

NASW Recommendations for the 2015 White House Conference on Aging

Theme: Long-Term Services and Supports

Submitted June 12, 2015

NASW appreciates the opportunity to submit comments on long-term services and supports (LTSS) for consideration by the 2015 White House Conference on Aging (WHCoA). As the largest membership organization of professional social workers in the world, NASW works to enhance the professional growth and development of its 132,000 members, to create and maintain professional standards, and to advance sound social policies.

NASW shares the White House's goal of making available to all older adults and families a broad range of LTSS. The association's specific comments, offered in response to the discussion questions on page 9 of the WHCoA LTSS policy brief, follow.

What supports will help caregivers continue to provide care while maintaining their own health and well-being?

Recognizing and supporting family caregivers as members of LTSS teams is paramount to the health and well-being both of older adults and of family caregivers themselves. Such recognition and support begin with respecting each individual's definition of "family," whether legally recognized family or family of choice (partners, friends, community elders, or others). In keeping with this person-centered approach, NASW encourages the 2015 White House Conference on Aging to define "families" and "family caregiving" broadly and to avoid terminology such as "family members or friends," which inadvertently undermines the role of older adults' family of choice. NASW also discourages use of the term "informal caregiving," which many family caregivers perceive as minimalizing their role in the LTSS team.

NASW concurs with the White House that educational, emotional, financial, and physical supports are essential for family caregivers. To that end, the association supports the administration's fiscal year (FY) 2016 funding request for the Lifespan Respite Care program, the Native American Caregiver Support program, and the newly proposed Family Support Initiative. Moreover, NASW recommends increased funding for both the Alzheimer's Disease Supportive Services and the Family Caregiver Support Services programs, in keeping with the [FY 2016 appropriations requests](#) of the Eldercare Workforce Alliance (of which NASW is a member).

The Health Resources and Service Administration's (HRSA's) Geriatrics Workforce Enhancement Program (GWEP) provides one avenue for training of family caregivers, but other resources are needed. Social workers, who interact with family caregivers of older adults throughout and beyond the LTSS continuum, are well trained to assist with such training. Additional information about the social work role with family caregivers is available in the [NASW Standards for Social Work Practice with Family Caregivers of Older Adults](#) (2010).

What assistance do older adults and families need when making decisions about long-term services and supports?

NASW promotes collaboration with older adults and families in all aspects of LTSS planning and provision. As described in the association's comments on the WHCoA Healthy Aging policy brief, an interdisciplinary, person- and family-centered biopsychosocial assessment should be the cornerstone of LTSS for every older adult. An ongoing collaborative assessment process helps older adults and families to identify and prioritize their values, goals, strengths, and needs. With this information and support, older adults and families are better equipped to make decisions about LTSS options.

LTSS needs often change over time—or they may change rapidly in response to fluctuations in the health of either older adults or family caregivers. Professional care coordination helps older adults and families to navigate such changes and determine the LTSS options they most need. Care coordination also facilitates communication among all members of the health care team (older adults, family caregivers, direct-care workers, and health care professionals) and fosters continuity of services, especially during care transitions between practitioners, settings, and service sectors. Ideally, assessment and care coordination are conducted or guided by an interdisciplinary team that is trained in geriatric and gerontological principles and best practices. With their person-in-environment, strengths-based perspective, social workers play an integral role in assessment and care coordination with older adults and families. The [NASW Standards for Social Work Case Management](#) (2013) and the [NASW Standards for Social Work Practice with Family Caregivers of Older Adults](#) (2010) elaborate on the aforementioned concepts. The SCAN Foundation's policy brief [Achieving Person-Centered Care Through Care Coordination](#) (2013), shaped in part by NASW and a variety of other organizations, also provides a useful framework.

What could be done to ensure sufficient numbers of highly qualified direct care workers for now and the future?

Direct-care workers are essential members of LTSS teams and need to be valued accordingly. NASW supports increased compensation, training, and support for the direct-care workforce. The association also supports the role of social workers in training and supporting direct-care workers regarding the psychosocial aspects of LTSS provision.

