American Academy
of Social Work & Social Welfare

Strengthening Health Care Systems:
Better Health Across America

Strengthening Health Care Systems:
Better Health Across America

Teri Browne
University of South Carolina

Sarah Gehlert
University of South Carolina

Christina M. Andrews
University of South Carolina

Bradley J. Zebrack
University of Michigan

Virginia N. Walther
Mount Sinai Hospital

Gail Steketee
Boston University

Peter Maramaldi
Simmons College and Harvard University

Barbara L. Jones
University of Texas at Austin

Robyn L. Golden
Rush University Medical Center

Bonnie Ewald
Rush University Medical Center

Susan R. Bernstein
Mount Sinai Hospital

Audrey L. Begun
The Ohio State University

Heidi L. Allen
Columbia University

Susan Guth
Society for Social Work Leadership in Health Care

Abigail Ross
Fordham University

Megan Moore
University of Washington

Joseph R. Merighi
University of Minnesota

GRAND CHALLENGES FOR SOCIAL WORK INITIATIVE

Working Paper No. 22

November 2017

Grand Challenge: *Close the Health Gap*

Grand Challenges for Social Work Initiative

The Grand Challenges for Social Work are designed to focus a world of thought and action on the most compelling and critical social issues of our day. Each grand challenge is a broad but discrete concept where social work expertise and leadership can be brought to bear on bold new ideas, scientific exploration and surprising innovations.

We invite you to review the following challenges with the goal of providing greater clarity, utility and meaning to this roadmap for lifting up the lives of individuals, families and communities struggling with the most fundamental requirements for social justice and human existence.

The Grand Challenges for Social Work include the following:

- Ensure healthy development of all youth
- Close the health gap
- Stop family violence
- Eradicate social isolation
- End homelessness
- Promote smart decarceration
- Reduce extreme economic inequality
- Build financial capability for all
- Harness technology for social good
- Create social responses to a changing environment
- Achieve equal opportunity and justice
- Advance long and productive lives

Executive Committee

Co-Chairs

Marilyn Flynn
University of Southern California

Michael Sherraden
Washington University in St. Louis

Edwina Uehara
University of Washington

Richard P. Barth
University of Maryland

John S. Brekke
University of Southern California

Darla Spence Coffey
Council on Social Work Education

Rowena Fong
University of Texas at Austin

Sarah Gehlert
University of South Carolina

J. David Hawkins
University of Washington

Charles E. Lewis Jr.
Congressional Research Institute for Social Work & Policy

James E. Lubben
Boston College

Ronald W. Manderscheid
National Association of County Behavioral Health & Developmental Disability Directors

Angelo McClain
National Association of Social Workers

Yolanda C. Padilla
University of Texas at Austin

Karina L. Walters
University of Washington

Patricia White
Hunter College

James Herbert Williams
Arizona State University

Gail Steketee (ex officio)
American Academy of Social Work & Social Welfare and *Boston University*

Sarah Christa Butts (staff)
University of Maryland

Michele Clark (staff)
University of Southern California

Lissa Johnson (staff)
Washington University in St. Louis

Strengthening Health Care Systems: Better Health Across America

Teri Browne, Sarah Gehlert, Christina M. Andrews, Bradley J. Zebrack, Virginia N. Walther, Gail Steketee, Peter Maramaldi, Barbara L. Jones, Robyn L. Golden, Bonnie Ewald, Susan R. Bernstein, Audrey L. Begun, Heidi L. Allen, Susan Guth, Abigail Ross, Megan Moore, and Joseph R. Merighi

In this Grand Challenges for Social Work paper, we explore how social work leadership can strengthen health care systems in the United States over the coming decade toward the goal of improving health across the country. This paper complements existing papers related to the Close the Health Gap Grand Challenge: *Health Equity: Eradicating Health Inequalities for Future Generations* and *Reducing and Preventing Alcohol Misuse and Its Consequences: A Grand Challenge for Social Work*. Eradicating health inequities in the United States requires diverse strategies that target the multiple settings in which disparities are created and perpetuated: in neighborhoods, communities and institutions, and the health care system itself. The addition of this proposal to the others addressing this Grand Challenge will significantly hasten our ability to close the nation's health gap within the next decade.

Key words: American Academy of Social Work & Social Welfare; Bridge Model; care transition; equity; Grand Challenge to Close the Health Gap; Grand Challenges for Social Work; health care; health equity; health social work; Ida M. Cannon; leadership; medical model; Patient Protection and Affordable Care Act of 2010; public relations; Richard C. Cabot; social determinants of health; social entrepreneurship; training

HEALTH AND HEALTH CARE IN THE UNITED STATES

Health-care payer and provider systems in the United States have historically been grounded in what has been termed a "medical model" of health care delivery. That model emphasizes treatment of acute illness (Adler, Glymour, & Fielding, 2016) but focuses little attention on the social and environmental context for health and wellness. A growing body of research suggests that the medical model has failed to produce desired improvements in population health.

In the United States, the National Center for Health Statistics reports that life expectancy at birth has declined for the first time since 1993 (Xu, Murphy, Kochanek, & Arias, 2016). The 10 leading causes of death remained the same in 2014 and 2015, and age-adjusted death rates increased for eight of those 10 leading causes.[1] The United States likewise performs poorly if

[1] In 2014 and 2015, the 10 leading causes of death in the United States were heart disease, cancer, chronic lower-respiratory diseases, unintended injuries, stroke, Alzheimer's disease, diabetes, influenza and pneumonia, kidney disease, and suicide (Xu et al., 2016).

compared with other industrialized nations. In 2007, the United States ranked dead last among 17 peer countries for life expectancy among men and 16th out of 17 for it among women (National Research Council & Institute of Medicine, 2013). Importantly, the report's authors note the following:

> Large within-country health disparities in the United States may contribute in important ways to the nation's overall health disadvantage relative to other high-income countries. Although studies reviewed in this report suggest that the health disadvantage relative to peer countries persists even when the U.S. data are limited to non-Hispanic whites or upper-income populations, *the U.S. health disadvantage is clearly far greater among the large proportion of Americans who live amid unfavorable health conditions.* (p. 41; emphasis added)

Health disadvantage is in large measure a product of social determinants. These determinants are the "conditions in the places where people live, learn, work, and play" (Centers for Disease Control and Prevention 2017, para. 1). They are estimated to contribute greatly to population health—more so than health behaviors and medical care (Braveman & Gottlieb, 2014; Centers for Disease Control and Prevention, 2017). Fortunately, enactment of the Patient Protection and Affordable Care Act (ACA) in 2010 has drawn attention to the important role of social determinants in population health outcomes.

Social determinants are mutable, and numerous efforts have attempted to shape them. Creating social and physical environments that promote good health for all is one of the four overarching goals identified by Healthy People 2020 (Office of Disease Prevention and Health Promotion, n.d.). For example, the Centers for Disease Control and Prevention (2016; CDC) seek to address social determinants of health through such efforts as Partnerships to Improve Community Health, the Built Environment and Health Initiative, and the Racial and Ethnic Approaches to Community Health (REACH) program. Likewise, the Innovation Center at the Centers for Medicare and Medicaid Services (CMS) launched the Accountable Health Communities Model to test interventions that address psychosocial barriers to outcomes (Alley, Asomugha, Conway, & Sanghavi, 2016). Ongoing evaluation research and policy advocacy are essential to ensure that such programs persist in the changing political environment.

