



National Association of Social Workers - Michigan Chapter

Better Health, Better Health Care, and Reduced Costs

Integrating Community Supports into Michigan's Health Care System

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	Page 3
ATTRIBUTION	Page 3
ORGANIZATIONS PARTICIPATING IN THIS EFFORT	Page 4
INTRODUCTION	Page 5
OPERATIONALIZING PRIMARY CARE	Page 6
THE PRIMARY CARE WORKFORCE	Page 7
Social Workers	Page 8
Community Health Workers	Page 9
CRISIS IN HEALTH CARE	Page 10
EVIDENCE FOR SOCIAL SUPPORTS IN PRIMARY CARE	Page 11
Clinical Impact	Page 11
Cost Savings & Impact	Page 12
Programs that Work in Primary Care	Page 12
RECOMMENDATIONS	Page 12
CONCLUSION	Page 14
REFERENCES	Page 14
APPENDIX	Page 16

EXECUTIVE SUMMARY

The existing system of primary care delivery in Michigan fails to deliver services where people are located and does not currently employ a workforce that can reach people in underserved or vulnerable communities impacted by the social determinants of health. Michigan has the opportunity to achieve the Triple Aim by operationalizing primary care as an integrated community-based system of health and human service delivery, to define the workforce providing services for vulnerable populations, to include social workers and community health workers, and to make the case for a sustainable payment policy that reimburses community support professionals for their contributions to the health and social service delivery team.

By focusing on the functionality of primary care providers instead of the rigid clinical roles dictated by existing medical credentialing processes, existing primary care systems have the opportunity to integrate community support roles in their practices that can yield better health, better health care, and reduced costs among Michigan's populations.

ATTRIBUTION

A group of organizations, led by the Michigan Chapter of the National Association of Social Workers, came together to develop this paper. The idea for this work began as part of the community discussion around integrated care for persons who are both Medicare and Medicaid eligible. Therefore, vulnerable populations were the initial focus of the work proposed in this paper. During the course of the paper's development this focus broadened to include Medicaid beneficiaries as well as other low-income individuals who will gain health care coverage under the Affordable Care Act (ACA). The timing of action is critically important now that Michigan is poised to implement a regional demonstration offering integrated care for persons with Medicare and Medicaid eligibility ("dual eligibles"), perhaps implement a Medicaid expansion, and work with the federal government to offer private insurance coverage through a health insurance exchange.

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Researchers have argued that by “expanding the scope of health care, the place where it is delivered, and the workforce that provides it, the US health care system could significantly improve health outcomes and reduce inefficiencies.” (Onie, 2012)

INTRODUCTION

Across the population of the United States, shortfalls in health care directly account for roughly 10% of early deaths, while genes, social circumstances, and behavioral and environmental factors account for the rest.^{1,2} Much has been written about the need for the American health care delivery system to rely less on specialty care and to strengthen and expand primary care. Physicians, hospitals, community health centers, community mental health agencies and other health care providers are on the front lines of efforts to improve health outcomes and reduce the cost of care while better integrating and coordinating health care delivery, through Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) as well as other initiatives. These patient-centered initiatives are gaining wider support and velocity in implementation as a result of the Affordable Care Act (ACA) and increasing recognition that the United States must achieve better health outcomes for the significant financial investment it makes in health care.

Many of these efforts, however, continue to focus solely on medical intervention and service organization, while neglecting the importance of social and community health services. Experts agree that medical care by itself cannot address the disparate health outcomes significantly impacted by social determinants.³ A renewed emphasis on primary care as a comprehensive health and social service delivery structure care can improve health, reduce disparities in population health, and help control the costs of care.⁴ While much can be accomplished through retooling the existing delivery system, achieving the Triple Aim⁵ of better health, better health care, and lower costs will require transformational change.