What could be done to ensure an adequate workforce with the knowledge and skills needed to support an increasing population of older Americans with chronic conditions and/or functional limitations?

Enhance cultural competence.

Older adults in the United States experience health disparities related to a variety of cultural factors, including documentation status, ethnicity, geographical location, language, race, sexual orientation, socioeconomic class, and gender, gender identity, and gender expression. To decrease such disparities and to ensure provision of culturally and linguistically appropriate services, all members of the LTSS workforce must receive ongoing training in cultural competence. Furthermore, older adults and families must have access to language services (such as professional interpreters and professionally translated materials).

Enhance geriatric and gerontological expertise.

The HRSA Geriatrics Workforce Enhancement Program (GWEP) program—which combines the Comprehensive Geriatrics Education Program (CGEP), the Geriatrics Academic Career Awards (GACA) program, Geriatric Education Centers (GECs), and the Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Providers (GTPD) program—plays a critical role in improving health outcomes for older adults. The GWEP supports health professions schools and training programs in providing interprofessional geriatrics education and training to health care professionals, direct-care workers, and family caregivers. When the four HRSA geriatrics programs were combined in GWEP in December 2014, the number of available slots was decreased to 40. NASW recommends increased funding in FY 2016 to support 10 additional GWEP grants, as described in an [issue brief](#) of the Eldercare Workforce Alliance (of which NASW is a member).

Enhance team-based training.

The GWEP supports team-based training, but additional training along these lines is needed for LTSS care providers (including family caregivers, direct-care workers, and health care professionals). One potential approach could be for the Centers for Medicare & Medicaid Services (CMS) to develop and guidance on LTSS workforce training to states. Ensuring the availability of federal matching funds for such training—which should address both cultural competence and geriatric and gerontological principles—would provide an incentive for states to participate. Another approach would be to incorporate workforce training in the Older Americans Act (OAA), as has been done in some past authorizations.

Enhance Medicare beneficiaries' access to clinical social workers.

As noted in the Institute of Medicine's (IOM's) recent reports, [Retooling for an Aging America: Building the Health Care Workforce](#) (2008) and [The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?](#) (2012), the workforce is not large enough to meet older adults' health, mental health, and substance use needs. Limited access to clinical social workers (CSWs) exacerbates this shortage and poses barriers to beneficiaries' health and well-being. The Health Resources and Services Administration (HRSA) recognizes social work as one of five core mental health professions ([Congressional Research Service](#), 2015), and there are more CSWs in the United States than psychiatrists, psychologists, and psychiatric nurses combined ([SAMHSA](#), 2013). Yet, Medicare beneficiary access to CSWs is restricted in certain respects:

- Medicare reimburses CSWs at only 75 percent of the rate reimbursed to psychiatrists and psychologists. This rate is even lower than the 85-percent reimbursement to other nonphysician practitioners (such as physical therapists, physician assistants, and occupational therapists). This discrepancy deters CSWs from becoming Medicare providers ([NASW](#), 2015a).
- Unlike psychologists and psychiatrists, CSWs are unable to bill Medicare Part B for services reflected in the health and behavior assessment and intervention (HBAI) CPT codes. HBAI services help Medicare beneficiaries to cope with the emotional and social concerns related to a medical condition (such as a diagnosis of cancer or Alzheimer's disease)—concerns that are unrelated to a mental health condition. CSWs' inability to use the codes stems from an overly narrow definition of "clinical social worker services" in [Section 1862\(s\)\(2\)](#) of the Social Security Act ([NASW](#), 2015b).

Thus, NASW recommends the following actions to enhance Medicare beneficiaries' access to mental and behavioral health care provided by clinical social workers:

- Promote payment for CSWs at the rate of 85 percent of the Medicare physician fee schedule to increase beneficiaries' access to CSWs who are Medicare providers.
- Grant CSWs access to the HBAI CPT codes; expand Medicare reimbursement to include other services within clinical social workers' scope of practice under state licensure laws and regulations.