Initiatives to address social determinants of health must be defined broadly enough to incorporate the full range of social, economic, and environmental forces shaping health. Some efforts have fallen short by focusing on individual behavior and demographics rather than on the physical and social contexts in which people live. Disregarding those contexts will likely produce errant interventions that negatively affect treatment choices and the outcomes of care. For example, an assessment of the likely health outcome for a 65-year-old African American woman diagnosed with breast cancer would typically take into account only her demographic variables: income, race, and age. But her health care (e.g., the type and frequency of chemotherapy and radiation) will be affected by the fact that she is raising two great-grandchildren, aged 3 and 7, who have a parent in addiction treatment. Those obligations require involvement with child care, a school, and the corrections office, which monitors visits between the children and their parent. If the patient attends a church with a health ministry, its services may reduce the need for community supports such as meal delivery and home health care. If she lacks child care, visits to the radiation, medical, and surgical oncologists will be

affected. Mental health services may be needed to address her worry about the fate of the children should she not survive her breast cancer.

Characterizing this woman only by race, age, and income would omit critical information about her social circumstances, potentially altering her treatment and worsening her outcomes. This example demonstrates how the traditional medical model can influence treatment decisions developed without considering the real world context, which determines whether patients can benefit from the prescribed treatment.

HEALTH SOCIAL WORK

Health Social Work and the Roles of Social Workers

From its beginning, health social work has served as a bridge to connect physicians with patients and their families. Dr. Richard Cabot hired the first medical social worker in the United States. This woman, Garnet Pelton, was hired at Massachusetts General Hospital in 1905 and paid out of pocket by Dr. Cabot. Dr. Cabot (1915) wrote that that social workers could translate physicians' explanations of illness and treatment instructions in terms that individuals and families could understand (Cabot, 1915). He also held that social workers were able to explain to physicians the factors in patients' social lives that might affect their health. Cabot (1912) asserted that physicians and social workers had much to learn from one another (Cabot, 1912). Social workers, he believed, should learn to be more systematic and scientific (Cabot, 1911). He asserted that physicians should learn how to understand the nonsomatic aspects of health.

Ida Cannon, who trained at the Simmons School of Social Work and became the first director of social work at Massachusetts General, worked with Cabot. Both recognized an important role played by social workers: problem solvers who could understand health and medicine as well as community resources and deficits. This recognition is germane in the United States today because social workers are positioned to tailor recommendations, treatments, and referrals in ways that match patients' daily routines and lived reality. Cannon emphasized social work's agility in adapting to accommodate developments:

> Basically, social work, wherever and whenever practiced at its best, is a constantly changing activity, gradually building up guiding principles from accumulated knowledge yet changing in techniques. Attitudes change, too, in response to shifting social philosophies (Cannon, 1952, p. 9).

Social work demonstrated the ability to adapt to sociopolitical shifts when Medicare and Medicaid legislation expanded hospital access for previously uninsured populations with complex medical and social issues. It did so again in the mid-1980s, when federally imposed cost-containment measures fundamentally changed health care delivery. This flexibility positions health social workers well to deal with health reform's changes in models of health care delivery.

Another enduring strength of the profession is its broad understanding that individuals are embedded in social networks, neighborhoods, and communities. Implicit in this understanding is

the recognition that those contexts influence knowledge, attitudes, beliefs, and behaviors, all of which can influence health choices and participation in health care. Securing positive long-term health outcomes requires the expertise of professionals who are familiar with the intricacies and intersections of the complex social systems in which individuals are situated. Social workers are trained to view health as part of the greater social context in which our patients live, work, and play (Newman, Baum, Javanparast, O'Rourke, & Carlon, 2015). They are equipped with the insights necessary to achieve population health goals.

In addition, social workers are uniquely trained to work across the continuum of health care settings to successfully identify, facilitate, coordinate, and monitor services that an individual requires to maintain optimal health. They also are trained to seek solutions and resources from within the individual's social context. The profession's unique understanding of the interdependent relationships among health, education, employment, criminal justice, education, and other systems enables it to serve as the nexus from which resources are drawn to protect, maintain, and restore health. Social workers routinely negotiate such systems to ensure that the many needs of clients are addressed in ways intended to advance optimal health. This work is done at the micro (individual), mezzo (health care system), and macro (socio-structural) levels. For example, social workers coordinate supports across multiple systems to address the needs of patients upon discharge, communicate with patients and caregivers to ensure that discharge instructions are understood, and confirm that necessary resources are in place for optimal care. Social workers serving in community settings know how to ensure access to services and resources that enable individuals to remain within their home and community. Social workers play an essential role in identifying nonmedical and social barriers that may impede an individual's ability to access health care services. They provide assistance in resolving these barriers. Social workers also use their skills to prevent adverse health conditions by intervening in community settings (e.g., schools, criminal justice) and by advocating for racial and environmental justice.

Social Work and Health Reform

The ACA's 2010 enactment created unprecedented opportunities to encourage the health care system to be more responsive to the influences of social determinants on health. It created new roles and opportunities for social work, including shifts toward preventive approaches to solving social problems and expansions outside of traditional health-care settings. In addition, the act established a wide range of demonstration programs and initiatives designed to improve health care financing and population health by attending to social context. Examples include new payment models tied to quality metrics and alternative payment strategies. Accountable Care Organizations (ACOs), bundled payments, managed long-term services and supports, Medicaid Health Homes, and Accountable Health Communities all represent the fruits of those new models. The models require interdisciplinary collaboration and better care coordination. They provide important opportunities for social workers to join delivery-system reform efforts in areas such as patient navigation, care management, transitional care, and end-of-life care, as well as in efforts to integrate behavioral and physical health services (National Association of Social Workers, 2016).

As we enter the next chapter in health social work's history, the ACA faces the prospect of repeal, major revision, or replacement. During the first half of 2017, congressional efforts

proposed several significant changes to the act, including removal of the requirements that individuals have health insurance coverage and that insurance policies provide essential health benefits. A proposed cap on federal Medicaid funding to states would convert the program's funding stream to a block grant system. Assurances of insurability for people with pre-existing conditions are also in jeopardy. Such changes would likely limit health care access and quality for all Americans (Congressional Budget Office, 2017a, 2017b, 2017c). Fortunately, those legislative efforts did not propose elimination of many initiatives that the ACA established to improve care coordination and value: ACOs, bundled payments, and financial incentives and penalties to improve care transitions. Now, as in 1965 when Medicare was enacted, social workers are needed at the front lines of health care policy to protect the health care system, to develop it in ways that make the system more responsive to social determinants of health, and to advocate for changes that will afford everyone access to the system.

MODELS OF HEALTH SOCIAL WORK

Efforts in five key domains can inform models of health social work practice that will leverage health care systems to address social and community factors shaping health outcomes: (1) increasing screening and prevention, (2) addressing economic and environmental stressors in health care, (3) improving care management and coordination, (4) promoting interventions tailored for vulnerable populations, and (5) facilitating successful care transitions.

Increasing Screening and Prevention

Helping individuals engage in health screenings and preventative services is one of the many important roles played by health social workers. Such screenings can include assessment of loneliness and social isolation, which are increasingly linked to negative health outcomes (Holt-Lunstad & Smith, 2016; Valtorta, Kanaan, Gilbody, Ronzi, & Hanratty, 2016), as well as efforts to screen for material hardship and other negative social determinants. Moreover, social workers deliver interventions that may prevent the physical consequences of such stressors.