It is imperative to address the social determinants of health, non-medical contributors to health and the individual’s role in his or her own health. The health care workforce must be able to address the social circumstances and factors such as education, income, social support, and available resources in a person’s community that affect health and healthy behaviors. The purpose of this paper is to discuss Michigan’s opportunities to achieve the Triple Aim by:

- Operationalizing primary care as an integrated, community-based system of health and human service delivery
- Defining the workforce providing services for vulnerable populations to include social workers and community health workers
- Making the case for sustainable payment policy that reimburses community support professionals for their contributions to the health and social service delivery team

When our communities are reached by people who can assist in addressing issues stemming from poverty, toxic stress, and other social and environmental determinants of health, the health of Michigan's vulnerable and underserved populations will improve.

OPERATIONALIZING PRIMARY CARE

The Institute of Medicine established the current definition of primary care:

The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.⁶

The existing definition highlights the need to connect with patients at the social and community level; however, it does not explain how primary care needs to function as a continuum of health and social service delivery. The enacted, predominant model in which primary care is solely delivered in the clinical office setting by a fragmented team of medical providers vastly differs from a continuum of care in which multiple types of providers perform different roles that collectively function to deliver comprehensive, holistic health and social services. Neighborhoods, homes, community and social resources, physician offices, clinics, and hospitals need to be connected in a multidirectional manner using information technology as a major infrastructure component.

Prevention, which is crucial to maintaining and improving health, must be a key component of primary care and is best addressed in the community. There is not only an urgent need to integrate behavioral and physical health care, because the effects on each other are significant, but also integrating and addressing the social factors such as socioeconomic status and education as a part of primary care can be an extremely effective practice for preventing adverse physical and behavioral health outcomes. Individuals with mental health or substance abuse diagnoses often experience poorer physical health than other individuals. Social determinants of health, including education, housing, public safety, availability of healthy foods, and toxin-free environments, must be considered by a care team as direct influencers of health status and treatment adherence.⁷ For example, level of education attainment has been associated with an increase in social support, which is associated with increased physical and mental health and also buffers against the health-damaging effects of stress.⁷ Additionally, providing holistic care earlier in life can help to decrease the likelihood of adverse health outcomes that are directly correlated with negative or traumatic childhood experiences that primary care systems may have the opportunity to impact when expanding their reach to the home or community level.⁸ Settings for primary care service delivery and connections must also expand beyond the medical clinic and include safety net providers, schools, community centers, faith-based organizations, public aid agencies, and other health and social service groups frequented by adults, children, and families in our communities.

A reoriented primary care delivery system integrates professionals into an interdisciplinary team that can address all the basic needs of an individual. This team would include medical professionals that are able to practice at the top of their credentialing to address health issues and social needs. These team members, including social workers and community health workers, are social service professionals that have expertise in case management and community support who can connect with individuals in their communities, neighborhoods and homes. By reorienting primary care in context of the community, providers can begin to serve patients on a continuum of care that serves the needs of patients beyond the four walls of the doctor’s office. This also provides opportunities for primary care systems to redefine who delivers primary care services and what roles they play. **By focusing on the functionality of primary care providers instead of the rigid clinical roles dictated by existing medical credentialing processes, existing primary care systems have the opportunity to integrate community support roles into their practices that can yield better health, better health care, and reduced costs among Michigan’s populations.** This transformation requires community support roles that can be filled by social workers and community health workers.

The Patient Centered Medical Home

The Patient Centered Medical Home (PCMH) model is comprised of four basic tenets: primary care, patient-centered care, new-model practice, and payment reform. Primary care as defined in the model is a comprehensive, first-contact care coordination system that encompasses acute, chronic, and preventative care across the life span delivered by a team of health providers and led by a primary care physician. Patient-centered care refers to the tailoring of care that meets the needs and preferences of patients and encourages active involvement of the patient in every aspect of the decision-making process for his or her care. New-model practice refers to the departure from the usual medical model practices and seeks to incorporate continuous quality improvement techniques by including evidence-based processes of care, population-based care management, performance measurement and improvement, point-of-care decision support, and information technology. Lastly, the PMCH model describes payment reform as a structure that combines fee-for-service, pay-for-performance, and a separate payment for care coordination and integration as incentive for expanding practice outside of the tradition clinical office visit.¹

THE PRIMARY CARE WORKFORCE

Rethinking primary care means rethinking who is on the health care team delivering primary care services and support. The existing workforce structure in primary care settings is not adequate. A core principle of the delivery system must be to treat the whole person. This innovation does not require new knowledge, but rather better implementation of interventions we already have⁹ – in other words, shifting our focus from medical staff roles to the functionality of those roles, resulting in the increased use of social workers and community health workers on interdisciplinary teams.

