Is There a Social Worker in the House?
Health Care Reform and the Future of Medical Social Work
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As medicine has become increasingly sophisticated and technologically complex, medical education and medical care have come to rely on increased specialization (Moore & Showstack, 2003). Dividing providers into specialties, however, has also led to a fragmented care delivery system in which a patient might go to one clinic for a check-up, a mental health service provider for treatment of anxiety, another service provider for rehabilitation after addiction, urgent care for a toothache, a specialist for diabetes management, and an imaging center for cancer screening. Fragmentation leads to lapses in communication among providers, which can be costly in dollars (when care is duplicated) and in outcomes (when prescription errors occur, for instance, or when diagnoses fail to take mental health into account). This fragmentation has measurable consequences: The number of specialty physicians per population has been associated with higher mortality, shorter life span, and low birth rates (Shi, 1994).

Recent health reform legislation aims to correct fragmentation by providing incentives to reorient health care around primary care and for existing practices to transform into medical homes (Kocher, Emanuel, & DeParle, 2010). The medical home offers a single place for the coordination of all outpatient care needs, including behavioral and dental health. The model imagines a site where patients access care easily, where interdisciplinary care teams understand each patient's history and needs, and where the method of payment reflects the coordination necessary for delivery of individualized care (American Academy of Pediatrics, 2002). Although definitions vary from single-site clinics to multiple-site primary care networks, the Agency for Healthcare Research and Quality (2011b) outlines five core medical home attributes: They must be patient-centered, comprehensive, coordinated, provide superb access to care, and have a systems-based approach to quality and safety. The medical home model purports to be a transformation of primary care that would set the foundation for a sustainable health care system by keeping people healthy.

Medical home models must include a social lens that considers the whole person in the context of the person's larger environment; without it, medical homes may not be transformational enough to achieve a healthy population within an affordable health care system. Despite increased access to care, the traditional medical model has failed to resolve growing public health problems such as obesity, and health disparities exhibited among low-income and minority populations include greater risk for chronic disease, anxiety, substance abuse, and depression (Cooper et al., 2000; Mensah, Mokdad, Ford, Greenland, & Croft, 2005; Piffath, Whiteman, Flaws, Fix, & Bush, 2001; Wells, Klap, Koike, & Sherbourne, 2001). Environmental health research demonstrates that upstream factors such as a lack of community resources, environments hostile to physical activity, social isolation, segregation, crime, and discrimination can increase susceptibility to health hazards and can lead to poor health outcomes (Lee, 2002; Merkin, Stevenson, & Powe, 2002; Sexton, 2000). Equipping primary care to achieve real gains in population health will likely require looking at old problems through a different lens, one that acknowledges inequality and incorporates social justice.

Social workers can bring this lens; we now have a unique opportunity to ensure that care
models adopted under health reform legislation truly improve outcomes for the communities that we serve. We work in hospitals and clinics nationwide, yet we are underrepresented in health policy development or practice redesign. This time must be different.

SOCIAL WORK SHARES VALUES WITH THE MEDICAL HOME

The conceptual principles of the medical home and the values of our profession are well-aligned. The medical home's emphasis on patient-centered care, for instance, asks practices and providers to build personal relationships with patients and to engage patients in making informed decisions about their own health. This means that the patient's capacity for self-determination takes precedence, just as it does within the field of social work. From a social work perspective, though, patient-centered care must acknowledge that patient health doesn't begin and end in a clinic; rather, individuals live within families and communities that present them with unique challenges and resources. How medical homes will encourage family and community involvement in health remains undefined. The medical home also would replace the traditional primary care/behavioral health divide, which sees the mind and body as operating in isolation of one another. Medical homes should provide comprehensive care: care that addresses physical and mental health needs and integrates the two in prevention and in treatment. Social workers have often been a bridge between behavioral and physical health settings, and members of our profession can provide important insights, conceptual models, and language that will develop the medical home's capacity to provide whole-person care. Another central element to the medical home model is the concept of coordinated care, in which seamless transitions between care providers and care sites ensure that care delivery is complete and uninterrupted. Care coordination is intuitive to social workers, who help clients navigate service systems and build resources to support clients through changing circumstances. Finally, the medical home's emphasis on access to care and on quality reflects social work values such as equity; inherent in the medical home model is the idea that all patients have the right to access the services they need and to demand the highest standard of care.

SOCIAL WORKERS HAVE A ROLE IN THE MEDICAL HOME

Social workers currently fill a variety of roles within the health care sector. A medical home may offer even more opportunities, provided we are able to articulate the unique qualifications and skill sets we bring to the table. The role of care coordinator, for instance, is usually filled by a nurse, and this professional is generally responsible for facilitating care transitions, assisting with chronic disease management, and addressing barriers to care. Yet while nurse coordinators are trained to answer patient questions about their physical health care, they are not usually tied to upstream nonmedical resources. Social workers, on the other hand, are often well qualified in patient-engagement techniques such as motivational interviewing, and have a sophisticated understanding of social and environmental barriers and resources to health. We can provide case management services and can aid patients in navigating social service systems, linking individuals to resources that will enable them to access healthy foods, active living resources, rehabilitation services, and social networks. Furthermore, social workers can collaborate with community-based social services such as domestic violence shelters, food banks, treatment programs, child protective services, and housing programs in order to improve health. Just like nurse coordinators, social workers are able to connect patients to specialty providers and ensure an iterative flow of information between points of care. We can smooth transitions between inpatient care, assisted living, and rehabilitation services and resolve difficulties with insurance, pharmacies, durable medical equipment, and home-based health care. We can also provide individual, family and couples counseling services that reach beyond the clinic appointment and can assist patients in building healthier skills, relationships, and lifestyles. Some pilot clinics have recognized the need for social worker skills and have employed “behaviorists” to meet with patients about depression, anxiety, and health-promoting behaviors such as tobacco cessation (Agency for Healthcare Research and Quality, 2011a). But there is more than one role for the social worker within the medical home; our skill set and perspective have evolved from our uniquely interdisciplinary professional education and even from our foundational roots in the settlement house movement. We broker medical and nonmedical resources. We
provide counseling services. We engage the patient and the family in change processes. We work with and within the community. In essence, we are prepared to advance care coordination.

