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To cite this article: Victoria Stanhope PhD, Lynn Videka PhD, Helle Thorning PhD & Mary McKay PhD (2015) Moving Toward Integrated Health: An Opportunity for Social Work, Social Work in Health Care, 54:5, 383-407, DOI: [10.1080/00981389.2015.1025122](https://doi.org/10.1080/00981389.2015.1025122)

To link to this article: <http://dx.doi.org/10.1080/00981389.2015.1025122>



Published online: 18 May 2015.



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## **Moving Toward Integrated Health: An Opportunity for Social Work**

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*With the passage of the Patient Protection and Affordable Care Act (PPACA) and ongoing health care reform efforts, this is a critical time for the social work profession. The approaches and values embedded in health care reform are congruent with social work. One strategy is to improve care for people with co-morbid and chronic illnesses by integrating primary care and behavioral health services. This paper defines integrated health and how the PPACA promotes integrated health care through system redesign and payment reform. We consider how social workers can prepare for health care reform and discuss the implications of these changes for the future of the profession.*

*KEYWORDS* health care reform, integrated health care, workforce training, behavioral health, mental health services, primary care

### INTRODUCTION

Not since the passage of Medicaid and Medicare in 1965 has the United States experienced such a large-scale effort to reform and expand health

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Received November 10, 2014; accepted February 26, 2015.

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care as we are witnessing with the implementation of the Patient Protection and Affordable Care Act of 2010 (“Patient Protection and Affordable Care Act,” 2010). While there has been considerable political resistance to the legislation, the type of system redesign that this policy emphasizes builds on changes that have already begun at the state and local level. Therefore, regardless of the political controversy at the federal level, the underlying need to reform a costly and ineffective system will continue to drive the health care system. With nearly 40% of social workers working in the health and behavioral health care sectors, this represents a critically important time for the social work profession (Center for Workforce Studies, 2006; Spitzer & Davidson, 2013). We have two challenges: one, to promote our unique contributions to health care reform and two, to prepare the existing and new workforce for the anticipated profound shift in their roles.

Health care reform is guided by the Triple Aim: improving the experience of care, improving the health of the population, and reducing per capita costs—goals that are not mutually exclusive if our health care system transforms in a positive way (Berwick, Nolan, & Whittington, 2008). In addition to expanding health care coverage, achieving these goals means realigning the system to focus on prevention rather than acute care, helping people manage their wellness, and fostering collaboration and integration across primary and behavioral health care. These changes are highly compatible with the values of social work (Andrews, Darnell, McBride, & Gehlert, 2013). Health care reform is grounded in Engel’s biopsychosocial approach, which is one of the guiding frameworks for the social work profession. Our challenge, therefore, is to adapt and thrive within new systems of care, which means demonstrating the unique contributions we can make both by translating current practice to these systems of care and acquiring new skills and approaches. This article explores how health care reform will impact social workers and how we can prepare ourselves for changes in health care practice environments. Moreover, we hope to convey a sense of optimism—if we engage proactively, health care reform presents an important opportunity for social work to reassert its value as a profession and reconfirm its core mission. At a recent briefing on social work education and health care reform at the White House, a leader from Health and Human Services proclaimed that “Social work gets it!”—the onus is now on us to demonstrate how and why we “get” health care reform.

### WHY DO AMERICANS NEED INTEGRATED HEALTH?

For social workers on the front line of delivering care, the failures of the U.S. health care system are all too apparent. In comparison to peer countries, such as Canada, Australia, Germany, and Japan, people who live in the United States experience significantly lower life expectancy and worse outcomes on

key health indicators, including infant mortality, HIV and AIDS, drug-related deaths and disability (Institute of Medicine, 2013). These poor outcomes are produced by a health care system that spends twice more per capita than countries who rank higher on health indicators, such as Japan, the United Kingdom, and Sweden (Davis, Stremikis, Squires, & Schoen, 2014). It is this combination of high costs and poor outcomes that has become the driver of health care reform and the impetus for the Triple Aim. The reasons for this misalignment of services and needs are myriad, but include a concentration of resources in high end acute care rather than prevention, funding streams that reward volume of service rather than quality, and a fragmented system that operates in parts rather than serving the whole (Berwick et al., 2008).

Another key impetus for reform is the lack of equity in how our system distributes care, resulting in profound disparities in services and health outcomes across populations. Poor health outcomes in the United States are due in large part to inequities based on race, class, gender, and sexual orientation. Life expectancy among African Americans is 74.6 years and among Native Americans 76.9, as compared to 78.9 for Whites (Lewis & Burd-Sharps, 2010). In 2010 infant mortality was 5.1 per 1,000 for births to White mothers, but 11.6 per 1,000 for Black or African-American mothers (Kids Count Data Center, 2013). The majority of African Americans and Hispanics report worse quality of care and less access to care than Whites and the majority of poor people report worse quality of care and less access to care than high income people (Agency for Healthcare Research and Quality, 2011). Lesbian, gay, bisexual, and transgender (LGBT) people are less likely to have insurance coverage, seek health care and report lower levels of health than heterosexuals (Krehely, 2009). Therefore, often health care reform is not going to succeed in improving overall outcomes unless it pays attention to population level well-being. This means focusing on the underlying causes of health care disparities, which are often driven by social determinants, such as education, employment, community, culture, and exposure to discrimination (Craig, Bejan, & Muskat, 2013).

