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Toward a Better Understanding of Social Workers on Integrated Care Teams

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BACKGROUND

Social workers' training and knowledge of psychosocial risk factors, behavioral health screening, assessment and intervention, and focus on the adaption of services to be culturally inclusive makes the profession uniquely positioned to assist in the treatment of the "whole person" in integrated care settings.[1,2] Recent literature describes how social work education prepares the workforce to serve as behavioral health specialists, patient navigators, and care managers,[1,3] but there is a limited understanding of what actively practicing social workers are currently doing in integrated care settings. Until now, work exploring social worker roles in integrated settings has been theoretical in nature and limited by sample size or geographical reach. To address these gaps, this study used a convenience sample of Masters of Social Work (MSW) students throughout the US in integrated field placement settings and their MSW field instructors (N=395) to clarify how this workforce, not traditionally captured in workforce research, not traditionally captured in workforce research, contributes to integrated healthcare.

METHODS

An electronic survey was developed using Qualtrics and administered to HRSA-funded Behavioral Health Workforce Education and Training (BHWET) MSW students and their field instructors. The survey focused on understanding the roles, tasks, and interventions of social workers in integrated health care. The survey included 25 social worker tasks selected and defined using SAMSHA-HRSA's core competencies and previous literature.[3,4] Descriptive and bivariate (t-test, chi-square) analyses were conducted. The survey took approximately 35 minutes to complete and was organized thematically to include: *Demographic Information and Educational Background; Job Title and Primary/Secondary Team Role (asked only of Field Instructors); Description of Setting Type and Patient Population; Frequency of Use Integrated Care Tasks and Functions ; Education and Training on Integrated Care Tasks and Functions; Barriers and Facilitators to Practice in Integrated Settings; Description of the Integrated Care Team and Practices;* and *Interprofessional Team Composition.*

CONCLUSIONS AND POLICY IMPLICATIONS

To deploy social workers in their fullest capacity, findings suggest that health systems will need continued support to implement integration elements in both hospital and across coordinated settings, such as collaborations with community-based agencies.

Findings highlight the heterogeneity of social worker roles in different settings and suggest that many social workers' functions may not be directly reimbursable in fee for service payment models. As social work continues employment in integrated settings, systems must prioritize appropriate billing protocols that support social work functions and roles. However, some skills regularly used by social workers in integrated settings (i.e. addressing patient social determinants of health), provide intrinsic value that is hard to measure. This type of indirect value renders the return on investment of the work of social workers in integrated settings difficult to define.

Further evidence is needed to quantify social work's value in integrated healthcare.

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[2] Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social work in health care*, *54*(5), 383-407.
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[4] Horevitz, E., & Manoleas, P. (2013). Professional competencies and training needs of professional social workers in integrated behavioral health in primary care. *Social Work in Health Care*, *52*(8), 752-787.
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KEY FINDINGS

Sample and Settings

Three hundred and ninety-five respondents, representing all ten Health and Human Service regions and over half of all BHWET-funded schools, participated in the survey. Approximately two-thirds of respondents were MSW students (64%) and one-third were field instructors. Participants were overwhelmingly female (89%) and students and field instructors averaged 29 (SD=7.7) and 44 (SD=11.8) years, respectively. Respondents worked mostly in outpatient care (57%), inpatient care (16%), or across both settings (12%). The majority worked within hospital systems (58%), including academic, private, or other hospital types; and 17% identified working in rural locations.

Tasks Used in Integrated Practice

Tasks and interventions performed by participants in their integrated settings varied widely. Field instructors used a wider range of skills (15.8 vs 13.9; *p<.01*) and performed most functions more often than did students although all respondents performed an average of 15 out of 25 tasks at least weekly. The most commonly used skills were: team-based care; motivational interviewing; psychoeducation; using the social determinants of health; and adapting services to be culturally inclusive. The least used skills were medication management; SBIRT (screening, brief intervention, and referral to treatment); warm hand-offs; functional assessment of daily living skills; and behavioral activation (Table 1).