Implementing a truly patient-centered, community-based primary care system for vulnerable populations requires a retooled workforce that includes social workers and community health workers. The current shortage of primary care practitioners⁴ is a perfect opportunity to overhaul primary care for vulnerable populations and implement a new system that uses social workers and community health workers to integrate health delivery and connect individuals to services in the community setting.

Social Workers

A social worker is a licensed professional who promotes social justice and social change with and on behalf of clients.¹⁰ “Social work is a profession devoted to helping people function the best they can in their environment. This can mean providing direct services or therapy directly to people. It also can mean working for change to improve social conditions. The phrase ‘in their environment’ points to a distinguishing characteristic of social work—one that sets it apart from other helping professions. Social workers help clients deal not only with how they feel about a situation but also with what they can do about it.”¹¹

Additionally, social workers help clients’ problem solve and cope with life stressors, link individuals with resources, services, and opportunities, and promote effective and humane service systems.¹² Social workers have the potential to intervene with primary care populations on multiple levels and at multiple stages of care. In addition, social workers can provide more specific services to the health care team, such as psychological and social issues assessment and patient counseling.¹³ “With its strengths-based, person-in-environment perspective, the social work profession is well trained to develop and improve support systems (including service delivery systems, resources, opportunities, and naturally occurring social supports) that advance the well-being of individuals, families, and communities.”¹⁴

“Social work is a health care profession that is “essential to a variety of client-centered settings, including community mental health centers, hospitals, substance use treatment and recovery programs, schools, primary health care centers, child welfare agencies, aging services, employee assistance programs, and private practice settings.”¹⁵ “Licensed social workers are well equipped to practice in the health care field, because of their broad perspective on the range of physical, emotional, and environmental factors that have an effect on the well-being of individuals and communities. Social workers look at the person-in-environment, including all of the factors that influence the total health care experience.”¹⁶

*Social Work Scope of Practice*¹⁷

- *Masters-Level Social Workers*

The licensed master level social worker has graduated from a CSWE accredited university and has completed 4,000 hours of supervised work experience. Social workers in Michigan must be licensed to practice at either the bachelors or masters level.

- Practice psychotherapy with adults and children

- Diagnose mental, emotional or substance abuse disorders with a diagnostic code and administer treatment plans and evaluations
- Plan, administer, and evaluate interventions including specialized and formal interactions and case interventions
- Administer and interpret assessments, including child or child custody assessments
- Provide consultation regarding agency practice, policy development, and clinical issues as well as developing and evaluating social welfare policy
- Coordinate and evaluate service delivery including provision of training which meets the needs of the community
- Direct clinical programs and social work agencies with or without clinical practice, including the supervision of clinical and macro social workers
- Design and analyze research
- *Bachelors-Level Social Workers*

The bachelor's level social worker must graduate from a CSWE accredited bachelors program. To be licensed they must have 4,000 hours of supervised work experience and pass the bachelor's level examination.

