

NASW Recommendations for the 2015 White House Conference on Aging

Theme: Healthy Aging

Submitted June 12, 2015

NASW appreciates the opportunity to submit comments on healthy aging 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 concurs with the White House's holistic conceptualization of healthy aging as encompassing physical function and mental, emotional, social, and spiritual well-being. The association's specific comments, organized in response to the discussion question on page 7 of the WHCoA Healthy Aging policy brief, follow.

What do older adults and their families need to manage their chronic conditions and to optimize their physical, cognitive, and behavioral health?

Access to biopsychosocial interdisciplinary assessment and professional care coordination needs to be expanded to a greater number of older adults and families.

An interdisciplinary, person- and family-centered biopsychosocial assessment should be the cornerstone of every older adult's health care. Assessment is an ongoing collaborative process that helps older adults and families to identify and prioritize their values, goals, strengths, and needs. This information guides service planning and implementation.

The assessment process also guides care coordination, which is equally important to older adults' health. Care coordination facilitates communication among all members of the health care team—older adults, family caregivers, direct-care workers, and health care professionals; fosters collaboration between health care and social service delivery systems; and promotes 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.

Older adults and families need greater understanding of, and support with, advance care planning.

Advance care planning is a process that enables individuals to determine and communicate their goals for health care. Older adults' engagement in advance care planning varies widely. Research indicates that adults are more likely to engage in advance care planning when (1) they have adequate information about, and understanding of, advance directives ([Bressi Nath, Hirschman, Lewis, & Strumpf, 2008](#)) and (2) when health care professionals inquire about advance directives ([Clark, Boehmer, Rogers, & Sullivan, 2010](#)).

Research also shows that a variety of biopsychosocial factors—including age, degree of acculturation, educational level, ethnicity, family functioning, health status, income level, race, relationship status, religion and spirituality, sexual orientation, social support, and mistrust of health care professionals—influence advance care planning behavior. To facilitate advance care planning effectively, therefore, health care professionals must understand each individual's and family's values and biopsychosocial context and tailor interventions accordingly.

During times of decision making, health care agents (people who are selected by an individual) and surrogates (people who are legally recognized decision makers by default, in the absence of an appointed health care agent) often struggle to fulfill their roles. Although this is especially true when communication with the individual represented has been minimal, even the most prepared health care agents and surrogates often need additional information and support ([Bern-Klug \[in Rogne & McCune\], 2013](#); [Buckey & Abell, 2010](#); [Moorman & Carr, 2008](#)).

The Institute of Medicine's (IOM's) [Dying in America](#) report (2014) calls for greater access to advance care planning services. NASW recommends the following actions to promote advance care planning.

- Promote initiatives such as [National Healthcare Decisions Day](#), of which NASW is an original participating organization. This initiative promotes advance care planning as an ongoing conversation among individuals, families, and health care professionals, of which completing written advance directives is just one component.
- Support research and education to identify and disseminate multidimensional approaches that support older adults' and families' health care decision making.
- Increased support for the role and responsibilities of health care agents and surrogates.
- Require coverage of voluntary advance care planning under Medicare, Medicaid, and other federally funded programs. This coverage could include, but is not limited to, strategies such as
 - adding reimbursement for assistance with advance care planning to the Medicare annual wellness visit
 - making payable the two new Current Procedural Terminology (CPT) codes for advance care planning currently available to physicians and other primary care practitioners
 - supporting other reimbursement streams, such as the development of new CPT codes, that reflect the role of the interdisciplinary team (including social workers) in advance care planning.

Furthermore, NASW encourages expansion of state programs based on, and education of health care practitioners regarding, the [National Physician Orders for Life-Sustaining Treatment \(POLST\) Paradigm](#). This paradigm, which has been endorsed by a growing number of states and is known by different names across states, refers to an individualized, portable set of medical orders to guide treatment of people living with serious or life-limiting illnesses. These orders are not intended to replace advance directives; rather, POLST can be a valuable component of the advance care planning process ([Bomba, Morrissey, & Leven, 2011](#); [Pile & Pole, 2013](#)).

Behavioral and mental health care need to be fully integrated within health care delivery systems.

NASW applauds the White House's focus on optimizing behavioral health. The growing shift toward integrated care is congruent with finding that most older adults prefer to receive care for behavioral and mental health conditions within their primary care provider's office ([John A. Hartford Foundation, 2012](#)). The following actions can enhance this integration.

