and the Joint Commission (2011). NASW asserts that individualized assessment and care planning should drive health care not only for targeted beneficiary populations, but for *every* ACO beneficiary. Assessment and care planning tailored to each person's health and psychosocial preferences, values, and needs forms the cornerstone of safe, appropriate, timely health care. For high-risk beneficiaries and individuals with multiple chronic conditions, the need for person-centered assessment and care planning is even more pressing.

The importance of this principle is illustrated by considering the variety of options available for end-of-life care. Life-prolonging medical treatments may be welcomed by one person and declined by another, even if the two have the same diagnosis and prognosis. In the absence of individualized assessment and care planning, health care providers risk not only wasting scarce health care resources but also—and even more importantly—disregarding beneficiaries' choices. The challenges associated with medication adherence also demonstrate the centrality of individualized assessment and care planning. A beneficiary cannot benefit from a prescribed medication if her or his health care provider does not ascertain whether the prescription is affordable, for example. Similarly, failing to assess if an individual understands how to take the medication can lead to dangerous, costly errors.

NASW concurs with CMS that community resources are critical in supporting beneficiary adherence to the health care plan. Social workers have long played an integral role in helping clients identify and connect with appropriate community resources (NASW, 2009); the profession is well equipped to help fulfill this responsibility as members of ACOs. NASW encourages CMS to include nonprofit social service organizations among community stakeholders in the ACO development and governance process.

5) Coordination of care. As previously noted, care coordination is essential to improving health care for Medicare beneficiaries, especially during transitions between health care providers or settings. NASW supports CMS's proposal requiring ACOs to outline care coordination mechanisms. NTOCC (2010b) recommends that "providers must have accountability for sending *and* receiving information about patients during care transitions [emphasis added]" (p. 20). Thus, each ACO's process of communicating care information must take into account this dual emphasis.

6) Communicating clinical knowledge/evidence-based medicine in a way that is understandable to beneficiaries. NASW affirms inclusion of this criterion for patient-centered care. Wide variation in literacy and health literacy exists among Medicare beneficiaries. The most recent National Assessment of Adult Literacy found that adults aged 65 and older—who constituted almost 83 percent of Medicare beneficiaries in 2009 (CMS, 2009)—were almost three times less likely to possess basic health literacy than 16- to 64-year-olds (Kutner, Greenberg, Jin, & Paulsen, 2006). Regardless of age, Hispanic adults had the lowest health literacy of all racial and ethnic groups; moreover, American Indian/Alaska Native, Black, and multiracial adults had lower health literacy than White (non-Hispanic) and Asian/Pacific Islander adults (Kutner et al., 2006).

Low health literacy may influence Medicare beneficiaries' ability to understand health information and treatment options, participate in assessment and care planning, and follow through on the plan of care (such as taking medications and following up with health care providers). Clear beneficiary-provider communication is fundamental to patient engagement in health care, as demonstrated by its inclusion in the *Consumer Bill of Rights and Responsibilities* adopted by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998, Appendix A).

7) Beneficiary engagement and shared decision making that reflects beneficiaries' unique needs, preferences, values, and priorities. NASW affirms inclusion of this criterion of patient-centeredness. The aforementioned *Consumer Bill of Rights and Responsibilities* (President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998) devotes an entire chapter to consumer participation in treatment decisions. This topic is also emphasized in multiple other publications addressing consumer health care rights:

> The American Hospital Association (2003) specifies involvement in care–including discussion of medically appropriate treatment choices, treatment plan, consumer goals and values, and surrogate decision making–as one of six rights consumers can expect to be met during hospitalization.

> The National Hospice and Palliative Care Organization (2008) affirms patients' right to be involved in developing the plan of care and to decline care or treatment.

> The National Pain Foundation (2011) lists participation in pain treatment decisions in its bill of rights.

> NTOCC's consumer bill of rights for transitions of care (2011b) encourages consumers to participate in planning care transitions and underscores respect for the culture, goals, needs, and strengths of each individual.

> CARF's accreditation standards for person-centered long-term care communities (2010) emphasize self-determination and cultural competence as fundamental to care provision. Moreover, the standards require programs to "implement a written procedure that…minimizes barriers to decision making by the persons served" (CARF, 2010, p. 155).

8) Written standards and process for beneficiary communication and access to medical records. NASW supports this criterion. The need for written standards and processes reflects the evolution of the Joint Commission's standards for home care (2011), which now require organizations to develop, put in writing, and adhere to processes related to care provision and information management.

9) Internal processes for measuring clinical or service performance by physicians; using results to improve care and service. NASW supports inclusion of this criterion as a way to demonstrate patient-centeredness.

In addition to supporting CMS's proposed criteria, NASW recommends adding a 10th criterion:
Collaboration in care provision with family caregivers, as guided by the beneficiary
Family caregivers–who include, but are not limited to, spouses, partners, significant others, family of origin, extended family, and friends (NASW, 2010)–play a critical role in supporting Medicare beneficiaries. Family caregivers provide physical, psychosocial, financial, and even medical support to people with disabilities and older adults. They also help beneficiaries communicate with health care providers and navigate service delivery systems.

