

Social Work & Care Coordination

General Background

Social workers play an integral role in *care coordination* for older adults, especially those living with advanced illness or multiple chronic conditions, by facilitating access to health and psychosocial services that improve health outcomes and support aging in place.

Care coordination is a *client-centered, assessment-based, interdisciplinary approach to integrating health care and psychosocial support services in which a care coordinator develops and implements a comprehensive care plan that addresses the client's needs, strengths, and goals*. Effective care coordination can decrease health care costs while improving health outcomes for older adults with multiple chronic conditions, yet it receives limited support from Medicaid and essentially none from Medicare.¹

Social work has a long history in case management and care coordination; in fact, the profession of social work and the specialty practice of case management developed simultaneously, and public health social workers were among the first case managers. A century later, the social work profession remains integral to care coordination. As discharge planners, social workers identify resources to help individuals maximize functioning and independence after leaving the hospital or other inpatient health care facility. Social workers play an equally important care coordination role in home- and community-based settings—such as Medicaid waiver programs, home health, and hospice and palliative care, to name just a few—helping individuals with chronic conditions, including mental health conditions and dementia, access the services necessary to age in place.

In addition to serving as resource brokers, social workers also bring to care coordination psychosocial expertise in individual, family, and community dynamics. Social workers operate from a *person-in-environment* perspective—in other words, they recognize that an individual cannot be understood apart from the multifaceted context of her or his environment.² With this perspective, social workers are uniquely equipped to assess both the psychological and social aspects of a client's behavior, and to intervene accordingly.³ This expertise is especially critical given the complex psychosocial issues underlying treatment nonadherence, lifestyle-related medical conditions, caregiving deficits, and lack of advance planning—problems that pose significant barriers to coordinated care and cannot be solved with medical interventions alone.

Recognizing the importance of the social work role in case management and health care, the National Association of Social Workers (NASW) has developed standards to guide social work practice in health care settings.⁴ These standards address multiple areas related to care coordination, including ethical concerns, comprehensive assessment, individualized intervention and treatment planning,

service navigation, and interdisciplinary and interagency collaboration. The standards also inform NASW's recommendations regarding care coordination.

Social workers' demonstrated expertise in navigating complex health and social service systems, combined with their unique psychosocial perspective, illustrates the profession's critical role in care coordination for older adults. In filling this role, social workers continue to realize the profession's mission of helping individuals and families access resources to maximize their independence, health, and well-being.

Recommendations

- Ensure care coordination is included in the current health care reform legislation.
- Ensure that health care reform legislation includes social workers among the professionals eligible to provide care coordination.
- Ensure that payment mechanisms for care coordination performed by social workers and other professionals are included in Medicare, Medicaid, and health care reform legislation.
- Develop pilot and demonstration projects for care coordination in which social workers have a central role, and if successful, rapidly replicate and scale these projects.

References

- ¹ Brown, R. (2009). *The promise of care coordination: Certain models of care coordination can reduce hospitalization and health care expenditures among Medicare beneficiaries, improve quality of care*. (Paper commissioned by the National Coalition on Care Coordination [N3C]). Retrieved June 25, 2009, from www.socialworkleadership.org/nsw/Brown_Full_Report.pdf.
- ² Kondrat, M. E. (2008). Person-in-environment. In T. Mizrahi & L. E. Davis (Eds. In Chief), *Encyclopedia of social work* (20th ed. Vol. 3, pp. 348-354). Washington, DC: NASW Press.
- ³ For a comprehensive assessment and intervention planning system based on the person-in-environment (PIE) perspective, see Karls, J. M., & O'Keefe, M. (2008). *Person-in-environment system manual* (2nd ed., with CompuPIE CD). Washington, DC: NASW Press.
- ⁴ NASW. (2005). *NASW standards for social work practice in health care settings*. Retrieved July 14, 2009, from www.socialworkers.org/practice/standards/NASWHealthCareStandards.pdf.

Additional Resources

- National Association of Social Workers. (2009). *Aging and Wellness. Social work speaks: National Association of Social Workers policy statement, 2009-2012* (8th ed., pp. 14-21). Washington, DC: NASW Press.
- National Association of Social Workers. (2009). *Health Care Policy. Social work speaks: National Association of Social Workers policy statement, 2009-2012* (8th ed., pp. 167-170). Washington, DC: NASW Press.
- National Association of Social Workers. (2009) *Health & Social Work: A Journal of the National Association of Social Workers*. Washington, DC: NASW Press.