SOCIAL WORKERS ARE CRITICAL TO MEDICAL HOME SUCCESS

Nurse coordinators or other traditional health care professionals could be trained in some of the skills listed above, and so the argument could be made that social workers are not any more necessary in this model of care delivery than in any other. But the Patient Protection and Affordable Care Act (P.L. 111-148) incentivizes medical homes specifically for the Medicare and Medicaid populations. Existing health disparities research suggests that an improvement in outcomes for these vulnerable communities will take more than care coordination and individual coaching; medical home models must move upstream to prevent disease, reduce inequalities in health outcomes, and improve population health. The field of social work can contribute a framework to address poverty, racism, and other forms of oppression that prevent marginalized communities from fully benefiting from the health care system.

As an example, the traditional model of care requires families to visit the doctor during work hours and to plan appointments well ahead of emergent need. Working families are at a disadvantage under this care delivery model, for it favors those who have the ability to schedule ahead and to take time off for family appointments. Those with very little employment leverage, such as migrant workers, have found it difficult to seek care in traditional settings (Hunter et al., 2003; Mohanty et al., 2005), and expanded electronic access may be less helpful for those populations that seldom access the Internet. As primary care practices work to increase accessibility for all groups, social workers are needed. As the traditional advocates for individuals and groups who have access to fewer resources, social workers could provide vital consultation services as access systems are built. Social workers are needed to advocate on behalf of the Medicaid and Medicare communities and to ensure that the local and national policies that ultimately define the medical home do so in such a way that even the most vulnerable will benefit from it.

As another example, the quality improvement efforts that characterize the medical home offer a pathway to advance health equity in service delivery. Transition to a medical home requires adopting electronic health records and using them for quality improvement efforts. This wealth of metrics and electronic data can reveal systematic inequities that occur at the provider level (Institute of Medicine, 2002). Social workers can and should advocate for quality improvement activities that identify and reduce health disparities. For instance, are all patients equally encouraged to quit smoking regardless of income? Does the clinic have adequate language translation and interpretation services? Should the medical home change recruitment and hiring practices so the diversity of the staff is reflective of the diversity of the population it serves? In medicine, quality assurance has meant something conceptually different than equity, but in the field of social work quality and equity are inextricably linked. Without a concerted effort to bring equity into discussions of quality, health inequities will persist within the very populations targeted by health care reform.

CONSEQUENCES OF PAYMENT REFORM

Transitioning traditional primary care clinics into medical homes represents a radical shift in service delivery practices and will require an equally radical shift in the way that care is paid for. Under the traditional care model, providers are paid for a clinic visit or for services such as the administration of a vaccine—they are not paid to integrate behavioral and physical health or to support a multidisciplinary team with roles such as care coordination. The incentive structure of the Affordable Care Act offers the potential to reform this payment system, including enhanced payment for services such as care coordination and integration of behavioral health and primary care.

Discussion around long-term payment reform in the medical home model centers on an approach known as capitiation (Berenson & Rich, 2010; Lester, 2011). In a capitated model, care teams receive a set amount per patient based on the health characteristics of the patient population; in return, the team is asked to keep that patient healthy. Instead of incentivizing sick care (and as much of it as possible), capitiation ideally incentivizes positive health outcomes and prevention of disease. Capitated payments are not new in health
care; this is how managed care works. Yet managed care, with similar conceptual goals of improving the quality of health care, coordinating services, and focusing on primary care, was soundly criticized for limiting access and “cherry-picking” the healthiest to serve (Cutler & Zeckhauser, 1998; Newhouse, 1996). Administrators who control purchasing power for Medicaid and for major insurers will likely regulate through policy the types of services that must be present within an accredited medical home clinic and the types of outcomes that are expected in order to receive up-front payment capitation or an alternative payment structure. However, we should learn from history that good intentions often fall to the wayside when efforts at cost control collide with an industry that has been immensely profitable. Will the medical home achieve the noble goals of health reform? Or will it just increase the profitability of primary care without improving patient outcomes? The answer will likely be determined by how the policy develops and is implemented from this point forward.

What it means to be a medical home and who will fill and define the new roles afforded by changes in payment will be decided by the individuals at the table; social workers can be included in the model or we can be left out. Now is the time for social workers to actively engage at every level of the reorganization of primary care practices into medical homes. We should do this not only for the opportunity it affords our profession in terms of expanded employment in medical social work, but because we bring a value-oriented perspective that fully complements this effort and is critical to achieving the ideals of health reform. HSW

REFERENCES

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