No health care system can be patient-centered without recognizing and supporting the family caregivers' role in supporting patients' biopsychosocial health and well-being. Opportunities for family collaboration include participation in the assessment process, care planning, service delivery and monitoring, and performance measurement (NASW, 2010). Identification of family members and decision making regarding their involvement in care is the right of each competent beneficiary. If the beneficiary is unable to identify whom she or he wants involved in care, the ACO should follow appropriate legal processes (for example, honoring the beneficiary's choice of health care agent).

Lack of clarity regarding beneficiary assignment to ACOs
The proposed rule [§ 425.6 (c)] specifies that ACO participants must notify beneficiaries in writing that their ACO providers/suppliers have chosen to participate in an ACO. Such notification should take place not only in writing but also in person by ACO providers or staff.

Need for safeguards to preserve beneficiary choice of providers

The proposed rule specifies that beneficiaries have the right to use health care providers who do not participate in the ACO. NASW encourages CMS to specify the processes by which beneficiaries may exercise this right and other protections to preserve beneficiary freedom of choice. In the absence of such protocol, we are concerned that ACOs–which, as noted in the rule, must pay for all care provided to their beneficiaries–will enact barriers to external providers.

Thank you for your consideration of these comments. NASW looks forward to collaborating with you to make ACOs successful in achieving better care, better health, and lower costs for Medicare beneficiaries.

Sincerely,

Elizabeth J. Clark

Elizabeth J. Clark, PhD, ACSW, MPH
Executive Director

NASW ACO Comment References

Agency for Healthcare Research and Quality. (2010). *The roles of patient-centered medical homes and accountable care organizations in coordinating patient care* (AHRQ Publication No. 11-M005-EF). Rockville, MD: Author.

Agency for Healthcare Research and Quality. (2011a). *2010 national healthcare disparities report* (AHRQ Publication No. 11-0005). Retrieved from www.ahrq.gov/qual/qrdr10.htm

Agency for Healthcare Research and Quality (2011b). *The patient-centered medical home: Strategies to put patients at the center of primary care* (AHRQ Publication No. 11-0029). Rockville, MD: Author.

American Hospital Association. (2003). *The patient care partnership: Understanding expectations, rights and responsibilities.* Retrieved from www.aha.org/aha/content/2003/pdf/pcp_english_030730.pdf

American Hospital Association. (2010). *Social Workers Enhance Post-Discharge Care for Seniors*. Retrieved from www.hpoe.org/PDFs/case%20study–rush.pdf

Camden Coalition of Healthcare Providers . (2011). Retrieved from www.camdenhealth.org/programs/care-management-program/

Centers for Disease Control and Prevention & Merck Company Foundation. *The state of aging and health in America 2007*. Retrieved from www.cdc.gov/aging/pdf/saha_2007.pdf

Centers for Medicare & Medicaid Services. (2009). Medicare enrollment: National trends 1966–2009 [Table]. Retrieved from www.cms.gov/MedicareEnRpts/Downloads/HISMI2009.pdf

Centers for Medicare & Medicaid Services. (2009). Rural health clinic (RHC) and federally qualified health center (FQHC) services (Rev. 114). In *Medicare Benefit Policy Manual*. Retrieved from www.cms.gov/manuals/Downloads/bp102c13.pdf

Commission on the Accreditation of Rehabilitation Facilities. (2010). 2010 aging services standards manual. Tucson, AZ: Author.

Commonwealth Fund. (2010). In Focus: Using Pharmacists, Social Workers, and Nurses to Improve the Reach and Quality of Primary Care. *Quality Matters.* Retrieved from: www.commonwealthfund.org/Content/Newsletters/Quality-Matters/2010/August-September-2010/In-Focus.aspx

Counsell, S.R., Callahan, C.M., Clark, D.O., Wanzhu, T., Buttar, A.B., Stump, T.E., & Ricketts, G.D. (2007). Geriatric care management for low-income seniors: A randomized controlled trial. *JAMA 22*, 2623–2633.

Council on Social Work Education. (2008). *2008 Educational policy and accreditation standards.* Retrieved from www.cswe.org/File.aspx?id=13780

Ell, K., Vourlekis, B., Lee, P.J., & Xie, B. (2007). Patient navigation and case management following an abnormal mammogram: A randomized clinical trial. *Preventive Medicine 44(1)*, 26–33.

Herman, C. (2009). *Biopsychosocial challenges related to transitions of care* [Practice update]. Retrieved from National Association of Social Workers website, www.socialworkers.org/practice/aging/2009/Biopsychosocial%20Challenges%20Related%20to%20Transitions%20of%20Care.pdf

Institute of Medicine. (2008). *Cancer care for the whole patient: Meeting psychosocial health needs.* Retrieved from http://books.nap.edu/openbook.php?record_id=11993&page=R1

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Retrieved from http://books.nap.edu/openbook.php?record_id=13128

Joint Commission. (2011). *Joint Commission comprehensive accreditation manual for home care.* Oakbrook Terrace, IL: Author.

Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy* (NCES 2006-483). Retrieved from U.S. Department of Education, National Center for Education Statistics website: http://nces.ed.gov/pubs2006/2006483.pdf

National Association of Social Workers. (2001). *NASW standards for cultural competence in social work practice.* Retrieved from www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf

National Association of Social Workers. (2005). *NASW standards for social work practice in health care settings.* Retrieved from www.socialworkers.org/practice/standards/NASWHealthCareStandards.pdf

National Association of Social Workers. (2007). *Indicators for the achievement of the NASW standards for cultural competence in social work practice.* Retrieved from www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers.* Retrieved from www.socialworkers.org/pubs/code/code.asp

National Association of Social Workers (with Social Work Leadership Institute at the New York Academy of Medicine). (2009). *Social work and care coordination* [Policy briefing paper]. Retrieved from www.socialworkers.org/advocacy/briefing/CareCoordinationBriefingPaper.pdf

National Association of Social Workers. (2010). *NASW standards for social work practice with family caregivers of older adults.* Retrieved from www.socialworkers.org/practice/standards/NASWFamilyCaregiverStandards.pdf

National Association of Social Workers. (n.d.-a). Information booklet with application and reference forms: Certified Social Work Case Manager (C-SWCM) and Certified Advanced Social Work Case Manager (C-ASWCM). Retrieved from http://preview.socialworkers.org/credentials/applications/c-aswcm.pdf

National Association of Social Workers. (n.d.-b). NASW HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project. Retrieved from www.socialworkers.org/practice/hiv_aids/default.asp

National Hospice and Palliative Care Organization. (2008). *Hospice patient's rights.* Retrieved from www.caringinfo.org/files/public/brochures/hospice_patient_rights.pdf

National Pain Foundation. (2011). *Pain patient bill of rights.* Retrieved from www.nationalpainfoundation.org/articles/295/patient-bill-of-rights

National Transitions of Care Coalition. (2008). *Elements of excellence in transitions of care (TOC): TOC checklist.* Retrieved from www.ntocc.org/Portals/0/TOC_Checklist.pdf

National Transitions of Care Coalition. (2010a). *Cultural competence: Essential ingredient for successful transitions of care.* Retrieved from www.ntocc.org/Portals/0/CulturalCompetence.pdf

National Transitions of Care Coalition. (2010b). *Improving transitions of care with health information technology: Position paper of the health information technology work group for the National Transitions of Care Coalition.* Retrieved from www.ntocc.org/Portals/0/HITPaper.pdf

National Transitions of Care Coalition. (2011a). Transitions of care compendium. Retrieved from www.ntocc.org/Toolbox/default.aspx

National Transitions of Care Coalition. (2011b). *Your rights during transitions of care: A guide for health care consumers and family caregivers.* Retrieved from www.ntocc.org/Home/Consumers/WWS_C_Tools.aspx

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (1998). *Quality first: Better health care for all Americans.* Retrieved from www.hcqualitycommission.gov/final/

Social Work Policy Institute. (2010). *Comparative effectiveness research and social work research: Strengthening the connection.* Retrieved from www.socialworkpolicy.org/wp-content/uploads/2010/03/SWPI-CER-Full-RPT-FINAL.pdf.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2010). *Mental health, United States, 2008* (HHS Publication No. (SMA) 10-4590). Rockville, MD: Author.

U.S. Department of Health & Human Services, Office of Minority Health. (2007). *National standards on culturally and linguistically appropriate services (CLAS).* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15

7 > EXAMPLES OF FEDERAL DEFINITIONS OF SOCIAL WORK IN CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) PROGRAMS

DEFINITION OF CLINCIAL SOCIAL WORKER IN RURAL HEALTH CENTER AND FEDERALLY QUALIFIED HEALTH CENTER – MEDICARE PROGRAMS (Medicare Benefit Policy Manual – www.cms.gov/manuals/Downloads/bp102c13.pdf)

110.1 - Clinical Social Worker Defined (Rev. 1, 10-01-03)
A clinical social worker is an individual who: Possesses a master's or doctor's degree in social work; Has performed at least two years of supervised clinical social work; and Either: Is licensed or certified as a clinical social worker by the State in which the services are performed; or in the case of an individual in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic.

110.2 - Clinical Social Worker Services Defined
Clinical social worker services for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services are covered as long as the CSW is legally authorized to perform them under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed. The services that are covered are those that are otherwise covered if furnished by a physician or as an incident to a physician's professional service. Services furnished to an inpatient or outpatient that a hospital is required to provide as a requirement for participation are not included.

DEFINITION OF SOCIAL WORK IN INPATIENT PSYCHIATRIC HOSPITAL SERVICES (Medicare Benefit Policy Manual – www.cms.gov/manuals/Downloads/bp102c02.pdf)

Chapter 2 - Inpatient Psychiatric Hospital Services; 60 - Social Services (Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)
There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures, according to 42 CFR 412.27 and 42 CFR 482.62.