- Conduct pre-admission general assessments for mental health facilities, identify presenting problems, and conduct psychosocial assessments
- Administer interventions with individuals, couples, families, and groups including teaching or education of clients to enhance or restore the capacity for social functioning
- Case Management (individuals, families, couples, groups, and child welfare)
- Advocate for groups, communities, and individuals, including child or adult custody determination, and impart general information and referral for assistance
- Plan and evaluate program interventions
- Organize communities
- Collect data for research

Community Health Workers

A community health worker can be defined as, "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served."¹⁸ Because of the connection to their communities, community health workers serve as liaisons or links between community members and health and social service systems, improving the quality and cultural

competence of service delivery. Community health workers also “build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.” Working alongside social workers, nurses, and other providers, the Patient Protection and Affordable Care Act of 2010 lists CHWs as professional members of the health care team.¹⁹ The term “community health worker” is used generically to cover a broad category of workers. Within specific programs, these workers may have titles including Peer Support Specialist, community-based doula, family health advocate, community outreach specialist, *promotore(a)*, social service technician, or others²⁰.

CRISIS IN HEALTH CARE

Only about thirty percent of physicians work in primary care and this trend is only worsening. By 2025 it is projected that there will be a shortage of 150,000 primary care physicians.⁹ With too few primary care practitioners and with efforts to create patient centered medical homes burgeoning, now is the time to incorporate social workers and community health workers into the structure of primary care, extending the reach of primary care into homes and communities. Social workers and community health workers build relationships with patients that assist care teams in working with community members holistically and provide a connection point between home and clinical office. Simply giving vulnerable community members’ access to physician office visits will not be enough to improve their health. In addition, the shortage of primary care clinicians and rising poverty will prohibit efficient care even in the face of higher levels of insurance coverage.⁹

In addition to a physician shortage, there is also a substantial shortage of social workers in healthcare settings who can address the social circumstances of patients. Social workers are not fully utilized as members of interdisciplinary teams. There are currently about 24,750 licensed social workers working in clinic and hospital settings in the United States. If each only served Medicaid patients, there would be only one social worker for every 2,404 patients.⁹

Together, social workers and community health workers have the opportunity to work collaboratively as team members with others in primary care settings. These other professionals include registered nurses, nurse practitioners, physician’s assistants, physicians, disease-specific coaches, case managers, psychologists, psychiatrists, and other health professionals who are part of the interdisciplinary team. By conceptualizing primary care delivery by function, these professions begin working in tandem versus in opposition with each other. Many have recommended that social workers and CHWs be paired as teammates to more effectively impact vulnerable populations while promoting social work values.^{21,22,23}

While working with the community health worker, social worker, nurse, clinical provider, and other team members, the patient can be connected to services that address physical, social, and environmental aspects of his or her health. These services function on a continuum, one that relies on connection points existing between primary care offices and community members’ doors. For some areas, that is the community health worker; in others, it may be a social worker or nurse care manager. It is not necessary to expand the clinical practitioner’s workload to address the primary care capacity shortage. Instead we should improve the system’s ability to address the social determinants of health

by making more and better use of social workers and community health workers, and improve the efficiency and effectiveness of the health care delivery system by freeing other providers to practice “at the top of their license”.⁹

Reorienting the primary care workforce isn’t about substituting or replacing medical care positions with social support personnel; instead, it’s about re-envisioning the functionality of care team members to serve the patient as a whole person through the continuum of primary care service delivery. The current system is not adequate and cannot address patient needs holistically. A new, re-oriented system must address social determinants of health through a primary care workforce – including social workers and community health workers – that bridge existing systems of care and impact health of the whole person at the community level and in the community setting.

Social Determinants of Health

Resources in communities such as access to safe and affordable housing, education, public safety, availability of healthy foods, local emergency and health services, and toxin-free environments are social determinants of health that directly influence quality of life and the health of the community. *Healthy People 2020* recognizes that improving these social determinants of health is the foundation for good health and therefore not only does health care need to be improved but also, education, housing, business, law, community planning, and agriculture needs to be addressed as well (<http://www.healthypeople.gov/2020/about/DOHAbout.aspx>).

EVIDENCE FOR SOCIAL SUPPORTS IN PRIMARY CARE

To make care more patient-centered, the system needs to support patients in the home and the community to reinforce what takes place in the medical care setting. Social workers, community health workers, and other peer support professionals, working with individuals in the community, can address the environmental factors and the emotional factors required for positive health habits and better health outcomes. Social workers have a longstanding, diverse skill set, a knowledge base, and a value set uniquely suited to ensure that Michigan’s health and human service delivery systems make the most of opportunities and challenges that its citizens face while community health workers are establishing themselves as vital members of the interdisciplinary team that represent and connect to the communities they serve.