In oncology settings, social workers help communities navigate the barriers to cancer screenings and prevention (Burg et al., 2010). Social workers also play a critical role in addressing psychosocial barriers to genetic cancer testing (Werner-Lin, McCoyd, Doyle, & Gehlert, 2016; Young et al., 2017). Nephrology social workers help dialysis patients to be tested and listed for kidney transplants (Browne, 2011). Social work scholars Jason Bird, Dexter Voisin, and Daryl Wheeler have provided a large body of research on the connections linking community and social factors with behaviors related to HIV prevention. That can also inform social work practice (Bird & Voisin, 2011; Holmes et al., 2008; Marrazzo et al., 2014; Voisin, Bird, Shiu, & Krieger, 2013; Wheeler, 2011).

Addressing Economic and Environmental Stressors in Health Care

Social work makes critical contributions to ameliorate the economic and environmental stressors in health care systems, including stressors related to health disparities. Within health systems,

social workers help individuals recognize and address the effects of stress experienced during life transitions (e.g., divorce and job loss). These experiences may cause health to decline. Medicaid Health Homes and ACOs, funded by the Medicare Shared Savings Program, represent important initiatives in which social workers can lead interventions to improve patient access to community resources. Through that leadership, social workers can reduce social isolation and discrimination, which adversely affect health outcomes (Allen, 2012). Social workers can advance efforts to address these stressors through ACOs (Gehlert, Collins, Golden, & Horn, 2015).[2] Research by Gehlert and colleagues on epigenomic neighborhood factors and health disparities offers further insights into social work's possible roles in addressing social determinants that can lead to health disparities (Gehlert & Coleman, 2010; Gehlert et al., 2008). To, wit, social work can help contextualize individuals and communities in order to facilitate identification of specific factors that influence health.

Improving Care Management and Coordination

The social work profession leads efforts to better coordinate health care. Kathleen Ell, at the University of Southern California's Suzanne Dworak-Peck School of Social Work, has demonstrated how care coordination and patient navigation interactions can improve community-based cancer services, particularly for racial and ethnic subpopulations (see, e.g., Ell et al., 2010, 2011, 2012). The Chicago Cancer Navigation Project is another example of successful social work leadership in patient navigation. The project helps to manage and coordinate care for vulnerable populations (Markossian, Darnell, & Calhoun, 2012; Tejeda et al., 2013). At Mount Sinai Hospital in New York City, social workers have played a key role in establishing and managing a Medicaid Health Home. Through the innovative Health Home model of care coordination, health care providers can receive an enhanced Medicaid match rate by providing care-coordination and wrap-around services for enrollees with specific chronic conditions.

Promoting Interventions Tailored for Vulnerable Populations

Vulnerable populations are more likely to suffer chronic health problems (Centers for Disease Control and Prevention, 2013). Social workers can lead research and interventions to promote health parity. The REACH-Detroit program offers an example of an integrated model of health care led by social work to reduce health disparities. One of 24 such programs initially funded by the CDC, REACH-Detroit began in 2000 and is overseen by Michael Spencer at the University of Michigan School of Social Work.[3] Now funded by the National Institutes of Health, the program evaluates the effectiveness of community health workers, particularly their effectiveness in aiding communities of color. Training is an important part of the program. Sessions for medical providers offer instruction on cultural humility and promoting

[2] The network of scholars engaged in the Grand Challenge to Achieve Equal Opportunity and Justice also has identified roles that social workers can play in addressing health disparities. For information on the network's efforts, see http://aaswsw.org/grand-challenges-initiative/12-challenges/achieve-equal-opportunity-and-justice/.

[3] For additional information on REACH (Racial and Ethnic Approaches to Community Health)-Detroit, see http://www.reachdetroit.org/about/index.php.

communication skills so that communication is comprehensible. Training is also provided for fitness instructors. Physical activity classes, walking clubs, and healthy eating programs are offered in the community, with an eye to safety. Research has shown that REACH leads to positive outcomes (Spencer et al., 2013; Tang et al., 2014).

Facilitating Successful Care Transitions

Care transitions are a prime target for social work intervention and can be improved in several key ways. Transitions from one care setting to another, in particular transitioning home after a hospitalization, often create complexities that can result in inadequate in-home care, hospital readmissions, and high costs for health systems and payers. Every year, 2.6 million older adults are readmitted to hospitals within 30 days of discharge, and these readmissions account for $26 million in Medicare spending each year (Centers for Medicare & Medicaid Services, 2016). Just over half of these transitioning patients had no physician contact after discharge (Jencks, Williams, & Coleman, 2009). The ACA offers incentives to reduce unnecessary hospitalizations and readmissions. Examples include value-based payments, the Hospital Readmission Reduction Program, and the move toward bundled payments for episodes of care. In addition to spurring significant research, these incentives have drawn attention to how payers, hospitals, and community-based providers can ease care transitions, improve patient experiences, and reduce unnecessary hospitalizations (admissions and readmissions).

Transitional care that supports individuals and families before and after a hospitalization is a critically important factor in positive health outcomes. It is also important for preventive primary care and for care-management efforts. Historically, the health-care and community services available at transition points have been delivered through differing funding streams by disparate professions with widely dissimilar training. Often, those delivering these services have not "spoken the same language" nor held contractual obligations to foster collaborative relationships with providers in other professions. Although ACA incentives have helped to address this fragmentation, the changing dynamics make the system especially complicated for patients and families to navigate on their own. Transitional-care social workers can serve as a critical hub for the coordination of health and social services. They also can integrate a person-in-environment perspective within health systems navigation and use client-centered interviewing skills to support patients and families after a hospitalization.

The conceptualization of health as an individual experience occurring within social context has led the social work profession to develop and participate in several transitional-care models that address context. These are models of care in which medical professionals (doctors, nurses, and physician assistants) collaborate closely with social workers, case managers, community care workers, and others to engage needed services that support recovery and continuing health.

Several groups around the country have made pioneering efforts to integrate social workers into transitional care efforts. The social-work-led Bridge Model of transitional care involves a collaboration among an academic medical center, a health policy organization, and several community-based Aging Network organizations. Bridge social workers combine care coordination, case management, and patient engagement, using a comprehensive set of tools and psychotherapeutic techniques to assess for gaps in care, improve self-efficacy, and enhance

patient activation (Boutwell, Johnson, & Watkins, 2016). Research on the model suggested an association between Bridge services and increased primary-care follow-up appointments. In addition, the model was associated with a 20% reduction in hospital readmissions among Medicare beneficiaries who received home health care after hospital discharge. The Bridge Model also supports individuals transitioning back to community treatment following an inpatient psychiatric stay or a short-term rehabilitative stay. Continuing to identify ways to integrate social work into transitional care efforts is imperative. Doing so will enable social workers to increase the impact of these programs and will foster opportunities for partnerships between community-based organizations and nearby health systems.

The Department of Social Work Services at Mount Sinai Hospital has had a long-standing leadership role in addressing the social determinants of health and in facilitating successful care transitions. The New York Academy of Medicine sections on Social Work and Health Care Delivery recognized the current leadership team of Mount Sinai Hospital's social work department for the success of social work interventions in improving health outcomes and reducing medical costs. The team has led multiple ACA-funded initiatives. Mount Sinai has four social-work initiatives that address care transitions: care coordination in a ACO for Medicare fee-for-service recipients, a CMS-funded program focusing on hospital discharge transitions to prevent 30-day readmissions among Medicare fee-for-service beneficiaries, an emergency department project funded by the CMS Innovation Center, and a program funded through the Robert Wood Johnson Foundation to improve health outcomes of women after childbirth.