Enhance psychosocial care for nursing home residents.

Access to mental health and other psychosocial care is a major concern for residents of nursing homes, which remain an integral component of the LTSS continuum. The Omnibus Budget Reconciliation Act of 1987 ([P.L. 100-203](#)) marked a watershed in federal policy to ensure the rights and safety of nursing home residents. Yet, much work remains to realize the law's goals, such as reducing the use of physical and chemical restraints ([CMS](#), 2014; National Consumer Voice for Quality Long-Term Care, [2007](#), [2011](#)). Meeting residents' psychosocial needs also remains an ongoing problem; although the revised Resident Assessment Instrument Minimum Data Set (MDS 3.0) includes enhanced psychosocial screening requirements, insufficient training and high caseloads preclude meeting resident needs identified therein ([Simons et al.](#), 2012). Other efforts to improve the quality of nursing home care include the culture change movement, which has strived to transform services—across settings, but with a historical focus on nursing homes—in accordance with person-directed values. This work has not only spawned the development of various socially oriented care models, but has also begun to influence federal requirements for nursing home care. Nonetheless, the quality of nursing home care remains problematic, in part because of insufficient staffing.

Federal law requires skilled nursing facilities (SNFs) and nursing facilities (NFs) of all sizes to provide medically related social services. NASW's policy statement on long-term services and supports ([NASW](#), 2015c) calls for access to professional social work services in all settings; the [NASW Standards for Social Work Services in Long-Term Care Facilities](#) (2003) define the educational preparation for a social worker as a baccalaureate or advanced degree in social work. In contrast, the [Conditions of Participation](#) for SNFs and NFs define a qualified social worker as someone with either "a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology" (42 CFR §483.15(g)(3)). Some state requirements are even weaker than federal regulations ([Bern-Klug](#), 2008). Such regulations represent a growing trend toward the deprofessionalization of social work; increasingly, persons providing social services lack social work values, knowledge, and skills. Although such deprofessionalization is a long-standing problem in nursing home social work, it has taken on new urgency with the introduction of MDS 3.0 ([Zimmerman, Connolly, Zlotnik, Bern-Klug, & Cohen](#), 2012). All BSWs and MSWs, regardless of specialization, receive training in interviewing and psychosocial assessment, care planning, and intervention. As such, degreed social workers possess the knowledge and skills to conduct resident interviews (although they may require training to learn how to use PHQ-9 or other tools required in MDS 3.0) and to determine when residents' responses warrant additional evaluation and services. On the other hand, social service staff members who lack social work education may not be adequately prepared to identify and address residents' psychosocial concerns ([Bern-Klug, Kramer, Chan, Kane, Dorfman, & Saunders](#), 2009).

Federal regulations specify that any SNF or NF with more than 120 beds must employ a “qualified social worker” (as defined by CMS, above) on a full-time basis. Long before the advent of MDS 3.0, practitioners, researchers, and policymakers have raised the question of caseload manageability for nursing home social service staff. An investigation by the Office of the Inspector General (OIG) found that more than one-third of nursing home residents with identified psychosocial needs had inadequate care plans, and almost half of those with care plans did not receive all planned services ([HHS, 2003](#)). Moreover, although almost all facilities reviewed complied with or exceeded federal staffing regulations, 45 percent of social services staff reported that barriers such as lack of time, burdensome paperwork, and insufficient staffing decreased their ability to provide comprehensive psychosocial services. A more recent OIG report found skilled nursing facilities often failed to meet Medicare requirements for care planning and discharge planning; failure to address psychosocial needs was among the problems cited in the report ([HHS, 2013](#)). Research has indicated that the one-to-120 (-plus) caseload is insufficient to meet the psychosocial needs of nursing home residents ([Bern-Klug, Kramer, Sharr, & Cruz, 2010](#); Bonifas, [2008](#), [2011](#); [Zhang, Gammonley, Paek, & Frahm, 2008](#)).