Clinical Impact

Effective primary care practice requires the skills of social workers to effectively address psychosocial and environmental aspects of illness.²⁴ Social workers in primary care settings or as members of interdisciplinary teams have been shown to decrease depression and anxiety among patients, improve the overall quality of life for patients with advanced cancer, increase social activities of chronically ill seniors, and reduce mortality in older adults.²⁵

Community health workers can support patient efforts to comply with medical advice, use their prescriptions appropriately, and operationalize positive health changes in their lives. In Michigan, community health workers have helped community residents successfully manage chronic disease, reduce depression, develop healthier lifestyles, improve maternal and child health, improve rates of preventative screenings, and improve access to, and use of, health care services.²⁶ Community health workers are already primed to connect patients in the community to patient-centered care.

Cost Savings & Impact

Social workers and community health workers assist in reducing the cost of health. Studies have shown social worker participation on an interdisciplinary primary care team saved an average of \$90 per patient.²⁷ Social workers have been effective in reducing costs in other areas of the health care system. Social workers in the emergency department offset costs by decreasing hospital and emergency department use and increasing efficiency of medical staff time.²⁸ Social workers also increase efficiency of systems by improving timeliness and effectiveness of patient discharge.²⁹

Community health worker interventions have demonstrated significant return on investment results. Between \$2.28 to \$4.00 have been saved for every \$1.00 invested in community health worker interventions, pointing to the effectiveness of a team-based health intervention approach addressing social and physical health.^{30,31,32,33} These interventions have worked with patients in various social situations and in multiple systems of care, pointing to the need to connect patients to people and resources on a continuum of care, not just within a singular system.

Programs that Work in Primary Care

Primary care systems are beginning to recognize the need for community supports in the form of social workers and community health workers to impact their populations at the community and clinic levels. A recent report of Patient Centered Medical Home (PCMH) initiatives highlights the results of two particularly successful initiatives to bridge medical and human services.³⁴ In Vermont, where community health teams comprised of social workers, nurse coordinators, and other behavioral health professionals are used, inpatient hospital use dropped from 15-40% and emergency room use decreased by 2.8-33.8%. The Camden Coalition of Health Care Providers in New Jersey uses a team approach to primary care that includes social workers and has demonstrated a 56% reduction in overall health care spending for their patients.

Health homes seek to address the need for integrated and comprehensive primary and behavioral health care. As outlined in the Patient Protection & Affordable Care Act, health homes are designed to provide comprehensive care management, care coordination and health management, comprehensive transitional care from inpatient to other settings and appropriate follow-up, patient and family support, referrals to community and social support services, and use of health information technology to link patients to services.³⁵

Please see Appendix A for a listing of other programs that have been effective in primary care.

RECOMMENDATIONS:

ADDRESSING THE ROLE OF SOCIAL WORKERS AND COMMUNITY HEALTH WORKERS IN PRIMARY CARE DELIVERY

NASW recommends that state policy makers in both the Executive and Legislative branches of government use a wide range of statutory, regulatory, contractual, and other policy-setting tools to ensure that the resources uniquely possessed by social workers are built into the changing health care system. These policy-setting tools would include:

1. Promote a more central role for social work clinicians and administrators in Patient Centered Medical Homes (PCMH's) (including the Care Bridge concept which is integral to Michigan's Dual Enrollee Integrated Care Demonstration), and Accountable Care Organizations (ACOs);
2. Advocating that Medicaid, including qualified health plans, and Medicare billing codes and other payment mechanisms for social work services in PCMHs, ACOs, and other primary care settings including direct services, case management, and outcomes-based services;
3. Planning cross-integration of case management services with and by social workers, including public and private non-profit safety net providers (Community Mental Health Centers, Federally Qualified Health Centers, free clinics, community-based behavioral health care, and Developmental Disability services providers), risk-based care managers in the public and private sectors (PIHPs, MHPs, Dual Project ICOs), hospitals and health systems, labs, pharmacies, county health plans, school health clinics, and the newly formed consumer health cooperative.