The focus on cost control within health care reform has brought attention to one particular population that generates high costs but continues to experience poor health. This is people who suffer from co-morbid mental and medical health conditions, an estimated 17% of the adult population (Druss & Walker, 2011). Within people who suffer from medical conditions, 29% also have mental health conditions and more strikingly, among people who suffer from mental health conditions, 68% also have a medical condition (Druss & Walker, 2011). These high rates of co-morbidity contributed to the finding that people with severe mental illnesses die on average 25 years before the general population, which was an important wake-up call for the urgent need to address fragmentation in our system (Colton & Manderscheid, 2006). From federal agencies on down, we have created a bifurcated system of mental health and physical health, with further divisions between mental

health and substance abuse. The cost is immense, both with regard to human suffering and the burden on public resources. Overall, there is small group (5%) of people suffering from co-morbid illnesses who account for more than 54% of the Medicaid budget (The Kaiser Commission on Medicaid and the Uninsured, 2013). A study of Washington State Medicaid users found among the small group of people who had more than 31 Emergency Room (ER) visits in one year, 89% of them had mental health, substance abuse, or co-occurring disorders (Mancuso, Nordlund, & Felver, 2004). The cost of treating a chronic disease when a person also has a mental health disorder is on average \$560 dollars more than the cost to treat someone without one (Druss & Walker, 2011). Furthermore, people with substance abuse disorders are among the group with the highest rates of hospitalizations with more than half of those hospitalizations due to physical conditions (Mauer, 2010).

Traditionally the care delivery system has been organized around illness and disease with each condition treated separately and care concentrated when the illness is acute. Illnesses or diseases have been treated as separate entities and by separate specialists. This episodic and fragmented treatment approach, prevalent in the medical model, can be effective for individuals who encounter an illness that is discrete, of short duration and has limited consequences to work and family, but it is rarely effective for people with chronic conditions. Care providers rarely differentiate their clinical approach to patients with acute and chronic illness, expecting that patients will initiate visits to the doctor, request relief from symptoms, and prioritize urgent needs over ongoing wellness (Kottke, Brekke, & Solberg, 1993). Consequently, patients are less likely to engage as active participants in care activities that promote health, collaborate with health care providers, maintain involvement with treatment protocols, and self-monitor physical and emotional health status (Wagner, Austin, & Von Korff, 1996). While the medical model has promoted great progress in the scientific understanding of etiology and treatment of distinct and unique diseases, the exclusive focus on illness and disease has left out important contextual influences, such as the subjective understanding and adaptation to illness, environmental and social factors.

## WHAT IS INTEGRATED HEALTH CARE?

At its simplest, integrated health is the “systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served” (Hogg Foundation for Mental Health, n.d.). Behavioral health in this context encompasses both mental health and substance

abuse. Fundamentally, integrated health is an acknowledgment of and a reorientation of services to the importance of the mind/body connection.

Integrated health takes a two-prong approach toward improving health outcomes. The first is *population-based care*, which emphasizes a public health approach that monitors the health status of groups of people, tracks health risks and determines sources of disease and transmission, assesses the impact of public policies, and improves communities. Central to this approach is a focus on primary prevention activities aimed at preventing predictable problems in individuals or population at risk by maintaining healthy functioning, promoting desired goals and enhancing human potential (Koh & Sebelius, 2010). The second is focusing on how to improve services for individuals, families and communities by shifting resources from treating episodic and illness oriented medical care to prevention, health management and care collaboration across providers and disciplines. This approach to care has been informed by the *Chronic Care Model* (Wagner et al., 1996). In this paradigm, the individual is at the center of the system and actively participates in all decisions regarding illness.

The key components of the model are a combination of interconnected practices that are integral to general social work practice. The engagement starts with a person-centered approach, which is individualized and holistic and includes the individual's family and community in both assessment and subsequent intervention plan. Person-centered care, which is defined by the Institute of Medicine as "Health care that should honor the individual patient, respecting the patient's choices, culture, social context, and specific needs" (Berwick, 2002, p. 83) is now a key organizing principle both in health and mental health service delivery. Accordingly, care planning is collaborative, empowering the individual to delineate personal goals and the steps toward achieving those goals. Decision support is essential via a process of providing the person with information about what is known of the given health or mental health challenge to help the person make the optimum care decisions (O'Connor, Légaré, & Stacey, 2003). The Chronic Care Model illustrates how coordinated care rests on good communication, both in terms of social interaction between providers, individuals and their families, and in terms of access to health records and assessment data. Calibrating care to the right level means having continuous assessments that are accessible to all providers in real time. This concept of "stepped care" or care delivered with attention to the information obtained about the individual underlies the importance of having a comprehensive health information technology infrastructure (Hegel et al., 2002).

Implementing the Chronic Care Model is complex at the system level. It is a substantial paradigm shift that requires a transformation of care delivery systems that has been built around acute care. This complexity is reflected in the evolving terminology of integrated health care that has resulted in overlapping technical terms to describe integration (Peek & National

Integration Academy Council, 2013). Fundamentally, there are two levels of integration: the *structural*, which refers to health care systems and *clinical*, which refers to how providers work with each other.