Another barrier to meeting residents’ psychosocial needs is restricted access to clinical social workers. Although CSWs have the expertise and knowledge to provide quality mental health care, they are unable to be reimbursed as independent Medicare Part B providers for mental health services delivered to beneficiaries receiving skilled nursing facility (SNF) services under Medicare Part A. This restriction limits beneficiaries’ access to qualified mental health providers. It also limits continuity of care for Medicare beneficiaries who transfer from a setting, such as home or assisted living, where they receive mental health services from a CSW to a SNF, where they cannot receive such services. This gap in care can even occur within a SNF when a beneficiary transitions to skilled care ([NASW, 2015a](#)).

Thus, NASW recommends the following actions to ensure that nursing home residents receive high-quality psychosocial care:

- Increase the ratio of social services staff to residents in Medicare- and Medicaid-certified nursing and skilled nursing facilities.
- Require that all social services staff have baccalaureate or advanced degrees in social work.
- Allow CSWs to bill Medicare Part B for mental health care provided to beneficiaries receiving SNF services under Medicare Part A.

Maintain, strengthen, and implement other workforce programs.

The aforementioned IOM and reports also described the barriers both health care professionals and direct-care workers face when specializing in aging. These findings are consistent with those of NASW’s study ([2006a](#), [2006b](#)) of licensed social workers in the United States. The GWEP is the only federal program dedicated to enhancing the geriatric and gerontological expertise of the health care workforce. This invaluable program is complemented by a number of other workforce programs that can increase the recruitment, training, and retention of the LTSS workforce.

- The Patient Protection and Affordable Care Act (ACA) established the HRSA Geriatric Career Incentive Awards (GCIA) program. The GCIA program parallels the GACA program (now part of GWEP), which

provides financial support to junior faculty at accredited schools of nursing, pharmacy, psychology, social work, and allopathic and osteopathic medicine who wish to pursue an academic career in geriatrics. The GCIA program is distinct from GACA, though, in that it includes master's-level candidates, thereby expanding the workforce prepared to serve older adults. NASW recommends reauthorization and appropriation of funds (\$3.3 million in FY 2016) for the GCIA program.

- The National Health Service Corps (NHSC) Loan Repayment Program: This program allows a variety of health care professionals (including licensed clinical social workers) \$50,000 to repay student loans in exchange for two years of serving in a community-based site in a high-need Health Professional Shortage Area. The Eldercare Workforce Alliance has created [A Guide for Geriatrics & Gerontology Sites](#) to assist providers of geriatrics and gerontology primary care in applying to become an NHSC site. As the number of such sites grows, so, too, will opportunities for NHSC Loan Repayment Program participants to enhance their knowledge and skills in aging.
- The NHSC makes clear the value of loan forgiveness in attracting qualified professionals in high-need areas, including aging. The 2008 reauthorization of the Higher Education Act included expanded loan forgiveness provisions. Although this debt cancellation program was authorized, it has not been funded by Congress. Reauthorization and appropriate funding of the Higher Education Act Loan Forgiveness provisions is essential for workforce recruitment and retention ([NASW](#), 2015d).
- Similar to the GCIA program, the National Health Care Workforce Commission was established by the ACA but has not yet received funding. The commission can play a central role in formulating a national strategy to bolster the eldercare workforce. NASW recommends \$3 million in commission funding in FY 2016.
- Gerontological social workers provide essential LTSS to older adults and families. Yet, similar to other health care professions, the social work profession faces substantial challenges in meeting the increased need for services to older adults (IOM, [2008](#), [2012](#); [NASW](#), 2006). The [Dorothy I. Height and Whitney M. Young, Jr., Social Work Reinvestment Act](#) (S. 789, H.R. 1378) provides a mechanism to address some of these challenges. Provisions of the act include establishment of a commission to assess and make recommendations related to the issues facing the social work profession.