CLOSING THE HEALTH GAP: SYSTEM-LEVEL STRATEGIES FOR SOCIAL WORK

Social workers can help close the health gap in the United States through six system-level strategies: increasing social work leadership in health care, providing leadership training in schools of social work and practice sites, enhancing public relations, embracing social entrepreneurship, transdisciplinary and interprofessional education and training, and research.

Increasing Social Work Leadership in Health Care

In addition to fostering our professional capacity to improve health services and health outcomes, the social work profession must continue to advocate broadly for the implementation of socially oriented models of health care. True leadership in the transformation of health care systems requires the profession to advance a vision for an effective health-care system that serves all Americans and to offer concrete recommendations for how this can be achieved. That vision should parallel the one elaborated through the ACA—a vision for the transformation of health care from a crisis-oriented and medically grounded system to one that is focused on prevention, well-being, and comprehensive care. Existing health-care systems are actively searching for solutions to major cost and care challenges. Perhaps more than ever before, they are open to new ideas and messages. This is a unique window of opportunity for social workers to actively set the nation's health-care agenda.

Crucially important decisions are being made by state health-insurance commissions and CMS: Which services are covered at what price, and who will be paid to provide them. It is essential

that social work actively influence those decisions. At the national level, social work representatives are needed on the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. Representation on all leadership bodies associated with the state-administered health exchanges is especially important. At the state level, the profession should strive for representation on every state Medicaid Advisory Committee as well as on mental-health and addiction service boards at state and county levels.

There is critical need to develop new social work leaders who possess the political sophistication to engage in high-level professional advocacy. Unfortunately, a 2-year graduate education simply does not allow the depth of skills training that such leadership requires. Accordingly, there is need for leadership-development programs in health policy, programs similar to those offered in the fields of medicine and public health. Such programs would train early- and mid-career professionals who have excellent potential to provide health leadership in advocacy and health management efforts at all levels of government. The programs would complement existing efforts like the Society for Social Work Leadership in Health Care's annual Leadership Institute. The Leadership Institute brings together experienced social work leaders and educators for an intensive, interactive program designed to develop or enhance participants' leadership knowledge and skills. Health-policy leadership programs can also build on recent efforts by the Council on Social Work Education and the National Association of Social Workers. Through the Social Work HEALS (Social Work Health Care Education and Leadership Scholars) initiative, the two organizations are collaborating to strengthen leadership training for health social work students.

Leadership Training in Schools and Practice Sites

Leadership training for individuals in schools of social work and in social work practice sites is a precursor to effective advocacy concerning the value of social work in health care. The rarity of such training seems to echo Richard Cabot's comment about the importance of being systematic rather than resting on the moral high ground. In this context, a systematic approach entails learning how to engage with health powerbrokers in federal, state, and local government; the health care industry; and funders of research and community demonstration projects. In addition, social work faculty and students can foster leadership training within their academic institutions by working closely with university and hospital administrators to identify opportunities. This type of training should begin early. Partnerships with academic schools/colleges of communication, with institutional or private marketing-and-communications departments, and with lobbying organizations may offer additional ways to obtain such specialized leadership training. Moreover, academic and industry leaders could provide especially helpful advice on ways to increase awareness of social work and social determinants of health within the health care industry.

Recent national social work meetings have begun this process by assembling the best minds in the field to grapple with how to promote the impact of social work on the nation's health. New energy to advance these goals was evident in the following recent events:

- A 2014 meeting brought together experts in health social work and policy with leaders from the Society for Social Work and Research, the Council on Social Work Education, the National Association of Social Workers, the American Academy of Social Work & Social Welfare, and the Society for Social Work Leadership in

Health Care. Participants developed recommendations for ways to maximize social work's contributions to the implementation of the ACA (Andrews et al., 2015).

- In 2015, Boston University's School of Social Work created the Center for Innovation in Social Work and Health, which has engaged 88 regional, national, and global transdisciplinary experts in exploration of the impact of social work and health in several domains, including education, policy, community, and global health.[4]
- In September 2016, Social Innovation for America's Renewal: Ideas, Evidence, Action, a conference held at Washington University in St. Louis, provided a forum to examine the policy implications of each of the Grand Challenges for Social Work, including the Grand Challenge to Close the Health Gap. Efforts to address that challenge have focused on eradicating health inequalities.[5]
- Through its Leadership Academy, the National Association of Deans and Directors of Schools of Social Work sponsored a November 2016 keynote address by Dr. Sally Bachman, director of Boston University's Center for Innovation in Social Work and Health. Given in conjunction with the Council on Social Work Education's meeting in Atlanta, Georgia, the address outlined recent and emerging developments in health policy.
- In January 2017, approximately 50 academic and practice leaders in social work and health attended the national Social Work and Health Convening 2017: State of Research and Training, which was sponsored by the University of Chicago.[6]

These events highlighted the opportunities for providing social work leaders with broad spectrum leadership training that enables them to effectively advance a social-work health agenda as they engage with interdisciplinary colleagues representing academic, industry, health-practice, government, and funder interests. We must continue and expand upon such efforts.

Social work faculty, administrators, and senior practitioners in medical and health-care systems will also benefit from training on communicating with the media about health care news that requires a knowledgeable social work response. Rather than deferring to other health professionals, social work faculty members and senior health practitioners must learn to speak effectively about their knowledge and must form relationships with media representatives so that they become go-to respondents when important health stories break. Social work writers can raise awareness of critical health issues by contributing op-eds. These efforts all require training that enables social workers to speak clearly with knowledge and confidence in professional responses and outreach to the media. Likewise, training in public speaking will benefit social

[4] For information on the Center for Innovation in Social Work & Health, see http://www.bu.edu/ssw/research/the-center-for-innovation-in-social-work-and-health/.

[5] Information on Social Innovation for America's Renewal may be found at https://csd.wustl.edu/events/ConferencesAndSymposia/Pages/Grand-Challenges-for-Social-Work-Policy-Conference.aspx.

[6] Information on Social Work & Health Convening 2017 may be found at https://chas.uchicago.edu/page/social-work-and-health-convening-2017.

workers who give longer talks in public or academic settings covered by the media. A willingness to make time for media interviews is also required in such settings.

Public Relations

Now is a critical time for the social work profession to articulate clearly its unique contributions to improving health care and reducing the influence of adverse social determinants of health. The profession should communicate to key policy makers the ways in social workers can help to improve health care quality and value. The profession must go beyond identifying the roles and activities that social workers execute well; it must link these interventions to address tangible, specific needs within health care systems. Moreover, the profession must articulate clear, consistent messages about how social workers can identify and meet these needs, especially as part of transdisciplinary health-care teams. A language that communicates these roles across the profession can be used effectively to convey the importance and value of social work to policy makers, insurers, other health-care professionals, the public, and other essential stakeholders. Key targets for advocacy include insurers and managed care organizations; federally qualified health centers; hospitals; patient-centered medical homes; large, private physician practices; and behavioral health programs. Social work leaders would benefit greatly from close collaboration with marketing and public relations firms in deciding how to publicize the profession's work to improve health in America.