Michigan should take additional steps to strengthen and broaden its ability to achieve the Triple Aim of better health, better healthcare and lower costs for its most vulnerable populations including the following:

4. Develop state level Medicaid policy to standardize payment for the functions related to pilot health care delivery models (i.e. Community Pathways Hub, Chronic Care Model, See Appendix A). This policy should be a key component of the Integrated Care for Medicare and Medicaid Eligible model. Infrastructure for accountable care coordination includes the following features which can be the basis for a payment policy:
 - a. Incentive payments for improved outcomes
 - b. Focus on coordinating existing resources and then building new ones as necessary
 - c. Process to link PCMH to broader social services support
 - d. Identify and treat the social determinants of health
 - e. Provider accountability for delivery of a full spectrum of care, including addressing the social determinants of health

- f. Continuous consumer involvement, participation and decision making in collaboration with health care service delivery in system development, patient outcomes, and individual health care decision making
 - g. Quality improvement (QI) in the overall service delivery system as assured by continuous data aggregation and evaluation
5. Promote policies for Community Health Workers' (CHWs') recognition and payment through Medicaid, Medicaid managed care, and other payers for integration of CHWs into Michigan's health and human service systems, including primary care systems such as PCMHs, ACOs and FQHCs, among others;
 6. Promote integration of social workers and CHWs into the health care system with recommendations made to Michigan's public health code.

It is also important to note that these changes create jobs and better define career paths for health professionals. Health care and human service professions are expected to be the fastest growing sector between now and 2020, and may account for one quarter of the jobs the economy is expected to create by the end of the decade.¹ Given Michigan's unemployment rate, the loss of manufacturing jobs, and the resultant need to develop other skills in our working age population, this report's recommendations would have two major benefits: improved health, and improved economic health through job training and creation.

CONCLUSION

Efforts to achieve the goal of better integration of clinical and social services are underway in Michigan; however, these efforts are lacking the necessary emphasis on services provided by social workers and community health workers. Health is a social issue; medical care alone cannot achieve better health, better health care, and reduced costs for optimum outcomes for Michigan's most vulnerable populations. Social workers are academically prepared and licensed to manage and deliver the services that have been identified as 80% of the determinants of positive health outcomes for primary care efforts. Full utilization of social work practice with community health worker integration is critical to the success of Michigan's health care reform.

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³⁵Health Homes: State Medicaid directors letter. Michigan Department of Community Health Web page. http://www.michigan.gov/documents/mdch/shCMS_Letter_to_Directors_Health_Home_SMD_Final_11-16-10_2_346164_7.pdf. Updated 2013.

APPENDIX

This appendix references models/projects which have been initiated nationally and in the state of Michigan to incorporate social work and social support functions into primary care as well as literature which discusses funding models for utilization of non-medical staff in the delivery of primary care services.

Bravemen, et. al, have presented a strong discussion of what has been learned of the “social determinants of health” (SDOH) over the last two decades of observation, research and published material. Among their summary points is the assertion that “The questions are no longer about whether social factors are important influences on health, but rather about how social factors operate and how we can most effectively intervene to activate health-promoting pathways and interrupt health-damaging ones.”

Health Care Delivery Models:

Michigan Child and Adolescent Health Centers

School-based and school-linked centers based on a care management model provide primary care, educational interventions, mental health, and social service linkages with a wide range of health benefits being demonstrated.

Prevention and Access to Care (PACT)– Boston.

PACT focuses on effectively integrating community health workers (CHWs) into primary care and mental health teams. PACT partners with clinics to develop the infrastructure, culture, quality improvement tools, and skills necessary to support effective CHW interventions for the most vulnerable patients. PACT strategies have been applied in multiple sites and to a broad range of chronic conditions. Multiple funding strategies.