More specifically, at the level of *clinical integration*, we can most clearly see the potential contribution of social workers—whose training grounded in ecological model, expertise working with families and communities, and case management skills make them ideally suited for tasks related to care coordination. The Agency for Healthcare Research and Quality (2010) defines the six core activities of clinically integrated care coordination as: (1) Determine and update care coordination needs, (2) Create and update a proactive plan of care, (3) Communicate and exchange information, preferences, goals, and experiences among participants in a patient's care, (4) Facilitate transitions by sharing information among providers and patients, (5) Connect with community resources, and (6) Align resources with population needs. These activities demonstrate the scope of care coordination that starts from engaging the individual to systems level intervention to meet population health needs. An important distinction within care coordination is between care management and case management. While traditional case management activities fall under the rubric of coordinated care, care management shifts the emphases to intervening at the system level rather than just with the individual. Whereas a case manager may link individuals to appointments with medical providers, a care manager will ensure that all providers are aware of the treatment plan by relaying information and collaborating between teams and agencies. Probably at no point do we appreciate the need for care coordination than at points of transition from one level of care to another and one setting to another. Transitions between different levels of care, such as hospital discharge to community based services, are vulnerable *exchange points* that can contribute to lapses in quality of care and safety for people with chronic illnesses (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). Transitional care offers a vision of multicomponent interventions from engagement of the individual and his or her family of choice, to the development of self-directed goals toward recovery and community integration (Engelberg Center for Health Care Reform, 2014).

## HOW DOES THE PPACA PROMOTE INTEGRATED HEALTH?

Realizing structural and clinical integration requires a profound reorientation of our current health care policies that have in the past incentivized acute care and created fragmented care systems. Therefore, a significant part of the Patient Protection and Affordable Care Act of 2010 (PPACA), commonly known as Obamacare, centers on the promotion of integrated health. While most of the media attention has been on expanding health insurance through the PPACA, the hope is that much of this will be paid for by cost

savings associated with efforts to streamline care especially for those with chronic illnesses. The PPACA achieves health care reform through four main components: insurance reform, coverage expansion, systems redesign, and payment reform. While access is a prerequisite to creating care coordination, the main strategies to achieving integration lie in systems redesign and payment reform.

With many social workers employed in behavioral health, achieving parity in coverage for mental health services and substance abuse services has been a major professional concern. In 2008, the passage of the Mental Health and Addiction Equity Act mandated parity for both mental health and substance abuse disorders for businesses with over 50 people (Aggarwal & Rowe, 2013). The PPACA then built on this landmark legislation by including mental health and substance abuse services in the essential benefit packages for both Medicaid and private policies. With the expansion of Medicaid and inclusion of substance abuse services, we are likely to see a considerable increase in demand for these services (Cochran, Roll, Jackson, & Kennedy, 2014).

Systems redesign seeks to promote structural integration of primary and behavioral health care services by providing financial incentives for systems to pursue new ways to deliver care. The PPACA created the Centers for Medicare and Medicaid Services (CMS), expressly charged with controlling the costs of Medicare and Medicaid by testing model innovation in service delivery and payments. Three service delivery structures that have shown great promise in moving health care toward this concept of “one-stop shopping” for health needs are the Patient Centered Medical Home, the Health Home, and the Accountable Care Organization.

The *Patient Centered Medical Home (PCMH)*, which first emerged in the area of pediatrics, designates the primary care setting as the coordinating entity for every person’s physical, behavioral, and preventive care needs (Vest et al., 2010). According to the Joint Principles of PCMH (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007), the individual being served must have a personal relationship with a primary care physician (PCP). The PCP delivers care with a team of practitioners, who practice using a whole person orientation, and the team coordinates or integrates care across systems. Teams can include specializing physicians, nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioralists, social workers, care coordinators, and others. Other important elements of PCMHs include offering individuals enhanced access through easier scheduling and expanded appointment hours, using health information technology to track status and care of patients, employing evidence based practices and focusing on self-management of disease (Burke, 2011). PCMHs have now been utilized in all sectors of health care—private pay, Medicaid, and Medicare.

*Health Homes* build on the PCMH model and principles, but specifically target people with chronic conditions who receive Medicaid (Alexander & Druss, 2012). PPACA created an option under Medicaid together with financial incentives to allow state Medicaid programs and providers to create Health Homes as an alternative service delivery system for people with chronic illnesses. To date, 12 states have elected to add the health home model into their Medicaid services. For individuals to be eligible for a “Health Home,” they must have two or more chronic conditions or have a severe mental illness. Unlike PCMH, Health Home providers are not restricted to primary care centers, but can be based in a community mental health agency, a Health Home agency, clinical/group practice, and community health centers. The services include comprehensive care management, care coordination and health promotion, transitional care from inpatient to other settings, family support, linkage to community and social support services and use of health technology to enhance coordination. A multidisciplinary team coordinates care and can include, depending on the setting, a care manager, a behavioral health clinician, a health navigator, a peer specialist, a nurse, social workers, and a PCP. Care is shaped by a single care plan developed collaboratively with the individual and the family, which addresses all the health and wellness needs (Alexander & Druss, 2012).