1. The director of the social work department or service must have a Master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a Master's degree in social work, at least one staff member must have this qualification.

2. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

DEFINITION OF SOCIAL WORK – MEDICARE AND MEDICAID PROGRAMS; CONDITIONS FOR COVERAGE FOR END-STAGE RENAL DISEASE FACILITIES; FINAL RULE - APRIL 15, 2008 www.cms.gov/cfcsandcops/downloads/esrdfinalrule0415.pdf

495.140 Personnel Qualifications (d) Standard: Social worker. The facility must have a social worker who– (1) Holds a master's degree in social work with a specialization in clinical practice from a school of social work accredited by the Council on Social Work Education; or (2) Has served at least 2 years as a social worker, 1 year of which was in dialysis unit or transplantation program prior to September 1, 1976, and has established a consultative relationship with a social worker who qualifies under § 494.140(d)(1). (CMS, 2008, p. 114)

495.90 Patient Plan of Care – The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. " (a) Development of Patient Plan; (6) Psychosocial Status – ''The interdisciplinary team must provide the necessary monitoring and social work interventions, including counseling and referrals for social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.'' (CMS, 2008, pp. 111-112)

DEFINITION OF SOCIAL WORK - CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS): HOSPICE CONDITIONS OF PARTICIPATION

418.114 (b) standard: personnel qualifications for certain disciplines:

3. Social worker. A person who–(i) (A) Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education and one year of social work experience in a health care setting; or (B) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph (b)(3)(i)(A) of this section; and (ii) Has one year of social work experience in a health care setting; or (iii) Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW" (CMS, 2009, p.32218).

DEFINITION OF SOCIAL WORK - CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS): LONG TERM CARE CONDITIONS OF PARTICIPATION

483.15 Quality of life. (g) Social Services. The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

Qualifications of social worker. A qualified social worker is an individual with–
(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
(ii) One year of supervised social work experience in a health care setting working directly with individuals.

DEFINITION OF SOCIAL WORK - CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS): HOME HEALTH AGENCIES CONDITIONS OF PARTICIPATION

484.4 Personnel Qualifications
Social work assistant. A person who: (1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or (2) Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a social work assistant after December 31, 1977.
Social worker. A person who has a master's degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

484.34 Medical Social Services – If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of care, prepares clinical and progress notes, works with the family, uses appropriate community resources, participates in discharge planning and in-service programs, and acts as a consultant to other agency personnel.

Congressional Social Work Caucus*

Rep. Karen R. Bass (D-CA33)
Rep. Shelley Berkley (D-NV1)
Rep. Sanford D. Bishop Jr. (D-GA2)
Rep. Corrine Brown (D-FL3)
Rep. G.K. Butterfield, Jr. (D-NC1)
Rep. Andre Carson (D-IN07)
Rep. Dennis Cardoza (D-CA18)
Rep. Donna Christensen (D-VI)
Rep. Hansen Clarke (D-MI13)
Rep. Yvette D. Clarke (D-NY11)
Rep. Wm. Lacy Clay (D-MO1)
Rep. Emanuel Cleaver, II (D-MO5)
Rep. Steve Cohen (D-TN9)
Rep. Gerald "Gerry" Connolly (D-VA11)
Rep. John Conyers (D-MI14)
Rep. Elijah E. Cummings (D-MD7)
Rep. Danny K. Davis (D-IL7)
Rep. Susan A. Davis (D-CA53)
Rep. Rosa L. DeLauro (D-CT3)
Rep. Lloyd Doggett (D-TX25)
Rep. Keith Ellison (D-MN5)
Rep. Bob Filner (D-CA51)
Rep. Marcia L. Fudge (D-OH11)
Rep. Raúl M. Grijalva (D-AZ7)
Rep. Luis V. Gutierrez (D-IL4)
Rep. Alcee Hastings (D-FL23)
Rep. Mazie K. Hironio (D-HI02)
Rep. Rush Holt (D-NJ12)

Rep. Michael Honda (D-CA15)
Rep. Darrell Issa (R-CA49)
Rep. Jesse Jackson, Jr. (D-IL2)
Rep. Sheila Jackson Lee (DTX18)
Rep. Barbara Lee (D-CA9)
Rep. John Lewis (D-GA5)
Rep. Dave Loebsack (D-IA2)
Rep. Gregory W. Meeks (D-NY6)
Rep. Betty McCollum (D-MN4)
Rep. Jerrold Nadler (D-NY8)
Rep. Donald M. Payne (D-NJ10)
Rep. Todd Russell Platts (R-PA19)
Rep. Jared Polis (D-CO2)
Rep. Nick J. Rahall, II (D-WV3)
Rep. Charles B. Rangel (D-NY15)
Rep. Laura Richardson (D-CA37)
Rep. Bobby L. Rush (D-IL1)
Rep. Linda T. Sanchez (D-CA39)
Rep. Loretta Sanchez (D-CA47)
Rep. Allyson Y. Schwartz (D-PA13)
Rep. Robert C. "Bobby" Scott (D-VA3)
Rep. José E. Serrano (D-NY16)
Rep. Fortney Pete Stark (D-CA13)
Rep. Paul D. Tonko (D-NY21)
Rep. Niki Tsongas (D-MA5)
Rep. Maxine Waters (D-CA35)
Rep. Mel L. Watt (D-NC12)
Rep. Henry A. Waxman (D-CA30)
Rep. John Yarmuth (D-KY3)