Table 1. Participant-Identified Five Most and Five Least Used Skills in Weekly Practice

Task	*MSW Students*		*Field Instructors*		*All Respondents*	
	Total 245	n (100%)	*Total* 128	n (100%)	*Total* 373	n (100%)
Most Used Tasks						
Team Based Care**	245	195 (80%)	128	116 (91%)	373	311 (83%)
Motivational Interviewing**	226	174 (77%)	118	107 (91%)	344	281 (82%)
Psychoeducation	228	187 (82%)	117	93 (79%)	346	280 (81%)
Use Social Determinants of Health to Inform Practice	224	181 (81%)	115	90 (78%)	339	271 (80%)
Adapt Services to Be Culturally Inclusive	225	174 (77%)	113	95 (84%)	338	269 (80%)
Least Used Tasks						
Behavioral Activation	227	117 (52%)	114	62 (54%)	341	179 (52%)
Functional Assessment of Daily Living	241	97 (40%)	126	57 (45%)	367	154 (42%)
Warm Hand-Off***	226	67 (30%)	119	62 (52%)	345	129 (37%)
Medication Management**	227	63 (28%)	118	53 (45%)	345	116 (34%)
SBIRT	223	34 (15%)	114	25 (22%)	337	59 (18%)

Note: Not all respondents answered every question due to skip patterns, survey fatigue and/or other reasons. Chi-square analyses were used to compare frequency of skill use between student and field instructor respondents.
** p<.05; **p<.01; ***p<.001*

Education of Tasks Used by Social Workers in Integrated Settings

Respondents had knowledge of or education related to most core competencies of integrated practice. However, many indicated they had not learned about SBIRT (34%); behavioral activation (25%); problem-solving therapy (19%); huddles (18%); or warm hand-offs (18%). Skills most widely learned in some capacity were linking patients to services and (100%); psychosocial assessment (99%); motivational interviewing (99%); standardized assessment (99%), and team-based care (98%).Students most often reported learning skills in their MSW programs whereas field instructors learned them on the job (*p<0.05*).

Elements of Team Integration

Based on the levels of integrated healthcare established by SAMHSA-HRSA,[5] respondents described to what extent their practices apply the following six characteristics of integration: *team co-location, communication, EHR use, collaboration and team culture, and team composition.*

Most were co-located with the rest of the integrated care team (62%). About 80% talked with the team in person at least weekly, with more than 42% doing so daily. Respondents also indicated regular communication with the interprofessional team via e-mail and phone (63% used emails and 44% used phone calls at least weekly). Frequency of communication significantly varied by setting type and co-location status. Most respondents (60%) felt their team collaborated *most or all of the time* on patient cases and treatment plans. Participants who were co-located or worked in inpatient settings were more likely to communicate with team members in person ($p<0.001$). Over 53% reported that team members *always* have access to the same electronic health record (EHR), but 15% indicated team members *never* use the same EHR. Participants who worked in co-located settings, within hospital systems, and in inpatient and outpatient settings (compared to school or "other") were significantly more likely to work on teams that all used the same EHR. More than 46% of participants reported the team had a *basic* understanding of other members' roles.

Team Compositions

Participants worked on interdisciplinary teams that included a variety of professionals (See table 2). Team composition was significantly influenced by setting type and co-location of team members. Social workers working in co-located settings were significantly more likely to work with NPs, RNs, PAs, nutritionists, and pharmacists ($p<0.05$). Social workers in non-co-located settings were significantly more likely to work with community health workers ($p<0.05$). Participants working in co-located settings and hospital systems worked with more types of professionals overall ($p<0.05$) (Table 2).