Social action, advocacy, and policy practice are at the core of the social work profession. Although grassroots political efforts can be meaningful and effective, professional lobbying organizations have greater influence on government in the long term, given their networks of relationships, longevity, and nuanced understanding of the political system (Hamilton, 2014). In presenting an analysis of data from the Senate Office of Public Relations, the Center for Responsive Politics (2017) reports that companies, unions, and other organizations spent more than $35.3 billion to lobby Congress and federal agencies during the last decade. During 2016 alone, a total of $3.32 billion was spent on lobbying entities of the federal government. The National Association of Social Workers and the Council on Social Work Education spent approximately .001% of that amount ($320,000) to promote the interests of the social work profession (Center for Responsive Politics, 2017). In an era when lobbying has a profound impact on the legislation and subsequent policies (De Figueiredo & Richter, 2014), it is imperative for social work to increase its lobbying efforts, particularly at the federal level. New and innovative entrepreneurial relationships have the potential to strengthen social work's lobbying power, enabling the profession to positively influence the nation's health care systems. To bring advocacy actions to scale, social work should develop a centralized lobbying institute designed and staffed by professional lobbyists. The institute would train and coordinate cohorts of social work leaders to influence lawmakers and federal agencies.

National attention to social determinants of health, and to the importance of addressing them in health care settings, could also be raised through a forthcoming consensus study released by the National Academies of Sciences, Engineering, and Medicine. Such studies and associated workshops provide independent, objective analysis on health-related issues. Reports that result from the consensus study process are well respected. They synthesize the state of affairs and recommend actions to address the analyzed issue. Recent reports have covered such topics as the

obesity epidemic, underage drinking, adjustments to Medicare payments for social risk factors, and reducing racial and ethnic disparities in access to health care.

A group of social work researchers, policymakers, and practitioners have proposed such a study to examine the profession's role in equipping the health-care delivery system to meet increasing population health challenges. In January 2017, the National Academies and the National Research Council approved Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. When funding is secured and the study launched, the interdisciplinary committee will gather information, deliberate on consensus findings, generate recommendations, and write the report. When the report is released, the social work community should identify ways to build upon it and to implement its recommendations. Social work should partner in this effort with other stakeholders across the country, perhaps through a national campaign similar to nursing's Campaign for Action, which has built upon the consensus report titled *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine, 2011).[7]

Social Entrepreneurship

Social entrepreneurship is another way for social workers to contribute to the dialogue on health care delivery. In his seminal work, Dees (1998) posited that intention distinguishes social entrepreneurship from other enterprises. A mission-driven social impact is pursued with the same intensity, creativity, discipline, and focus associated with traditional business models. Social entrepreneurial models go beyond the status quo, seeking new solutions with the potential for transformative, sustainable change that will benefit society as well as traditionally vulnerable and underserved populations (Dees, 1998; Peredo & McLean, 2006). The tenets of social entrepreneurship offer great promise for social work, a profession driven by the values of social justice and the inherent worth and dignity of the individual (National Association of Social Workers, 2008).

Finding ways to maximize mission-driven social impact is especially important at times when the demands for social work services increase but tenuous financial or political conditions preclude innovation and co-opt social workers in the task of maintaining the viability of current health-care systems. As a model for service delivery, social entrepreneurship enables social workers to consider new and creative approaches to attaining mission objectives (Seelos & Mair, 2005; Thompson, Alvy, & Lees, 2000). The Brides Project in Ann Arbor, Michigan, is an example of such an approach. Social workers identified an untapped commercial market for recycled wedding gowns and used profits to fund psychosocial support services for cancer patients.[8]

As a paradigm for health social work, social entrepreneurship offers unprecedented opportunities to foster new partnerships in mission-related investing (Germak & Singh, 2009; Linton, 2013; Nandan, London, & Bent-Goodley, 2015), both investment from foundations (e.g., the Bill & Melinda Gates Foundation's vaccine innovation) and private sources (e.g., microfinance opportunities in developing countries). Approaches to developing initiatives (Dees, Emerson, &

[7] For information on the campaign, see http://campaignforaction.org/.

[8] See http://www.thebridesproject.org.

Economy, 2001) and instructive case studies (Alvord, Brown, & Letts, 2004) are readily available in the literature and on foundation web pages such as that of the Rockefeller Foundation (Rockefeller Foundation, n.d.).

Transdisciplinary and Interprofessional Education and Training

As we have suggested, social workers have essential knowledge and skills to contribute to the development of new models of care in health care systems that continue to embrace patient- and family-centered care, collaborative practice, and attention to health inequities. Training within interprofessional health teams enables social work practitioners to provide leadership within the nation's changing health care systems. Such training deliberately educates social work students and practitioners in how to speak clearly and effectively about what the social work profession brings to the table. It also enables the profession to specify how we can contribute to creating a more patient-centered care that is responsive to the social and environmental contexts greatly influencing health outcomes. Moreover, such training enables all members of interprofessional medical teams to learn from each other about the integral and complimentary role each plays in serving patients. The Institute of Medicine (2001; Levit, Balogh, Nass, & Ganz, 2013) and the World Health Organization (1998, 2010) have recommended interprofessional education to create graduates capable of joining and promoting team-based models of health care delivery. Their recommendations parallel the Council on Social Work Education's 2015 Educational Policy and Accreditation Standards, which emphasize that social workers should develop skill in relationship building, interprofessional collaboration, and communication. The standards also emphasize the importance of the ability to apply multidisciplinary theory in provision of assessments, interventions, and evaluations of outcomes. Social work can serve a critical role in the development of these models.

Social workers provide leadership in the development of interprofessional education programs that can improve health systems in several ways. Such training can enhance communication between interdisciplinary team members and emphasize the unique and common roles, values, ethical concerns of each profession (Jones & Phillips, 2016; Dauenhauer, Glose, & Watt, 2015). Interprofessional education can build professional confidence and creativity; advance professional equity and shared-decision making (Chan, Chi, Ching, & Lam, 2010; Nimmagadda & Murphy, 2014; Sims, 2011). Interprofessional training can also enhance patient and community care outcomes (Addy et al. 2015; Taylor et al., 2016; Terry et al., 2015). Social work educators and practitioners must continue to lead the way in innovative interprofessional education (Jones & Phillips, 2016). Recommendations for such social work leadership include the following:

- Introduce interprofessional education early in undergraduate social work programs,
- develop collaborative interprofessional field experiences,
- provide service-learning and shadowing experiences with other disciplines,
- coteach and cocreate courses,
- lead campus-wide initiatives,

- bring together social work practitioners and educators to create learning experiences that mirror current practice needs, and
- evaluate these initiatives (Jones & Phillips, 2016; Taylor et al., 2016).

To demonstrate the value of social work in health systems, social work students at all levels also must be trained in how to conduct transdisciplinary and translational research (Gehlert, Hall, & Palinkas, 2017).

Social Work Research

Although several high-quality studies have documented how social workers can improve health outcomes, particularly in the areas of care coordination and transition management, more work is needed to comprehensively document social workers' effectiveness in health care *systems*. Researchers should develop and test entirely new models for improving health, models in which social workers play key roles. At the individual level, interventions are needed to help patients achieve their own goals for healthier living—particularly interventions that are sensitive and responsive to the broader family, community, social, physical, and cultural contexts in which patients live. At the community level, social workers have the opportunity to develop interventions that foster understanding of community health needs, to work collaboratively with communities in organizing for change, and to advocate for resources and environmental change that can promote better community health.