Transition to Success (TTS)

TTS transitions youth and families from dependency to self-sufficiency through a comprehensive system of care operated by Matrix Human Services. The program frames and treats poverty as a disease through treatment defined by a CARE (Coordinating All Resources Effectively) plan.

Community Pathways / Community Hubs

Pathways/Community HUB is a model of care that utilizes a network of local agencies to coordinate client care by providing a centralized process to track what services the individual needs so that services are not duplicated and needs are not unmet.

Literature:

1) Multi-disciplinary team approach to chronic illness care in a comprehensive care setting, which includes multiple non-medical providers. Grant funded.

Blash L, Chapman S, Dower C, 2010, revised 2011. Research Brief, Center for the Health Professions: The Special Care Center – A Joint Venture to address Chronic Disease.

2) Use of Medicaid funding to finance service delivery which spans medical care, behavioral health care, health education, counseling and assistance with social services.

Witgert K, Giles B, Richardson A, 2012. Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities and Challenges.

3) Describes positive impact of establishment of social work within primary care settings of National Health Service reporting faster implementation of social services, improved working relationships among providers, decreased crisis, improved continuity of care and decreased hospitalizations.

Mark Lymberry MPhil & Andy Millward MA (2002) Community Care in Practice, Social Work in Health Care 34:3-4, 241-259. DOI:10.1300/JO10v34n03_01

4) Primary care collaborative practice shows potential for reducing utilization and maintaining health status for seniors with chronic illnesses.

Somers LS, Marton KI, Barbaccia JC, Randolph J, 2000. Physician, Nurse, and Social Worker Collaboration in Primary Care for Chronically Ill Seniors.

5) Discussion of relationship between social determinants and health service use by marginalized populations who receive social support to facilitate participation with health care and resilience.

Duy D. Nguyen MSW PhD , Kiu H. Ho MSW & James Herbert Williams MSW MPA PhD (2011) Social Determinants and Health Service Use Among Racial and Ethnic Minorities: Findings From a Community Sample, Social Work in Health Care, 50:5, 390-405

6) Importance of social work in linking the “medical world to the patient’s world in the community.”

Foster, Sue and Beddoe, Liz. Social work with older adults in primary health - is it time to move our focus? [online]. Aotearoa New Zealand Social Work, Vol. 24, No. 2, 2012: 37-48.

7) This article develops the argument that medical social workers possess the professional knowledge and skill base to provide to improve communication, continuation and engagement which are measures on which US health has ranked poorly.

K. Jean Peterson DSW (2012) Shared Decision Making in Health Care Settings: A Role for Social Work, *Social Work in Health Care*, 51:10, 894-908, DOI: [10.1080/00981389.2012.714448](https://doi.org/10.1080/00981389.2012.714448)

8) Presents findings from three focus groups with primary care physicians and nurses to examine the perspectives of these key providers about the benefits and challenges of integrating social workers into the primary care team. Identification of SW provision a continuum of care and support.

Bronwyn Keefe MSW MPH , Scott Miyake Geron PhD & Susan Enguidanos PhD (2009) Integrating Social Workers into Primary Care: Physician and Nurse Perceptions of Roles, Benefits, and Challenges, *Social Work in Health Care*, 48:6, 579-596, DOI:[10.1080/00981380902765592](https://doi.org/10.1080/00981380902765592)

9) Identification of hospital social workers addressing SDOH including housing, disability, income and employment security as a top priority; it is posited that these issues would not be addressed adequately by other health care professionals.

Shelley L. Craig PhD LCSW , Raluca Bejan MSW & Barbara Muskat PhD RSW (2013) Making the Invisible Visible: Are Health Social Workers Addressing the Social Determinants of Health?, *Social Work in Health Care*, 52:4, 311-331, DOI:[10.1080/00981389.2013.764379](https://doi.org/10.1080/00981389.2013.764379)