- Resume funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) Older Adult Behavioral Technical Assistance Center and associated grants program, which support implementation of evidence-based practices. Evaluations of the center and the grant program determined that both were successful. Yet, both programs were ended in 2012 and have not been replaced with similar initiatives.
- Provide funding to support research and development of programs to prevent suicide among older adults.
- Promote Medicare and Medicaid financing mechanisms that support the integration of behavioral health and primary care. Such mechanisms should also support assessment, care coordination, and intervention by an interdisciplinary team.
- Avoid diminishment or dismantling of Medicaid and Medicare program benefits; abstain from shifting additional health care costs to Medicare beneficiaries; continue to promote Medicaid expansion.
- Reauthorize the Older Americans Act (S. 192). Such reauthorization should include funding to implement amendments, added in 2006, for grant programs providing mental health screening and treatment services for older adults and programs. These grant programs will increase public awareness and reduce the stigma of mental illness.
- Analyze workforce patterns (including social work staffing) in pilot programs funded by the Center for Medicare & Medicaid Innovation (CMMI) and the Patient Centered Outcomes Research Institute (PCORI); dedicate CMMI and PCORI funds to programs that feature social workers in both care coordination and mental and behavioral health roles.
- Recognize social workers as essential members of health care teams in all coordinated care models, including patient-centered medical homes and health homes in behavioral health settings, and promote the role of social workers as providers of mental and behavioral health services.

As noted in the 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' optimal health. 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.

Access to mental health and other psychosocial care is a particular concern for residents of nursing homes. 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 also 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 (CSWs). 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 mental and behavioral health 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.

Older adults and their families need greater awareness of, and earlier access to, hospice and palliative care.

Hospice and palliative care programs provide person- and family-centered, interdisciplinary health care that maximize physical, psychosocial, and spiritual quality of life for individuals and families facing serious or life-limiting illness. Although use of hospice care has grown steadily in recent years, median length of service has

decreased (18.5 days in 2013), and more than one-third of hospice enrollees die or are discharged within seven days of admission ([National Hospice and Palliative Care Organization](#), 2014). Individuals and families who use hospice for such short periods of time may not benefit from the full range of services and support available in hospice care. Similarly, although access to palliative care in settings beyond hospice has also grown in recent years, more than one-third of hospitals do not have palliative care programs ([Center to Advance Palliative Care](#), 2014), and access to palliative care remains even more limited in other service settings. The IOM's [Dying in America](#) (2014) report calls for increased access to hospice and palliative care.

The 2013 [Clinical Practice Guidelines for Quality Palliative Care](#) (3rd ed.), which NASW helped to revise, emphasize the role of the interdisciplinary team in eight domains of palliative care. The guidelines recognize social workers as core members of such teams. The guidelines also emphasize the importance of professional education and training for all disciplines, specifying that a bachelor's or advanced degree in social work is necessary to provide palliative care services in hospices and other settings. This specification is consistent with NASW's definition of professional social work. Yet, the only educational preparation required by the recently revised [Conditions of Participation](#) (2008) for hospices is "a baccalaureate degree in psychology, sociology, or other field related to social work" (42 CFR § 418.114(b)(3)). Such deprofessionalization of the social work role limits older adults' and families' access to qualified, competent social work services. NASW encourages the administration to revisit this issue as it considers how to improve older adults' and family caregivers' health and well-being over the coming decade.

Among the many services provided by hospice and palliative care programs is relief from pain. Access to pain management services in other service delivery models, whether primary or specialty care, is limited. The IOM's 2011 report, [Relieving Pain in America](#), notes that pain is particularly undertreated in older adults and calls for an integrated, multifactorial approach to pain management. Social workers play an integral role in such approaches (see, for example, [Altilio & Pasquale Doran](#), 2013; [Otis-Green](#), n.d.).

In light of these considerations, NASW supports policies that promote the following outcomes:

- enhanced consumer and professional education about hospice and palliative care
- inclusion of a professional social worker within every hospice and palliative care program
- increased availability of hospice and palliative care across settings
- comprehensive utilization of hospice services, including early access to hospice care and access to multiple hospice benefit periods for individuals with life-limiting conditions
- access to palliative care from the time of diagnosis with a serious illness
- sustainable public and private reimbursement for hospice and palliative care, including the Medicare hospice benefit, services available to Medicaid beneficiaries and veterans, and federal and state health insurance marketplace (exchange) plans
- expansion of medical and psychosocial treatments to ease pain and other symptoms associated with life-limiting illness and dying
- multidimensional approaches to prevent and alleviate pain and other symptoms common at the end of life.

How can we ensure that older adults know about, and take advantage of, the preventive services available to them under Medicare?

NASW supports wellness, prevention, early intervention, and outreach services for older adults. Such services may be available in both health care and social service settings. The Annual Wellness Visit (AWV) is an important example of preventive services available to Medicare beneficiaries. Enhanced access to an interdisciplinary team—including, among other disciplines, geriatricians, geriatric nurses, and gerontological social workers—can enhance beneficiaries' utilization and experience of the AWV. Such teams can promote the AWV to beneficiaries throughout the year, and their involvement can enhance the value of this service.