The social work profession must demonstrate that it has the capacity to achieve good health outcomes for patients while also bringing down health care costs. As team-based care and bundled payments become more common in health care settings, social work researchers will be challenged to conduct studies that demonstrate the contribution of social work interventions in support of cost effectiveness and positive patient outcomes. Design and implementation of such studies should be a priority within the social work research community. There is a need for the profession to train and hire more health economists and health services researchers in schools of social work—that is, investigators who can conduct and collaborate with social work students, professionals, and faculty in these areas. Our outcomes and findings are more likely to have impact for the health care field—and the many different kinds of health professionals working in it—if we initiate projects with researchers from these fields.

Greatly needed are social work practice-based research networks that promote the creation of coordinated, community-based studies in multiple real-world settings (Gehlert, Walters, et al., 2015). Widely used by other health professionals, practice-based research networks bring together practitioners and researchers for the purpose of advancing research. Led by the Society for Social Work and Research and other key stakeholders, including the National Association of Social Workers, the Society for Social Work Leadership in Health Care, and the Council on Social Work Education, such a network could serve as a national coordinating body through which to share resources, coordinate cross-state efforts, and develop a vision for enhancing the profession's role in shaping health care policy over time.

CONCLUSION

Social work has an important role in strengthening health care systems and improving health equity in the United States over the next decade. This paper complements two others released as part of efforts to address the Grand Challenge to Close the Health Gap: *Health Equity: Eradicating Health Inequalities for Future Generations* (Walters et al., 2016) and *Reducing and Preventing Alcohol Misuse and Its Consequences: A Grand Challenge for Social Work* (Begun et al., 2015).[9] It does so by elaborating a set of strategies for increasing health equity within health care systems. Eradicating health inequities in the United States requires diverse strategies that target the multiple settings in which disparities are created and perpetuated: in neighborhoods, communities, and institutions, and within the health care system itself. Our suggestions, along with other Grand Challenge efforts, provide a call to action for social work practitioners, leaders, educators, and researchers. Through coordinated action, the profession can close the nation's health gap within the next decade.

[9] For information on the Grand Challenge to Close the Health Gap, see http://aaswsw.org/grand-challenges-initiative/12-challenges/close-the-health-gap/.

REFERENCES

Addy, C. L., Browne, T., Blake, E. W., & Bailey, J. (2015). Enhancing interprofessional education: Integrating public health and social work perspectives. *American Journal of Public Health, 105*(1), S106–S108. doi:10.2105/AJPH.2014.302502

Adler, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing social determinants of health and health inequalities. *JAMA, 316*(16), 1641–1642. doi:10.1001/jama.2016.14058c

Allen, H. (2012). Is there a social worker in the house? Health care reform and the future of medical social work. *Health and Social Work, 37*(3), 183–186. doi:10.1093/hsw/hls021

Alley, D. E., Asomugha, C. N., Conway, P. H., & Sanghavi, D. M. (2016). Accountable health communities—addressing social needs through Medicare and Medicaid. *New England Journal of Medicine, 374*(1), 8–11. doi:10.1056/NEJMp1512532

Alvord, S. H., Brown, L. D., & Letts, C. W. (2004). Social entrepreneurship and societal transformation: An exploratory study. *Journal of Applied Behavioral Science, 40*(3), 260–282. doi:10.1177/0021886304266847

Andrews, C., Browne, T., Allen, H., Coffey, D. S., Gehlert, S., Golden, R., … Woomer, E. (2015). *Social work and the Affordable Care Act: Maximizing the profession's role in health reform*. Retrieved from University of South Carolina, College of Social Work website: http://cosw.sc.edu/images/pdfs/swaca/swaca-FINAL-04-20-2015.pdf

Bachman, S.S. (2016, November). *Current health policy developments.* Address given at the Leadership Academy of the National Association of Deans and Directors of Schools of Social Work, Council on Social Work Education Annual Program Meeting, Atlanta, GA.

Begun, A. L., Clapp, J. D., & The Alcohol Misuse Grand Challenge Collective. (2015). *Preventing and reducing alcohol misuse and its consequences: A grand challenge for social work* (Grand Challenges for Social Work initiative Working Paper No. 14). Retrieved from American Academy of Social Work & Social Welfare website: http://aaswsw.org/wp-content/uploads/2015/12/WP14-with-cover.pdf

Bird, J. D. P., & Voisin, D. R. (2011). A conceptual model of HIV disclosure in casual sexual encounters among men who have sex with men. *Journal of Health Psychology, 16*(2), 365–373. doi:10.1177/1359105310379064

Boutwell, A. E., Johnson, M. B., & Watkins, R. (2016). Analysis of a social work–based model of transitional care to reduce hospital readmissions: Preliminary data. *Journal of the American Geriatrics Society, 64*(5), 1104–1107. doi:10.1111/jgs.14086

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports, 129*(1, Suppl. 2), 19–31. doi:10.1177/00333549141291S206

Browne, T. (2011). The relationship between social networks and pathways to kidney transplant parity: Evidence from black Americans in Chicago. *Social Science & Medicine, 73*(5), 663–667. doi:10.1016/j.socscimed.2011.06.031

Burg, M. A., Zebrack, B., Walsh, K., Maramaldi, P., Lim, J.-W., Smolinski, K. M., & Lawson, K. (2010). Barriers to accessing quality health care for cancer patients: A survey of members of the Association of Oncology Social Work. *Social Work in Health Care, 49*(1), 38–52. doi:10.1080/00981380903018470

Cabot, R. C. (1911). Social service work in hospitals. *Chicago Medical Recorder, 33*, 307–321.

Cabot, R.C. (1912). Humanizing the hospitals. In S. Breckenridge (Ed.), *The child in the city: A series of papers presented at the conferences held during the Chicago Child Welfare Exhibit* (pp. 41–52). Chicago, IL: Chicago School of Civics and Philanthropy.

Cabot, R.C. (1915). *Social service and the art of healing*. New York, NY: Moffat, Yard and Co.

Cannon, I. M. (1952). *On the social frontier of medicine: Pioneering in medical social service*. Cambridge, MA: Harvard University Press.

Center for Responsive Politics. (2017). Lobbying database. Retrieved from https://www.opensecrets.org/lobby/

Centers for Disease Control and Prevention. (2013). CDC health disparities and inequalities report—United States, 2013. *Morbidity and Mortality Weekly Report, 62*(3, Suppl.). Retrieved from https://www.cdc.gov/mmwr/pdf/other/su6203.pdf

Centers for Disease Control and Prevention. (2016, February 29). CDC programs addressing social determinants of health. Retrieved from https://www.cdc.gov/socialdeterminants/cdcprograms/index.htm

Centers for Disease Control and Prevention. (2017). Social determinants of health: Know what affects health. Retrieved from https://www.cdc.gov/socialdeterminants/

Centers for Medicare & Medicaid Services. (2016). Community-based care transitions program. Retrieved from https://innovation.cms.gov/initiatives/CCTP/

Chan, E. A., Chi, S. P. M., Ching, S., & Lam, S. K. S. (2010). Interprofessional education: The interface of nursing and social work. *Journal of Clinical Nursing, 19*(1–2), 168–176. doi: 10.1111/j.1365-2702.2009.02854.x