An *Accountable Care Organization* (ACO) is essentially a financing model made up of a network of hospitals, primary care settings, and other providers who enter into agreements to provide coordinated care to a designated population of individuals (Collins, 2011; Spitzer & Davidson, 2013). In the same way as managed care entities operate, ACOs receive a set amount of funding per patient taking on the “risk” of providing care within that budget. What differentiates ACOs from managed care is a focus on person-centered primary care, prevention and disease self-management and performance measurement. To achieve these goals, ACOs utilize PCMH to coordinate and deliver care. However, there will still be demand for specialty care, which will mean that ACOs can create a “medical neighborhood” with community based providers, which could include social workers in private practice. Although the private sector is increasingly adopting the ACO model, the PPACA has focused on promoting the use of ACOs within the Medicare Program. The CMS launched the Medicare Shared Saving Program, which gives ACOs financial incentives if they demonstrate quality improvement and cost savings. There are now an estimated 500 private and public ACOs (Muhlestein, 2013). Many see this becoming the dominant model to organize care across the private sector, Medicare, and Medicaid.

Health services have always been fundamentally shaped by the way they are funded. Therefore, a vital part of changing the system is to encourage higher quality and lower costs through payment reform. Much of the inefficiency within the system has been due to a fee-for-service system that

has rewarded quantity over quality (Takach, 2012). Although the details can be complicated, overall we see a move toward funding services according to per person covered by insurance (capitated rate) or per person served (case rates) with calibrations according to type and complexity of illnesses (case mix adjustment) (Manderscheid, 2014). Even within a fee-for-service system, PCMHs often receive additional per person payments to support the infrastructure needed to coordinate care. Also we will see more pay-for-performance incentives, with providers receiving higher levels of reimbursement, based on attaining specific stated goals, such as patient satisfaction and cost reduction. One example of this is the federally funded Delivery System Reform Incentive Program (DSRIP). New York and California are using DSRIP funds to implement innovative system reform and community collaborations designed to reduce hospital use (National Association of Medicaid Directors, 2014). Similarly, the Medicare Shared Saving Program for ACOs ensures that if improved primary care leads to reduced costs for acute care, savings will be distributed to all providers maintaining the incentive for higher quality care across the network (Spitzer & Davidson, 2013). The PPACA has also increased the reimbursement rates for primary care, permitted same day reimbursement for physical and behavioral services and allowed Medicaid reimbursement for a broader range of services, including home- and community-based services, preventions activities, peer support, and family supports.

### WHAT ROLES WILL SOCIAL WORKERS HAVE?

The PPACA is changing the landscape for behavioral health agencies, which, since deinstitutionalization in the 1960s have become a major practice setting for social workers. With this change there are expanded opportunities for workers in primary care settings as they increase their capacity to deliver holistic care. Social workers have much to contribute to primary care through their understanding of engagement and motivational strategies with people who experience behavioral health problems. Most importantly, social workers understand how to address stigma and promote a recovery orientation in these settings. Community Health Centers are also becoming a major target for health care reform. These federally funded safety-net providers of primary, dental, behavioral and prevention services are a natural fit for the PCMH model (Mauer, 2005). These settings will also provide opportunity for social workers as Community Health Centers convert to more team based care and expand their behavioral health services for underserved populations.

Health care reform has both created new roles and emphasized traditional roles for social workers (see [Table 1](#)). Positions that are identified as key to health care reform include patient navigator, family navigator,

**TABLE 1** Social Work Related Roles Under the PPACA

Role	Description
Care coordinator	A person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored.
Care Manager	A health care provider (usually an RN) who helps patients and caregivers more effectively manage their health and associated psychosocial situation.
Disease Manager	A provider or peer or community health worker who is responsible for the management of care for persons in a population defined as having a chronic illness and a need for management of one's health.
Case manager	Patient advocate and resource as well as providing critical information and recommendations to the rest of the care team: physicians, surgeons, nurses, administrators, benefits coordinators, employers, and family caregivers.
Implementation specialist	A person responsible for the adoption, implementation, and sustainment of evidence-based practices in agency practice.
Patient navigator	Help individuals apply, establish eligibility and enroll in health insurance through marketplaces; Provide outreach and education about the Marketplace and other health care resources; Refer to health insurance ombudsmen and individual counselors as necessary.
Family navigator	Patient navigators who focus on family health care needs.
Peer counselor	Person with similar lived experience who assists others through counseling, advocacy, and information and fellowship exchange.
Community organizer	Identify and build collective action among members of a community to achieve a set of social goals.
Community health worker	An individual who promotes health within a community that he/she resides by providing guidance, liaison services, cultural and linguistically appropriate communication, advocacy, referral, follow-up, and proactive identification.
Community integrator	A person responsible for integrating health and behavioral health care for integrating health and behavioral health care for people with chronic health conditions.

community organizer, peer counselor, community health worker, and community integrator along with the standard roles of care coordinator and care manager (National Association of Social Workers, 2012). Traditional social work roles that are identified as key to promoting the goals of integrated health are community organizer, care coordinator, and case manager. The health-focused community organizer can contribute to more responsive and accessible health services within a given community by gathering information about community needs, enabling a community to voice its needs, and influencing organizational and political systems to respond to the health needs of the community in culturally appropriate ways.