As of September 2011

The Components of the Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act include:
Social Work Reinvestment Commission: Addressing the Future of the Profession

A Social Work Reinvestment Commission is established to provide a comprehensive analysis of current trends within the academic and professional social work communities. Specifically, the Commission will develop long-term recommendations and strategies to maximize the ability of America's social workers to serve individuals, families, and communities with expertise and care. The recommendations will be presented to Congress and the Executive Branch.

Areas of Focus: Fair market compensation, high social work educational debt, social work workforce trends, translating social work research to practice, social work safety, the lack of diversity in the social work profession, and state level social work licensure (as it implicates social work service across state lines) and the impact these issues have on the areas of aging, child welfare, military and veterans affairs, mental and behavioral health and disability, criminal justice and correctional systems, health and issues affecting women and families.

Reinvestment Demonstration Programs: Addressing The Current State of the Profession of Social Work
Demonstration programs will address relevant, "on the ground" realities experienced by our nation's professional social workers. These competitive grant programs will prioritize activities in the areas of workplace improvements, research, education and training, and community based programs of excellence. This component of the legislation supports efforts underway within both the private and public sectors, in the post doctoral research community, at our nation's institutions of higher learning, and within organizations already administering effective social work services to millions of people. This investment will be returned many times over both in support of ongoing efforts to establish the most effective social work solutions and in direct service to the growing numbers of individuals, families, and communities in need.

Types of Programs Authorized by the Act:
Workplace Improvements – Four grants will be awarded to address high caseloads, fair market compensation, social work safety, supervision, and working conditions.

Research – Twenty-five grants will be awarded to social workers for post doctoral research activity to further the knowledge base of effective social work interventions and to promote usable strategies to translate research into practice across diverse community settings and service systems. At least ten of these grants will be awarded to grantees employed by historically black colleges or universities or minority serving institutions.

Education and Training – Twenty grants are made available to institutions of higher education to support recruitment and education of social work students from high need and high demand areas at the Baccalaureate, Master's and Doctoral levels as well as the development of faculty. At least four of these grants will be awarded to historically black colleges and universities or minority serving institutions.

Community Based Programs of Excellence – Six grants are made available to not-for-profit or public community based programs of excellence to further test and replicate effective social work interventions from the areas of aging, child welfare, military and veteran's issues, mental and behavioral health and disability, criminal justice and correctional systems, health and issues affecting women and families.

National Coordinating Center – One component of the demonstration programs will be a coordinating center which will work with universities, research entities, and social work practice settings to identify key research areas to be pursued, select fellows, and organize appropriate mentorship and professional development efforts.

Excerpted from *Myths & Opportunities: An Examination of the Impact of Discipline – Specific Accreditation on Interprofessional Education – Executive Summary,* a collaborative project carried out by the Council on Social Work Education (1999), University of Southern California and California State University – Fullerton and funded by the Annie E. Casey Foundation.

Core Principles

1. There is a growing need for a different kind of professional competence in addition to specialized skills in a profession or discipline.
The need arises from three prime sources: (1) desire to serve "the whole child" in a family in a community, (2) statistical indicators on the condition of children that show that children face challenges requiring human service professionals to move beyond the provision of categorical services and to deal preventively and promotively with children and families, and (3) new abilities to track and therefore document that a single high-risk family may be served by several agencies which do not communicate well with each other.

2. Disciplines are the base for interprofessional work.
Service settings, academic settings, and disciplines each have unique cultures, ways of organizing knowledge, and ways of setting priorities that shape activities. Professionals working with children and families should acquire knowledge within specific disciplines. Replacing disciplines with a purely generalist outlook on practice will not be as effective as building better bridges among disciplines so that they can reinforce and support each other in meeting clients' needs.

3. Community perceptions of needs and strengths and of avenues for early intervention, should guide service professionals. They can then work with community members to help shape realistic shared expectations and outcomes. Systems and workers should identify assets in both clients and communities and take a preventative approach to planning and providing services. This moves away from a crisis-oriented deficit orientation that focuses on identification of specific problems and service programs based on categorical funding streams. This orientation does not respond holistically to the needs of children and families toward a system that promotes early-interventive, holistic approaches to child, family, and community well-being.

4. Professionals should be trained to work with parents as equals and to understand the contributions they can and must make as service planners, evaluators, designers, advisors, and as the primary providers of key supports and services for their children. Parents play a critical role as non-professional partners in service and empowerment. Working collaboratively with family members may require professionals to wear multiple hats, and adjust to ambiguity and shifting roles.

5. All members of a team demonstrate cultural competence and community-based competence.
They often learn these from non- and para-professional members of a team.