Congressional Budget Office. (2017a, May 24). *H.R. 1628: American Health Care Act of 2017; as passed by the House of Representatives on May 4, 2017* (Congressional Budget Office cost estimate). Retreived from https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf

Congressional Budget Office. (2017b, June 26). *H.R. 1628: Better Care Reconciliation Act of 2017; an amendment in the nature of a substitute [LYN17343] as posted on the website of the Senate Committee on the Budget on June 26, 2017* (Congressional Budget Office cost

estimate). Retreived from https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf

Congressional Budget Office. (2017c, July 19). *H.R. 1628: Obamacare Repeal Reconciliation Act of 2017; an amendment in the nature of a substitute [LYN17479] as posted on the website of the Senate Committee on the Budget on July 19, 2017* (Congressional Budget Office cost estimate). Retreived from https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf

Council on Social Work Education, Commission on Accreditation and Commission on Educational Policy. (2015). *2015 educational policy and accreditation standards for baccalaureate and master's social work programs.* Retrieved from https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx

Dauenhauer, J. A., Glose, S., & Watt, C. (2015). Design, delivery, and outcomes from an interprofessional fall prevention course. *Gerontology & Geriatrics Education*, *36*(3), 278–301. doi:10.1080/02701960.2015.1031891

Dees, J. G. (1998). *The meaning of social entrepreneurship* [Working paper]. Kansas City, MO: Kauffman Center for Entrepreneurial Leadership.

Dees, J. G., Emerson, J., & Economy, P. (2001). *Enterprising nonprofits: A toolkit for social entrepreneurs.* New York, NY: Wiley.

De Figueiredo, J. M., & Richter, B. K. (2014). Advancing the empirical research on lobbying. *Annual Review of Political Science, 17*, 163–185. doi:10.1146/annurev-polisci-100711-135308

Ell, K., Katon, W., Lee, P.-J., Kapetanovic, S., Guterman, J., Xie, B., & Chou, C.-P. (2012). Depressive symptom deterioration among predominantly Hispanic diabetes patients in safety net care. *Psychosomatics*, *53*(4), 347–355. doi:10.1016/j.psym.2011.12.009

Ell, K., Katon, W., Xie, B., Lee, P.J., Kapetanovic, S., Guterman, J., & Chou, C.-P. (2010). Collaborative care management of major depression among low-income, predominantly Hispanic subjects with diabetes: A randomized controlled trial. *Diabetes Care*, *33*(4), 706–713. doi:10.2337/dc09-1711

Ell, K., Katon, W., Xie, B., Lee, P.-J., Kapetanovic, S., Guterman, J., & Chou, C.-P. (2011). One-year postcollaborative depression care trial outcomes among predominantly Hispanic diabetes safety net patients. *General Hospital Psychiatry*, *33*(5), 436–442. doi:10.1016/j.genhosppsych.2011.05.018

Gehlert, S., & Coleman, R. (2010). Using community-based participatory research to ameliorate cancer disparities. *Health & Social Work*, *35*(4), 302–309. doi:10.1093/hsw/35.4.302

Gehlert, S., Collins, S., Golden, R., & Horn, P. (2015). Social work participation in accountable care organizations under the Patient Protection and Affordable Care Act. *Health & Social Work*, *40*(4), e142–e147. doi:10.1093/hsw/hlv054

Gehlert, S., Hall, K. L., & Palinkas, L. A. (2017). Preparing our next-generation scientific workforce to address the Grand Challenges for Social Work. *Journal of the Society for Social Work & Research, 8*(1), 119–136. doi:10.1086/690659

Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs, 27*(2), 339–349. doi:10.1377/hlthaff.27.2.339

Gehlert, S., Walters, K., Uehara, E., & Lawlor, E. (2015). The case for a national health social work practice–based research network in addressing health equity. *Health & Social Work, 40*(4), 253–255. doi:10.1093/hsw/hlv060

Germak, A. J., & Singh, K. K. (2009). Social entrepreneurship: Changing the way social workers do business. *Administration in Social Work, 34*(1), 79–95. doi:10.1080/03643100903432974

Hamilton, L. (2014). What makes a strong lobbyist. Retrieved from Center on Congress at Indiana University website: http://centeroncongress.org/what-makes-strong-lobbyist

Holmes, J. H., Lehman, A., Hade, E., Ferketich, A. K., Gehlert, S., Rauscher, G. H., … Bird, C. E. (2008). Challenges for multilevel health disparities research in a transdisciplinary environment. *American Journal of Preventive Medicine, 35*(2, Suppl.), S182–S192. doi:10.1016/j.amepre.2008.05.019

Holt-Lunstad, J., & Smith, T. B. (2016). Loneliness and social isolation as risk factors for CVD: Implications for evidence-based patient care and scientific inquiry. *Heart, 102*(13), 987–989. doi:10.1136/heartjnl-2015-309242

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century* [Report]. Washington, DC: National Academy Press.

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health* [Report]. Washington, DC: National Academies Press.

Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine, 360*(14), 1418–1428. doi:10.1056/NEJMsa0803563

Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education, 52*(1), 18–29. doi:10.1080/10437797.2016.1112629

Levit, L. A., Balogh, E. P., Nass, S. J., & Ganz, P. A. (2013). *Delivering high-quality cancer care: Charting a new course for a system in crisis.* Washington, DC: National Academies Press.

Linton, K. F. (2013). Developing a social enterprise as a social worker. *Administration in Social Work, 37*(5), 458–470. doi:10.1080/03643107.2013.828000

Markossian, T. W., Darnell, J. S., & Calhoun, E. A. (2012). Follow-up and timeliness after an abnormal cancer screening among underserved, urban women in a patient navigation

program. *Cancer Epidemiology, Biomarkers & Prevention, 21*(10), 1691–1700. doi:10.1158/1055-9965.EPI-12-0535

Marrazzo, J. M., Del Rio, C., Holtgrave, D. R., Cohen, M. S., Kalichman, S. C., Mayer, K. H., … Benson, C. A. (2014). HIV prevention in clinical care settings: 2014 recommendations of the International Antiviral Society–USA Panel. *JAMA, 312*(4), 390–409. doi:10.1001/jama.2014.7999

Nandan, M., London, M., & Bent-Goodley, T. (2015). Social workers as social change agents: Social innovation, social intrapreneurship, and social entrepreneurship. *Human Service Organizations: Management, Leadership & Governance, 39*(1), 38–56. doi:10.1080/23303131.2014.955236

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

National Association of Social Workers. (2016). *NASW standards for social work practice in health care settings*. Washington, DC: Author.

National Research Council & Institute of Medicine. (2013). *US health in international perspective: Shorter lives, poorer health*. Washington, DC: National Academies Press.

Newman, L., Baum, F., Javanparast, S., O'Rourke, K., & Carlon, L. (2015). Addressing social determinants of health inequities through settings: a rapid review. *Health Promotion International, 30*(2), ii126–ii143. doi:10.1093/heapro/dav054

Nimmagadda, J., & Murphy, J. I. (2014). Using simulations to enhance interprofessional competencies for social work and nursing students. *Social Work Education, 33*(4), 539–548. doi:10.1080/02615479.2013.877128

Office of Disease Prevention and Health Promotion. (n.d.). Social determinants of health. Retrieved from HealthyPeople.gov website: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2012).