Care coordinator, case manager, disease manager and care manager are related roles with nuanced differences. Each of these roles targets the management of care of individuals with complex health care needs and social circumstances (such as mental health disabilities, addictions, and homelessness). Case management is a role that has been defined for several decades now in both health care and in social services. Case management has typically focused on individuals and on coordinating social and medical care services in uncoordinated environments. Care coordinators also work with high need populations, such as homeless families and work to integrate health and social services for the population at the patient and system level. Service integration and communication among providers is targeted to improve care and to reduce unnecessary health care costs. Social workers, as well as nurses and community health workers, frequently serve as care coordinators. Key components of care management include identifying individuals and families most likely to benefit from greater efficiency in care, assessment of patient and family risks and needs, creation of a collaborative care plan with the patient, coordination and communication activities across providers, and motivational services such as education and coaching regarding health conditions and medication (Goodell, Bodenheimer, & Berry-Millett, 2009).

Disease management is specifically chronic illness focused. It involves specific programs that link resources for persons with serious chronic illnesses that often include co-morbid conditions and complications, such as cancer, asthma, congestive heart failure, mental health disabilities, and diabetes. The focus of disease management is to assure that competent and cost-effective care is provided to the population with a targeted chronic health condition. Disease managers may be social workers, nurses, community health workers, or peer supporters. Disease management includes working with individuals to manage their own illness and wellness.

The implementation specialist is a new role that has emerged with the call for the adoption, implementation and sustainment of evidenced-based practices. It has been widely documented that there is a long delay between the demonstration that a treatment is effective to a widespread dissemination (Dixon & Schwarz, 2014). While training is important in the acquisition of a new skill-set, training is not enough to change practice behavior. Consequently, there is a need for identifying someone in the agency who can provide ongoing leadership in the implementation of a new treatment approach.

Many of the roles newly defined under the PPACA are not necessarily restricted or targeted to social work professionals. Most health workforce projections show the largest growth for non-professional positions (Hoge et al., 2013). This reflects both the need for cost containment under the PPACA and general trends in the health workforce growth. These roles include the patient or family navigator, peer counselor, community health

worker, and community integrator. They focus on functions rather than professional identities. Some, such as peer counselor and community health worker, are oriented to indigenous persons who are highly identified with the persons receiving care either through lived experience or shared cultural background. Very often these roles are thought of as nonprofessional or lay roles. The social worker often supervises, facilitates or coordinates the peer support or community health workers in a supervisory position, or a leadership position such as program coordinator, community liaison, or patient care coordinator position. In these associated positions, the social worker is not delivering the peer or community health worker services but plays a critical boundary-spanning role in educating and supervising the work of the peer counselor. The social worker supervisor models listening and responsiveness to the peer or community health worker and ensures that their work is central and valued rather than marginalized and devalued.

Patient and family navigators and community integrator roles are new under the PPACA. Patient and family navigators are focused on ensuring access to previously uninsured or underinsured populations through the health insurance marketplaces (Andrews et al., 2013). These roles involve demystifying complex bureaucratic processes to people who have little experience with health care insurance, as well as critical health education such as changing behavior and expectation sets toward using primary care rather than emergency rooms, making use of insurance benefits, and orientation of care toward basic prevention services which are now provided without copayment as a result of the PPACA. The community integrator role, while a traditional social work role of integrating services and service systems, is now more explicitly emphasized and will operate in a very changed institutional environment that is less siloed in terms of organizational connectedness. While patient and family navigator are usually seen as paraprofessional positions, the community integrator role is likely to require a sophisticated set of skills to build interorganizational connections and collaborations to serve a health care population. This role is suited to social workers who have strong organizational and communication skills.

Professions are not protected in defining these new health care roles; the goal of cost savings looms large and drives hiring the most cost efficient workforce such as nurses over physicians, paraprofessionals over professionals including social workers, especially when outcomes are demonstrated to be equivalent. Many of the functions embedded in these health care management and coordination roles are the core skill set of social workers. They provide important opportunities but social work will have to demonstrate their "value added" for these service delivery roles in terms of outcomes. Leadership roles will always be available for social workers in the design and delivery of these programs, calling for a diverse skill set involving clinical skills, program leadership and design skills, and program evaluation skills.

## WHAT PRACTICE SKILLS DO SOCIAL WORKERS NEED FOR INTEGRATED HEALTH?

The knowledge core of social work will serve the profession well in these new practice environments. However, there are also new knowledge and skills that social workers will have to acquire to be able to negotiate and bridge the worlds of behavioral health and primary care. Several efforts have been made to identify competencies needed for health care reform. In an early study of competencies and training needs of social workers in integrated health care, Horevitz and Manoleas (2013) identified 19 competencies. The Council on Social Work Education (CSWE) and that National Council for Behavioral Health created a set of competencies for their field education fellowship program (<http://www.cswe.org/CentersInitiatives/DataStatistics/IntegratedCare.aspx>). Most recently the SAMHSA-HRSA Center for Integrated Health Solutions developed the following Core Competencies for Integrated Behavioral Health and Primary Care, which we have outlined and applied to social work practice (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014).

### Interpersonal Communication

Coordination of care is predicated on the ability to be able to effectively communicate using active listening skills and engaging individuals in making decisions about their care and changing health care behaviors. In Gawande's (2011) seminal article "The Hot Spotters," which articulates the integrated health vision, he describes the vital role of social workers and stresses "the ones you can build a relationship with, you can change behavior" (p. 44). While this process is labeled as "patient activation" in integrated health, it clearly maps onto the CSWE competency of engagement and foundational social work skills. As well as building trust and relationships, social workers must be able to convey health-related information to individuals that is understandable and judgment-free taking into account linguistic and cultural diversity.