Are there current long-term services and supports programs or policies you think are the most or least effective or potentially duplicative?

NASW strongly supports the family caregiving programs administered by the Administration for Community Living: Alzheimer's Disease Supportive Services, Family Caregiver Support Services, Lifespan Respite Care, Native American Caregiver Support, and the newly proposed Family Support Initiative.

Hospitals' growing use of observation status creates a barrier to Medicare beneficiaries' use of the skilled nursing facility (SNF) benefit. NASW strongly recommends that time spent in observation status be counted toward the three-day prior hospitalization requirement beneficiaries must meet to qualify for the Medicare SNF benefit.

Programs funded by the Older Americans Act (OAA) are among the primary and most effective LTSS ([NASW, 2015e](#)). NASW recommends the following actions to maintain the successes of the OAA and ensure its viability and utility in the coming years:

- Preserve funding for OAA programs by ending sequestration and by restoring all FY 2016 OAA programs to pre-sequester FY 2010 funding levels (at a minimum).
- Reauthorize the Older Americans Act (S. 192). Because mental health affects LTSS needs, OAA reauthorization should include funding to implement new provisions (within the 2006 amendments) for grant programs for mental health screening and treatment services for older adults and programs to increase public awareness and reduce the stigma of mental illness.

The social work profession has long promulgated a person-centered approach to LTSS, promoting each individual's choice and dignity. Enabling older adults to live in the least restrictive setting possible is one indicator of such an approach. Publicly funded programs such as the Program for All-Inclusive Care of the Elderly (PACE), Money Follows the Person (MFP), and home health provide essential home and community-based services. Innovative initiatives such as age-friendly communities, Communities for All Ages, Livable Communities, NORC (naturally occurring retirement communities) Supportive Service Programs, and Villages also play important roles in supporting community living for older adults.

Advance care planning and hospice and palliative care are integral components of the LTSS continuum. NASW addresses these topics in detail in its response to the WHCoA Healthy Aging policy brief.

The integration of behavioral and mental health within health care delivery systems is essential to effective LTSS delivery. NASW addresses this theme in greater detail in its comments on the Healthy Aging policy brief.

Many Medicare beneficiaries face challenges in accessing LTSS because of lack of information about Medicare eligibility, options, and appeals. Moreover, steps are needed to ensure same-sex couples' equitable access to Medicare and other federal programs as *United States v. Windsor* (2013) continues to be implemented. NASW addresses these topics in its response to the WHCoA Retirement Security policy brief.

How can we better address the costs and increasing need for long-term services and supports?

Older adults and families need a comprehensive, integrated continuum of supports, services, settings, and delivery models to meet each older adult's and family's LTSS needs. NASW supports development of a comprehensive social insurance financing system that provides universal access to affordable, high-quality, culturally and linguistically appropriate LTSS. Such access must be provided without regard to age, disability, ethnicity, gender, gender identity, geographic location, immigration status, income, language, medical diagnosis, preexisting health conditions, race, sexual orientation, or other factors. NASW also supports increased federal and state funding to enable older adults to access high-quality, cost-effective LTSS in the setting of their choice. Specifically, NASW supports the elimination of the institutional bias within Medicaid. All eligible low-income older adults should have access to home and community-based services through all state plans without the need for Medicaid waivers (which are frequently inadequate to meet beneficiary

need, and under which benefits can vary greatly). Finally, NASW emphasizes preserving the integrity of Social Security, Medicaid, Medicare, and other economic and social support programs related to LTSS.

How can we harness technology to assist individuals with their long-term service and support needs?

Technology plays an increasingly important role in enabling older adults to live in their communities. However, assistive technology and other tools remain unaffordable to many people ([Commission on Long-Term Care](#), 2013). Health information technology (HIT) has great potential both to engage older adults and family caregivers and to support effective care coordination within teams and across settings. As HIT continues to be implemented, safeguarding the privacy of mental health information is critical.