Peredo, A. M., & McLean, M. (2006). Social entrepreneurship: A critical review of the concept. *Journal of World Business, 41*(1), 56–65. doi:10.1016/j.jwb.2005.10.007

Rockefeller Foundation. (n.d.). Mission-related investing. Retrieved from https://www.rockefellerfoundation.org/our-work/initiatives/mission-related-investing/

Seelos, C., & Mair, J. (2005). Social entrepreneurship: Creating new business models to serve the poor. *Business Horizons, 48*(3), 241–246. doi:10.1016/j.bushor.2004.11.006

Sims, D. (2011). Achieving collaborative competence through interprofessional education. Lessons learned from joint training in learning disability nursing and social work. *Social Work Education, 30*(1), 98–112. doi:10.1080/02615471003748056

Spencer, M. S., Hawkins, J., Espitia, N. R., Sinco, B., Jennings, T., Lewis, C., … Kieffer, E. (2013). Influence of a community health worker intervention on mental health outcomes

among low-income Latino and African American adults with Type 2 diabetes. *Race and Social Problems, 5*(2), 137–146. doi:10.1007/s12552-013-9098-6

Tang, T. S., Funnell, M., Sinco, B., Piatt, G., Palmisano, G., Spencer, M. S., … Heisler, M. (2014). Comparative effectiveness of peer leaders and community health workers in diabetes self-management support: Results of a randomized controlled trial. *Diabetes Care, 37*(6), 1525–1534. doi:10.2337/dc13-2161

Taylor, L. D., Coffey, D. S., & Kashner, T. M. (2016). Interprofessional education of health professionals: Social workers should lead the way. *Health & Social Work, 41*(1), 5–8. doi: 10.1093/hsw/hlv082

Tejeda, S., Darnell, J. S., Cho, Y. I., Stolley, M. R., Markossian, T. W., & Calhoun, E. A. (2013). Patient barriers to follow-up care for breast and cervical cancer abnormalities. *Journal of Women's Health, 22*(6), 507–517. doi:10.1089/jwh.2012.3590

Terry, J., Raithby, M., Cutter, J., & Murphy, F. (2015). A menu for learning: A World Café approach for user involvement and inter-professional learning on mental health. *Social Work Education, 34*(4), 437–458. doi:10.1080/02615479.2015.1031651

Thompson, J., Alvy, G., & Lees, A. (2000). Social entrepreneurship – a new look at the people and the potential. *Management Decision, 38*(5), 328–338. doi:10.1108/00251740010340517

Valtorta, N. K., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B. (2016). Loneliness and social isolation as risk factors for coronary heart disease and stroke: Systematic review and meta-analysis of longitudinal observational studies. *Heart, 102*(13), 1009–1016. doi:10.1136 /heartjnl-2015-308790

Voisin, D. R., Bird, J. D. P., Shiu, C.-S., & Krieger, C. (2013). "It's crazy being a Black, gay youth." Getting information about HIV prevention: A pilot study. *Journal of Adolescence, 36*(1), 111–119. doi:10.1016/j.adolescence.2012.09.009

Walters, K. L., Spencer, M. S., Smukler, M., Allen, H. L., Andrews, C., Browne, T., ... Uehara, E. (2016). *Health equity: Eradicating health inequalities for future generations* (Grand Challenges for Social Work initiative Working Paper No. 19). Retrieved from American Academy of Social Work & Social Welfare website: http://aaswsw.org/wp-content/uploads /2016/01/WP19-with-cover2.pdf

Werner-Lin, A., McCoyd, J. L. M., Doyle, M. H., & Gehlert, S. J. (2016). Leadership, literacy, and translational expertise in genomics: Challenges and opportunities for social work. *Health & Social Work, 41*(3), e52–e59. doi:10.1093/hsw/hlw022

Wheeler, D. P. (2011). Advancing HIV/AIDS domestic agenda: Social work and community health workers unite. *Health & Social Work, 36*(2), 157–158. doi:10.1093/hsw/36.2.157

World Health Organization. (1998). *The world health report 1998 – Life in the 21st century: A vision for all.* Geneva, Switzerland: Author.

World Health Organization. (2010*). Framework for action on interprofessional education and collaborative practice* (Report No. WHO/HRH/HPN/10.3). Geneva, Switzerland: Author.

Xu, J., Murphy, S. L., Kochanek, K. D., & Arias, E. (2016, December). *Mortality in the United States, 2015* (NCHS Data Brief No. 267). Hyattsville, MD: National Center for Health Statistics.

Young, J. L., Werner-Lin, A., Mueller, R., Hoskins, L., Epstein, N., & Greene, M. H. (2017). Longitudinal cancer risk management trajectories of BRCA1/2 mutation-positive reproductive-age women. *Journal of Psychosocial Oncology*, doi:10.1080/07347332.2017.1292574

ABOUT THE AUTHORS

TERI BROWNE,[10] is Associate Professor in the University of South Carolina College of Social Work.

SARAH GEHLERT is Dean of the University of South Carolina School of Social Work and President of the American Academy of Social Work & Social Welfare.

CHRISTINA M. ANDREWS is Assistant Professor in the University of South Carolina College of Social Work.

BRADLEY J. ZEBRACK is Professor in the University of Michigan School of Social Work.

VIRGINIA N. WALTHER is Assistant Professor in the departments of Preventive Medicine, Obstetrics, Gynecology and Reproductive Science, and Pediatrics at Mount Sinai Hospital.

GAIL STEKETEE is Professor in the Boston University School of Social Work and Vice President of the American Academy of Social Work & Social Welfare.

PETER MARAMALDI is Professor in the Simmons College School of Social Work and Adjunct Professor in the T. H. Chan School of Public Health at Harvard University.

BARBARA L. JONES is University Distinguished Teaching Professor in the Steve Hicks School of Social Work and Co-Director of the Institute for Collaborative Health Research and Practice at the University of Texas at Austin.

ROBYN L. GOLDEN is Professor in the Department of Health Systems Management and Director of Health Population Health and Aging at Rush University Medical Center.

BONNIE EWALD, is Project Coordinator with the Health and Aging Department at Rush University Medical Center.

SUSAN R. BERNSTEIN is Assistant Professor in Environmental Medicine & Public Health at Mount Sinai Hospital.

AUDREY L. BEGUN is Professor in the Ohio State University College of Social Work.

HEIDI L. ALLEN is Associate Professor in the Columbia University School of Social Work.

SUSAN GUTH is Board Director with the Society for Social Work Leadership in Health Care.

ABIGAIL ROSS is Assistant Professor in the Fordham University Graduate School of Social Service.

[10] Corresponding author. Email: browne@sc.edu.

MEGAN MOORE is Assistant Professor in the University of Washington School of Social Work.

JOSEPH R. MERIGHI is Associate Professor in the University of Minnesota School of Social Work.

ACKNOWLEDGMENTS

Sandra Audia Little at the University of Maryland School of Social Work designed the cover. Chris Leiker at Washington University's Center for Social Development provided editorial support.

SUGGESTED CITATION

Browne, T., Gehlert, S., Andrews, C. M., Zebrack, B. J., Walther, V. N., Steketee, G., … Merighi, J. R. (2017). *Strengthening health care systems: Better health across America* (Grand Challenges for Social Work initiative Working Paper No. 22). Cleveland, OH: American Academy of Social Work & Social Welfare.

CONTACT

American Academy of Social Work & Social Welfare
Sarah Christa Butts, Executive Director

academy@aaswsw.org