6. In the new arena of interprofessional education, relations across education, health, human services, and a wide variety of other disciplines are assumed to be genuinely co-equal.
There is no presumptive academic home, nor host discipline, nor integrating base for services. Professions share equal interest in helping children and families. No profession holds a monopoly on that commitment.

7. Interprofessional practice skills are a composite of team-building, case management, conflict resolution, self-reflection, outcome measurement, organizational behavior, and interorganizational structures.
To these skills might be added the concepts of understanding power relationships within different metropolitan and rural communities, urban geographic and demographic impacts on service systems, the ethics of service provision and client choice, theories of leadership, and knowledge management in an information society.

1. Central to client and community well-being is a recognition that public policy issues related to children, families, and communities are beyond the scope of any single profession's jurisdiction and responsibility.
Workers and community members need to understand how they are part of public policy and how they can be involved to change the status quo in which one-third of children and families face serious hardships. Ideally, generation and interpretation of public policy are shared by all members of the team.

2. Results-based accountability–the development and use of outcomes to determine funding–is the only way human services can reclaim credibility and re-emphasize client-centered practice over agency-centered practice.
This includes an emphasis upon programs' effectiveness and an emphasis upon new methods of evaluating programs (Connell, Kubisch, Schorr, & Weiss, 1995).

3. Cultural competence should not be restricted to being one of a desired group of competencies and be set out as an organizing principle.
Design, delivery, and evaluation of programs requires respect for ethnic and linguistic identity; reduction of marginalization, invisibility, and devaluation that occurs for certain cultures, groups, or communities perceived as "different"; engagement of diverse community perspectives at all levels of decision making; and the practice of cultural democracy, which implies an active effort to assure equal standing for people from all cultures.

4. Decategorized funding strategies, which seed greater flexibility at the community level, should meet the test of responsiveness to the client's full range of needs, emphasize the capacity of frontline teams, and legitimize community planning processes.
Clarification of common assumptions about funding is needed. Such flexibility at the community level is a better way of allocating resources than categorical decisions made in legislatures far from clients.

5. Higher education needs a reform agenda based upon the needs of children and families (Hooper-Briar & Lawson, 1996; Lawson & Hooper-Briar, 1994).
Faculty must be supported and provided with new incentives to develop programs of interprofessional education, because these are some of the best ways of connecting the university in more significant ways with the community. Higher education should make greater efforts to train community members to be the professionals for the future, identifying youth and community volunteers for early training and developing appropriate career paths with clear articulation between community colleges, four-year institutions, and graduate programs.

6. The rights and responsibilities of the clients–children and families–are fundamental and ethical issues in the preparation of professionals.
Thus ethics should be included as one of the disciplines needed for interprofessional practice with children and families.

7. Field-based education (including internships and clinical placements in community settings) is a core component of interprofessional education.
Bringing pre-professionals together in teams in their early encounters with practice provides critically needed exposure to the realities of interprofessional work. Such field work must be supervised by faculty who understand how professions can work together and who themselves have had such experience. Practitioners may also act as supervisors for such professionals, as they may be more deeply involved in new forms of collaborative practice than some faculty less familiar with current forms of integrated practice. Such practitioners are assets for the university and should be treated as the equals of faculty in supervising field work, regardless of their disciplinary backgrounds. Field-based education also raises issues of how community members are treated in a university setting. When community members are 'partners' in a developmental process rather than 'clients' in an agency, professionals are often unprepared for new demands and behaviors.

8. A "reality test" for interprofessional education is its capacity and credibility in providing useful assistance to local service providers, coalitions, and community-based organizations. Multidisciplinary work often takes place at the level of the "natural community"– an elementary school, parish, ethnic neighborhood, or park district, in a base that is sometimes geographic, ethnic, linguistic, vocational, or family-defined. Professionals need to work with all these kinds of communities from a multidisciplinary perspective, rather than bring a single skill to a community requiring integrated support.

9. Interprofessional education is most successful when it is integrated early in the socialization and educational experience of diverse professionals. Adding new courses and seminars will be less effective than re-orienting existing curricula to broader themes of collaboration. If interprofessional education is merely additive, it reproduces the same syndromes that fragment the services system, as we add new programs on top of old ones, instead of rationalizing the system. If interprofessional strategies are only learned in the workplace, such retraining is time consuming and difficult. Interprofessional education must be infused throughout the curriculum, instead of becoming a new, marginal discipline with its own restrictive boundaries and, eventually, professional barriers. This infused learning can and should build on the best of our disciplinary traditions.

Authors of the full report are: Zlotnik, J.L., McCroskey, J., Gardner, S., Gil de Gibaja, M., Taylor, H., George, J., Lind, J., Jordan-Marsh, M., Costa, V., & Taylor-Dinwiddie, S.

SOCIAL SERVICES: Activities that enable individuals, families, and groups to cope with social and psychological problems interfering with their functioning.