Another way to improve beneficiary awareness and utilization of Medicare-funded preventive services is by ensuring that information about these services is available in a variety of language. To this end, NASW recommends translation of Medicare materials, including *Medicare & You*, into a greater number of languages. Moreover, NASW suggests that taglines informing beneficiaries how to access language services in 15 languages on all notices and Web sites.

Routine screening and testing for HIV infection is an integral component of preventive care. Research indicates that about half the people living with HIV/AIDS in the United States will soon be aged 50 or older ([SAGE](#), 2015). NASW supports the recommendation by the Centers for Medicare & Medicaid Services (CMS) to expand coverage in section 210.7 of the Medicare National Coverage Determinations Manual to include routine screening and testing for HIV infection for all individuals between the ages of 15 and 65 years. At the same time, a recent national study found that more than half of adults aged 65 to 74, and one-quarter of adults aged 75 to 85, as being sexually active with one or more partners ([Lindau, Schumm, Laumann, Levinson, O'Muircheartaigh, & Waite](#), 2007). Thus, NASW encourages CMS to expand coverage of routine screening and testing for HIV infection to people older than 65 years of age.

How can we provide more opportunities for older adults to stay engaged and connected to their communities?

NASW affirms the value of both Senior Corps (including the Foster Grandparents Program, the Retired Senior Volunteer Program [RSVP], and Senior Companion Programs) and Senior Community Service Employment Program (SCSEP). NASW recommends the following actions in support of these programs:

- Restore Senior Corps funding to the levels that were in place in prior to sequester cuts.
- Reverse the 20 percent cut applied to RSVP in fiscal year (FY) 2011.

NASW also encourages the White House to consider other services that can strengthen older adults' community engagement, such as lifelong learning programs, arts and other cultural activities, senior centers, adult day health services, and intergenerational programs.

Are there current healthy aging programs or policies you think are the most or least effective or potentially duplicative?

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).

What steps can help Americans to live safely and comfortably in their homes and communities as they age?

NASW concurs with the White House that accessible, affordable housing and transportation in helping older adults to live safely and comfortably in their homes. In support of this goal, NASW suggests the following strategies:

- sustenance of the Federal Transit Administration (FTA) funding for the National Center for Senior Transportation and Easter Seals Project ACTION, both of which have increased the mobility of people with disabilities and older adults
- increased funding for home and vehicle modifications
- increased funding for the Low-Income Home Energy Assistance Program (LIHEAP).

What additional actions could help ensure that older adults of all backgrounds can equally enjoy a long, productive, and healthy quality of life?

Increase older adults' access to culturally and linguistically appropriate services.

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. Training in cultural competence is essential for all members of the health care and social service workforce, as is access to language services.

Increase funding for aging-related research.

Federal funding of aging-related research is essential to improving the health and longevity of older adults. Research focusing on the following topics is especially needed:

- improvement of communication between health care professionals (especially physicians) and older adults & family caregivers
- interventions to support people living with Alzheimer's disease and related dementias
- prevention of geriatric syndromes
- comparative effectiveness of psychosocial interventions supporting older adults and family caregivers.

Thus, NASW support the following actions:

- Restore funding for the National Institutes of Health (NIH) to FY 2010 presequestration levels, at a minimum.
- Increase NIA funding by \$500 million above the FY 2015 level (thus, \$1.67B), including at least \$200 million in new investments in dementia research, in the FY 2016 budget.
- Increase Administration for Community Living funding for dementia-related care and support services by \$20 million in FY 2016.
- Expand older adults' inclusion in clinical trials and other federally funded studies.

Strengthen the workforce serving older adults by increasing recruitment, training, and retention.

Both the [2008](#) and [2012](#) IOM reports 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 aforementioned Geriatrics Workforce Enhancement Program 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 eldercare 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 services 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.

Take action to address ageism.

Additional steps must be taken to eliminate the ageism that pervades U.S. culture. Ageist stereotypes limit older adults' perceived and actual opportunities to engage in their communities. Internalization of such stereotypes is detrimental to older adults' mental health.

Related themes

Services funded by the Older Americans Act (OAA) play a central role in enabling older adults to maintain their health, live safely in their homes, and remain engaged with their communities. NASW addresses OAA services in its response to the WHCoA Long-Term Services and Supports (LTSS) policy brief.

Nutrition is integral to healthy aging. NASW addresses this topic in its response to the WHCoA Retirement Security policy brief.

Many Medicare beneficiaries face challenges in accessing health care 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 Retirement Security policy brief.