### Collaboration and Teamwork

Health care services will be much more team based than they have been in the past. This means that team skills are paramount, together with a clear sense of the professions' purpose and value-added contributions to outcomes given the team's goals. Collegial and collaborative work will be valued, as will leadership skills, both in formal and in informal roles. Social workers need to be assertive in communicating with physicians, nurses, and other professionals in the health care setting. Assertive communication is indispensable in a fast-paced health care setting. In order to perform effectively the social worker must have a strong set of intervention and communication

skills, must have a sense of self-efficacy of her skills, must be able to communicate them in a strong and authoritative way, and must follow-through and report on outcomes to the colleague or team (Pecukonis et al., 2013).

### Screening and Assessment

A key part of ensuring that there is no “wrong door” for individuals seeking care is to ensure that behavioral and physical health disorders are diagnosed in whatever setting people present. Social workers, therefore, need the skills to be able conduct screenings and assessment across settings especially for conditions associated with chronic illness. CSWE and the Center for Integrated Health Solutions (2013) recommended standard and structured screening tools for mental disorders, trauma, substance abuse, activities of daily living and mental status including the Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance abuse behaviors. For social workers in behavioral health settings, there are extensive screening and assessment tools for conditions such as diabetes and asthma in behavioral settings. Social workers can also be trained to screen and assess for dental needs, which are prevalent among low-income people with co-morbidity.

### Care Planning and Care Coordination

This competency builds on the CSWE assessment competency but articulates more clearly the ways in which implementing a care plan requires communication and collaboration across multiple providers. In developing plans, social workers can utilize their “person-in-environment” perspective and ethic of “self-determination” to ensure that plans are person-centered and recovery-oriented (Tondora, Pocklington, Gorges, Osher, & Davidson, 2005). Integrated health also emphasizes the concept of “stepped care,” which demands that care plans be constantly adjusted in real time to ensure the right level of care. Social workers need, therefore, to be closely attuned to an individual’s needs in relation to their plan and in constant communication with other health care providers to ensure the flow of information and collaboration.

### Intervention

While CSWE competencies stress the importance of identifying and utilizing evidence-based practices, integrated health places a special emphasis on use of short-term evidence-based interventions. Social workers will often be in less structured fast-moving settings where interventions are brief and focused. The focus on open access means more flexible scheduling for individuals and more opportunities for triage. Horovitz and Manoleas (2013) found that clinicians practicing in integrated health settings listed the

following intervention models as used by more than 50% of social workers who practiced in integrated health care settings: warm handoff, motivational interviewing, cognitive-behavioral therapy, relaxation training, psychotropic medications, psychoeducation, and case management. Other key interventions focus on health promotion, wellness-self management, nutrition and weight management, and smoking cessation.

### Cultural Competence and Adaptation

Addressing the persistent health disparities in care requires a culturally responsive health care system. Social workers are educated according to CSWE competencies related to diversity and therefore, can play a key role in ensuring that agencies meet the needs of diverse populations. Being attuned to individual and cultural preferences in how health care is delivered and language is part of tailoring evidence-based practice. In their role as implementation specialists, social workers can use their skills in cultural competence, program development and evaluation, and evidence-based practice to help agencies adapt practices to the needs of their individuals. Understanding the role of social determinants, promoting a diverse workforce and working closely with communities is also central to the work of creating a cultural responsive health care system.

### Systems-Oriented Practice

Grounded in social work's ecological perspective, we need to have a keen appreciation for the systems of health care and how to interact with delivery systems to ensure high quality and cost-effective care. Part of our role is to translate the health care system to individuals so that they can have access to health care benefits and link to health care providers. While brokering and linking has been a foundation skill related to case management, integrated health requires a higher level of coordination so social workers are directly impacting the organization and delivery services. Most importantly, social workers must understand health care financing and be able to demonstrate how their services contribute to cost-effectiveness, which means being able to evaluate practice according to quality and cost. As leaders, social workers need to understand and implement health care reform initiatives, seeing how their agencies can benefit from new structures such as PCMHs and Health Homes.

### Practice-Based Learning and Quality Improvement Strategies

It will be increasingly important for social workers in all fields, and especially in integrated health and behavioral health, to have the skills to keep current on medical and intervention knowledge. While medical centers generally

provide access for patient care staff to online libraries and continuing education experiences, not all agencies have the learning infrastructure to provide access to the newest knowledge and intervention technologies. This is an increasing problem for practicing social workers who have the values to continue lifelong learning as professional social workers and who have the skills and preference to use evidence-based practices, most of which require specific training and updates to keep skills current. Practitioners in private practice or independent contractor arrangements need to build continuing education and library access costs into their business budgets. With nearly every state requiring continuing education as a condition to maintain social work licensure, allocating resources for continual learning is an increasing demand on the practice sponsor, the health organization, social agency or independent practitioner.

### Informatics

The PPACA designates the Electronic Medical Record (EMR) as the central tool to achieve integrated, efficient, and effective health care. Similar to the omission of interprofessional collaboration, use of contemporary technologies to document and support practice is not a core competency listed in the 2008 Educational Policy and Accreditation Standards (Council on Social Work Education, 2012). Social workers will use the EMR as a tool to communicate with other health care professionals, to receive prompts for screenings or referrals for behavioral health or care coordination actions that are designated to them as social workers and behavioral health specialists, and to document the services provided to the patient for quality assurance and reimbursement processes. EMRs often include prompts for practice, such as annual depression and addictions screenings, and intervention prompts for follow-up assessment and treatment when the screening is positive. Other examples of using technology to enhance care is decision support tools, social media and mobile technologies to manage wellness, and telemedicine for aging and rural populations (Claiborne et al., 2010; Gellis et al., 2012; Guilamo-Ramos et al., 2014).