SOCIAL WORK: Professionally responsible interventions carried out by persons with formal, professional education at the BSW or MSW level from an accredited school of social work and appropriate licensing, certification, and registration credentials. Interventions are directed toward improving the transactions between people and environments to enhance the adaptive capacities of the participants and improve environments for all that function within them. Social work is a professional practice with a consumer group consisting of individuals, families, small groups, organizations, neighborhoods, and communities and involving the disciplined application of knowledge and skill.

A. SOCIAL WORK RESOURCES ON HEALTH CARE REFORM

Implications of Health Care Reform on the Social Work Profession
Congressional Briefing, February 16, 2011; www.socialworkreinvestment.org/2011/briefing.html

Social Workers and Healthcare Reform – Legal Defense Fund Legal Issue of the Month, April 2011
www.socialworkers.org/ldf/legal_issue/2011/042011.asp

CSWE Guide to Patient Protection and Affordable Care Act
Provisions relating to social work that were included in the Patient Protection and Affordable Care Act of 2010 www.cswe.org/File.aspx?id=48334

B. COUNCIL ON ACCREDITATION (COA) STANDARDS GLOSSARY DESCRIPTION OF SOCIAL WORK
COA STANDARDS GLOSSARY
www.coastandards.org/glossary.php#gs

SOCIAL SERVICE MODEL: Organizationally based practice that seeks to enhance personal and social functioning, based on the theory and techniques of social work and closely related professions. Five elements are generally present in an organization adopting the social service model: personnel who have been professionally trained in social work; professional supervision; accountability to the community; consumer participation in decisions about services provided on their behalf; and use of a holistic approach that recognizes the interaction of social/environmental and psychodynamic/psychological factors.

C. CASE MANAGEMENT SOCIETY OF AMERICA
STANDARDS QUALIFICATIONS FOR CASE MANAGERS
www.cmsa.org/Individual/MemberToolkit/StandardsofPractice/tabid/69/Default.aspx
Case managers should maintain competence in their area(s) of practice by having one of the following:
Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; and/or b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization, and the individual must have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

D. RESOURCES ON SOCIAL WORK EFFECTIVENESS AND SOCIAL WORK IMPACT ON SERVICE DELIVERY OUTCOMES

Research finds that a social work degree coupled with specialized preparation in a field of practice can result in improved client outcomes, worker retention, greater sense of self-efficacy, a decrease in the amount of required pre-service and in-service training, enhanced cultural competency, commitment to ethical practice and a person-in-environment orientation.

Los Angeles Conference on Intervention Research in Social Work - A special issue of *Research on Social Work Practice* (Vol. 20, issue 5) is devoted to exploring research on social work interventions for youth at risk, individuals experiencing mental illness and their families, persons involved with the criminal justice system and clinic patients experiencing depression and other health conditions. The articles address methodological challenges and research designs as well as the current state of social work intervention research, with studies addressing the needs of persons from diverse cultures. The articles are drawn from the proceedings of the Los Angeles Conference on Intervention Research in Social Work, organized by the University of Southern California School of Social Work and the Institute for the Advancement of Social Work Research (IASWR) in October 2009.

Outcomes of Social Work Intervention in the Context of Evidence-Based Practice – an article by Edward Mullen and Joseph Shuluk, *Journal of Social Work, 11*(1): 49-63 is adapted from a November 2009 presentation by Mullen, *What is known from research about the effectiveness of social work interventions,* that was presented at "Social Work Research and Comparative Effectiveness Research (CER): A Research Symposium to Strengthen the Connection" sponsored by the NASW Social Work Policy Institute (www.socialworkpolicy.org/news-events/social-work-research-and-comparative-effectiveness-research-cer-a-research-symposium-to-strengthen-the-connection.html). According to the synthesis of research reviews there is a large body of evidence supporting the effectiveness of a wide range of social work interventions.

Evidence Database in Aging Care (EDAC) – New York Academy of Medicine (funded by Atlantic Philanthropies). EDAC is a database designed to provide evidence on social work outcomes, www.searchedac.org/index.php.

Factors Influencing Retention of Child Welfare Staff: A Systematic Review of Research, a systematic review of research from the 1970s through 2004 by Zlotnik, DePanfilis, Daining and McDermott-Lane, available from www.socialworkpolicy.org/publications/iaswr-publications/iaswr-child-welfare-workforce-initiative.html.

The Relationship between Staff Turnover, Child Welfare System Functioning and Recent Child Abuse, by the National Council on Crime and Delinquency, February 2006 compares high turnover and low turnover counties in California and finds that low rates of re-abuse relate to low turnover, better staff pay and compliance with recognized practice standards. www.cornerstones4kids.org/images/nccd_relationships_306.pdf.

Studies of the Cost-Effectiveness of Social Work Services in Aging: A Review of the Literature by Rizzo and Rowe (*Research on Social Work Practice*, 2006, Vol. 16; 167-73) finds that the aging of the population creates an increased demand for social work services and that reimbursement structures for Medicare and Medicaid present significant barriers. The literature review finds that social work interventions can have a positive impact on health care costs, the use of health care services and the quality of life of older Americans.