Table 2. Types of Professionals Most Likely to Work on Teams with Respondents

Professional	n	%	Professional	n	%
Another Social Worker on team	289	91	Nutritionist	88	28
Registered Nurse (RN)	197	62	Occupational Therapist	70	22
Psychiatrist	193	61	Community Health Worker	67	21
Nurse Practitioner (NP)	192	60	Physical Therapist	60	19
Psychologist	153	48	Health Educator	52	16
Primary Care Provider	143	45	Other Professional	42	13
Behavioral Health Specialist (other)	125	39	Dentistry Professional	37	12
Medical Assistant	108	34	Public Health Worker	36	11
Pharmacist	99	31	Other Type Physician	26	8
Physician Assistant (PA)	88	28			

CONCLUSIONS

Social work students and field instructors in this study identified performing a mixture of roles, tasks, and interventions in a variety of healthcare settings with diverse patient populations who have an array of health needs. In short, findings suggest that social workers are a flexible workforce with a skill mix that can be adapted to patient needs in many healthcare settings. Flexibility in the workforce can help optimize care when labor shortages or maldistribution of providers exists.[8] A flexible workforce prioritizes the skill mix to meet patient needs, regardless of professional disciplines on the team.[8] Because social workers have a diverse set of skills and have the ability to adapt interventions to the needs of the patient and team, social workers can fill important roles in changing models of healthcare. However, future work is needed to understand how the entire team works together when a social worker is involved.

In this study, social workers performed activities that supported team-functions such as team-based care, facilitation of team communication, and the regular provision of informal consultation to medical providers. They also assessed patients using standardized measures, and utilized evidence-based interventions (i.e. motivational interviewing). Social workers acted as care managers and contributed to care coordination through use of EHRs. As is central to the social work profession, respondents performed functions in ways that were culturally inclusive and addressed patient social determinants of health. Many of these functions are not directly reimbursable. Further, it is unknown which tasks and interventions social workers bill for in the clinic or agency. As social workers continue to conduct interventions in integrated settings, systems must prioritize employing appropriate payment structures and billing codes (i.e. CMS CPT Behavioral Health Care Management codes) that facilitate social work roles. Some skills regularly used by social workers in integrated settings provide intrinsic value that is hard to measure. This type of indirect value renders the return on investment of the work of social workers in integrated settings difficult to define. Further evidence is needed to better quantify social work's value in integrated healthcare.

The flexibility and variability of roles filled by social workers on integrated care teams is a strength of the profession but may also contribute to role confusion by other professionals who do not understand the full scope of social work practice.[6,7] Many studies have identified success of integration to be dependent on team understanding of roles and functions of each member. This finding highlights the importance of interprofessional education to acculturate future providers to the functions and skills of social work within integrated settings. If providers do not understand the social worker's role on the team, they may not be aware of social work's full scope of practice, which limits the tasks social workers are likely to do. Current providers may benefit from continued education efforts related to interprofessional team-based care to enhance team collaboration and ultimately improve patient care.

This study supports that integration of services is on a continuum (from not integrated to fully integrated) and few respondents reported all elements of integration (e.g., colocation, shared EHR, frequent team communication) occurred in their respective clinic or agency. For example, community-based agencies, which not unexpectedly, were least likely to have shared EHR and exhibited less team communication than hospital settings. Measures aimed at increasing integration should target the unique needs of community-based settings and focus on strengthening partnerships between health and behavioral health providers both within the health system and across the community. Efforts should also promote administrative structures that facilitate team communication, shared use of EHRs, and billing structures that will support social worker and team integration.

Overwhelmingly, respondents in this study had knowledge of the core competencies of integrated care. Findings suggest the importance of programs to train and deploy social workers in integrated settings, such as the BHWET federal funding mechanism, as MSW students appear to be learning the necessary skills needed to work in integrated care. However, social workers currently in practice still require retooling and training. The majority of field instructors indicated learning tasks and skills "on the job". This education gap provides an opportunity for MSW educators to develop continuing education curriculums to support and re-tool the current social work workforce.

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