### WHAT DOES THE PROFESSION NEED TO DO TO GET READY?

Social work is well positioned for leadership and employment opportunities under the PPACA for several reasons. Social work has long held a person-in-environment perspective and a commitment to social justice. We are increasingly educated to provide evidence-based practices and to think critically about adapting evidence-based protocols to new populations, often those who are underserved, have multiple co-morbidities, and are excluded from research protocols. Moreover, social workers are already the profession that

delivers the bulk of behavioral health care services (Hoge et al., 2013). Social workers have the core skills to carry out and to supervise and direct many of the initiatives promoted in the PPACA. So, are we ready to go? Not quite.

### Workforce Needs

Over the last several decades the U.S. Bureau of Labor Statistics has projected social work to be a growth profession through 2020 (Bureau of Labor Statistics, 2014). This growth is largely driven by the aging of the population. Social work jobs are expected to grow at a rate of 19% between 2012 and 2022, faster than the national average of all job growth. The largest growth specialty areas within social work are health care at a projected 27% growth between 2012 and 2022, and mental health and substance abuse services at a projected 23% growth. By 2022, health and behavioral health social work is expected to account for 71% of the entire social services workforce.

While nursing has played a major role in the research and forecasting on health care workforce needs, social work has largely been absent from this planning table. As a result social work is more often than not excluded from health care workforce analyses, a sign that social work is marginalized as a health care profession. This very exclusion has occurred during the time when social work has increasingly emphasized its “clinical” services and role. While licensure has developed in every state and title protections have been strengthened in many states, the profession’s increasing emphasis on the historically “carved out” and seemingly separate mental health and addictions sectors, only recently reclaimed as “behavioral health care,” has added to the exclusion of the profession from health services.

### Strengthen Social Work’s Identity as a Health Profession

Social work must claim its identity as a health profession. Social workers must assert and claim their contributions to reducing health disparities, to identifying and addressing social and behavioral determinants of health care and to playing a critical role in health care reform at the leadership and at the service delivery level. With over three quarters of social workers practicing in health or behavioral health care sectors, it is important for social work education to prepare graduates to practice in this important and increasingly integrated section of health care. Many social workers graduate without basic health literacy at the level needed by a health care professional. This must change if social workers are to fulfill their potential role under PPACA.

Core knowledge includes an understanding of the nation’s health care goals as articulated in *Healthy People 2020* (<http://www.healthypeople.gov/2020/default.aspx>), the nation’s goals to achieve better health for its citizens. In order to achieve this position social work education must better integrate and more comprehensively cover the “bio” knowledge and skills referred

to in the bio-psycho-social model. Health literacy and skills to acquire and refine health knowledge must be integral to social work education, not a peripheral specialty. One way to achieve this perspective is to offer a public health perspective as part of the social work educational foundation.

### Assertively Articulate the Social Work Role

Social work must educate and advocate for the skills that social workers have to offer in the quest for accessible, effective, culturally sensitive, and efficient health care for all. This calls for leadership at every level of the profession. Social work chief executive officers (CEOs) and program directors need to make sure that social work is at the table in creating new programs, in evaluating them, in disseminating the results of what is learned, and in designing programs that meet individual needs. As practitioners, social workers need to speak up about the contribution their work can make with people with complex needs. As an example, health care providers often throw up their arms in frustration when there is family conflict over the care of an older family member, who may well have his or her own conflicting point of view as well. The social worker needs to claim this mediating role when mediation is a critical ingredient of care coordination and treatment adherence.

Clearly, there is still much advocacy to be done at the national, state, and local level as health care reform continues to face considerable political opposition. The National Association of Social Workers (NASW) and the CSWE have focused their efforts on both informing its members about the PPACA and educating policymakers about the contribution of social workers to health care reform. Recent examples include a briefing with White House staff on the social determinants of care and Congressional briefings on social work's role in primary and behavioral health care. NASW and CSWE must also work closely with other health care professions including nursing, medicine, and dentistry. Participation in interprofessional education is one door that social work can open. Over the past 10 years health professions including medicine, dentistry, and nursing have focused increasingly on interprofessional education for integrated health care (National Research Council, 2013). Although social work has long worked in varied work settings and with many collaborating professions and disciplines, social work has largely been excluded from interprofessional education initiatives, and social work education has not explicitly recognized competency for interprofessional practice in its accreditation guidelines.

Social work researchers must also participate in creating the growing evidence-base related to integrated health (Andrews et al., 2013). There are increasing funding opportunities to conduct research at the system and practice level both from federal and private sources. The PPACA created the Patient Centered Outcomes Research Institute (<http://www.pcori.org>) focused on health care decision making and outcomes of concern

to patients, caregivers, and the broader health care community. This new research entity presents social workers in coordination with other professionals the opportunity to create and test innovative models of health care services for populations with specific needs.