The Effects of the ARC Organizational Intervention on Caseworker Turnover, Climate, and Culture in Children's Service Systems by Glisson, Dukes and Green (*Child Abuse & Neglect,* 2006, 855-880) examines the effects of the Availability, Responsiveness, and Continuity (ARC) organizational intervention strategy on caseworker turnover, climate, and culture in child welfare and juvenile justice agencies. The results of a randomized controlled design finds that organizational intervention strategies can be used to reduce staff turnover and improve organizational climates in urban and rural systems. This is important because child welfare and juvenile justice systems in the U.S.A. are plagued by high turnover rates, and there is evidence that high staff turnover and poor organizational climates negatively affect service quality and outcomes in these systems.

Collaborative Care Management of Major Depression Among Low-Income, Predominantly Hispanic Subjects With Diabetes by Ell, Katon, Xie, Lee, Kapetanovic, Guterman and Chou, published in *Diabetes Care* (2010, 33;706–713). The results from a randomized controlled trial that tested an evidence-based, socioculturally adapted collaborative depression (telephone support and outreach, systems navigation and assistance, problem solving therapy and medication) and diabetes care models for low-income Hispanic subjects found that those receiving the enhanced treatment had significantly greater improvement in depression and decreased diabetes complications.

Enhanced Discharge Planning Program (EDPP) is a follow-up intervention tested in a randomized study at Chicago's Rush University Medical Center's Older Adult Programs and Case Management Department. The effective program has social workers phone patients and caregivers after discharge to ensure they are receiving the services detailed in their discharge plan and to investigate any unanticipated needs. If necessary, social workers intervene to help patients resolve problems and connect patients and caregivers to health care providers and community-based services. This program has been highlighted in numerous publications including the AARP Bulletin Today in September 2009, http://bulletin.aarp.org/yourhealth/medicare/articles/transition_care.html.

Project SAFe (Screening Adherence Follow-Up Program) developed by social work researcher Kathleen Ell (University of Southern California) and a team of researchers including project co-director Betsy Vourlekis, is a social work model that provides a system of patient navigation counseling and case management designed to help low-income, ethnic-minority women overcome barriers to timely breast cancer screening and follow-up after receiving an abnormal mammogram. The service involves a structured interactive telephone assessment of screening-adherence risk (i.e., barriers), health counseling, and follow-up services, including patient tracking, appointment reminders, and referral to community resources. It can be found on the Research-tested Intervention Programs (RTIPs) website http://rtips.cancer.gov/rtips/agreement.do;jsessionid=9B10034A6C72E2734469D8538CE1FE5D.

Using Pharmacists, Social Workers, and Nurses to Improve the Reach and Quality of Primary Care - Commonwealth Fund Quality Matters, August/September 2010. Studies of interdisciplinary health care teams have demonstrated that use of these teams can lead to improvements in the quality of primary care, but their impact on total health care costs and utilization has not yet received sufficient attention. Still, available evidence suggests that these teams may help expand the nation's capacity to provide primary care services, which is much needed due to a shortage of physicians and other primary care providers. But doing so quickly will require the financial support of federal, state, and private payers, as well as an investment of time by health care providers. www.commonwealthfund.org/Content/Newsletters/Quality-Matters/2010/August-September-2010.aspx.

E. USEFUL WORKFORCE RESOURCE LINKS AND REPORTS RESOURCE LINKS

NASW Center for Workforce Studies – http://workforce.socialworkers.org.
(See more detailed information on Center resources below) Social Work Reinvestment Initiative – provides information on federal and state strategies to strengthen and support the social work workforce - www.socialworkreinvestment.org/

Cornerstones for Kids – A website for the Annie E. Casey Foundation's Human Services Workforce Initiative – www.cornerstones4kids.org/

National Child Welfare Workforce Institute – A service of the U.S. Children's Bureau – www.ncwwi.org.

The Annapolis Coalition – dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field - www.annapoliscoalition.org/aboutus.aspx.

John A. Hartford Foundation – funded Geriatric Social Work Initiative – is a multi-faceted, multi-year effort to build aging capacity in social work including field placements, curriculum building, competency development and strengthened leadership and agency/school partnerships. See the initiative website for more information – www.gswi.org.

NASW Data Show Behavioral Health Social Workers Earn $50,000 –
www.socialworkblog.org/featured-articles/2011/04/survey-finds-behavioral-health-professionals-earn-less-than-fast-food-workers/

REPORTS
The Unsolved Challenge of System Reform: The Condition of the Frontline Human Services Workforce, Annie E. Casey Foundation, 2003; www.cornerstones4kids.org/images/the_unsolved_challenge.pdf.

Assuring the Sufficiency of the Front-Line Workforce: A National Study of Licensed Social Workers
http://workforce.socialworkers.org/studies/nasw_06_execsummary.pdf.

Strengthening the Child Welfare Workforce: Promoting Recruitment and Retention (Special Issue) of the Journal Child Welfare (2009, vol. 88, 5) edited by Anderson and Zlotnik.

Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, Institute of Medicine, 2008.

Retooling for an Aging America: Building the Health Care Workforce, Institute of Medicine, 2008.