### Advocate for Capacity-Building Initiatives

Recent capacity-building initiatives in social work and integrated health and behavioral health have helped the profession move forward to take the opportunity provided by the PPACA. Through the collaborative efforts of CSWE, The National Council for Behavioral Health, and the U.S. Health Resources and Services Administration (HRSA), the Mental and Behavioral Health Education and Training Program (MBHET) provided 13 schools of social work with field education stipends and educational program support resources. The aim is to create sustainable programs that will educate social workers in integrated health and behavioral health care systems of tomorrow. Stipends have spurred student interest and awareness of this new area of practice. Approximately 400 MSW students will be the first generation of practitioners prepared for integrated health care.

In addition to their success with HRSA, CSWE and the National Council for Behavioral Health partnered successfully to obtain a grant from the New York Community Trust that supported field education stipends for 14 students nationwide in integrated health and behavioral health. The CSWE also took leadership in creating curriculum reform task forces that created model syllabi in integrated health policy and practice. These syllabi, which are available to all Schools of Social Work on CSWE's website (see Online Resources Box) offer social work faculty the opportunity to educate students about the PPACA and its impact, particularly within the area of integrated health, and provide them with the necessary practice skills to succeed in this environment.

There are other opportunities for Schools of Social Work to generate resources for new educational initiatives through partnering with other health professions. For example, the New York University (NYU) Silver School of Social Work partnered with the NYU College of Nursing to obtain a separate HRSA grant to support interprofessional education for nurse practitioner–social worker–pharmacist teams to provide home health care for elderly patients with multiple health conditions, multiple medications and behavioral health issues in a coordinated interprofessional service model.

### Adapting Social Work to the New Health Care Business Model

As social work moves to establish itself in the new health care system reforms in the United States, the profession is challenged with integrating itself in

the business of health care, the sector of the American economy that now accounts for more than 15% of all economic activity. Historically, social work has focused on the social service business enterprise only as nonprofit management executives. In order to thrive in today's health care sector social work must understand the health sector business models and be able to contribute to its effectiveness and efficiency.

One question for schools of social work is whether we should finally come to terms with the legitimacy of preparing a private practitioner workforce. Private practice requires business management skills, which to our knowledge, no school of social work provides. With more and more social workers operating as independent contractors, a trend that has grown with the reduction in benefits-carrying jobs, it is time to take the business management side of independent clinical practice seriously. In an organizational context social workers must meet compliance requirements and design new programs that will meet the organization's bottom line financial goals and that are based on cost-benefit analyses of health outcomes to cost. This suggests that clinical skills alone are not sufficient for the leader in health care for tomorrow. Should community, financial, and organizational skills be taught in schools of social work as part of the MSW? Should social workers be educated with business skills through continuing education? Should social workers be expected to get business credentials through continuing education or another degree in order to compete in the clinical business world of tomorrow? These are the questions that face the profession and social work education as we think of positioning social work for the new business realities of health care.

## CONCLUSION

In a presentation to behavioral health leaders, Linda Rosenberg of the National Council for Behavioral Health urged them not to act like "a deer in headlights," but instead to embrace the PPACA as an opportunity (Rosenberg, 2013). Social workers, both as leaders and direct providers, must step up to embrace this opportunity for professional growth. Critical thinking, creative "out-of-the-box" ideas, accomplishing targets and goals efficiently are key skills in this environment. Social work's orientation to social determinants will put the profession in good stead providing that social work practitioners can articulate these skills and abilities in the context and jargon of the reformed health care system. The holistic approach to health care, which includes individual, families, communities, and health care settings is reflected by our person-in-environment framework and seeking health equity aligns with our guiding principle of social justice. We are therefore, well positioned to not only contribute but to lead these historic changes in our health care system.

However, together with these opportunities come some important decision points for the profession. In the 1980s, social work decided to take advantage of the emergence of managed care to become a leader in providing mental health services. We may now be at another such fork in the road, as social work considers whether and to what extent it chooses to define itself as a holistic health care profession with specialized behavioral health skills as opposed to a behavioral health care profession distinct from primary and other forms of health care. The opportunity lies before the profession to embrace mind and body, to make the link between poverty and negative health outcomes, to integrate beliefs, behaviors, and health. The future of the profession may hang on the choice that is made. Therefore, to make the most of the opportunities that the PPACA provides social work needs to take stock, to pay attention to its role as a health care profession beyond behavioral health, and educate its students to deliver effective, efficient, and person-centered care.

#### KEY ONLINE RESOURCES ON SOCIAL WORK AND INTEGRATED HEALTH

AHRQ: The Academy Integrating Behavioral Health and Primary Care <http://integrationacademy.ahrq.gov/>  
 Council on Social Work Education Integrated Health Project <http://www.cswe.org/CentersInitiatives/DataStatistics/IntegratedCare.aspx>.  
 Healthy People 2020 (<http://www.healthypeople.gov/2020/default.aspx>)  
 SAMHSA-HRSA Center for Integrated Health Solutions <http://www.integration.samhsa.gov/>  
 Information For Practice (<http://ifp.nyu.edu/>)  
 National Association of Social Workers Health Care Reform <http://www.socialworkers.org/advocacy/healthcarereform/>  
 National Council for Behavioral Health <http://www.thenationalcouncil.org/>  
 NIH PubMed Central (<http://www.ncbi.nlm.nih.gov/pmc/about/intro/>)  
 Patient Centered Outcomes Research Institute (<http://www.pcori.org>)

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