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Toward a Better Understanding of Social Workers on Integrated Care Teams

August 2017

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KEY FINDINGS

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. The research literature describes how social work education prepares the workforce to serve as behavioral health specialists, patient navigators, and care managers but there is limited understanding as to what roles actively practicing social workers are performing in integrated settings. Until now, work exploring social worker roles in integrated settings has been theoretical in nature and limited by sample size or geographical reach.

This study developed and administered a survey to a convenience sample of Masters of Social Work (MSW) students in integrated field placement settings and their field instructors across the U.S. (n=395) to clarify how the workforce is utilized in integrated healthcare. Overall, social work respondents identified knowledge and use of core competencies of integrated practice. Yet, the mixture of interventions used significantly varied by team co-location and type of setting, highlighting the heterogeneity of social worker roles in different settings. Findings suggest that many of the functions respondents were most likely to use in daily practice may not be directly reimbursable in fee for service payment models. Workforce preparation and policy changes at the administrative and system levels require billing and reimbursement mechanisms to further support social work functions and roles in integrated behavioral health settings.

CONTENTS:

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

- 1 -

BACKGROUND

Social workers are increasingly deployed in expanded roles in newly developed models of health care, particularly on integrated care teams.[1] 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.[2] Social work's attention to systems barriers and multidisciplinary training is recognized as having a key role in the successful implementation of team-based models of care.[2,3] The proportion of social workers in health care settings is expected to grow by 20% over the next five years[4] and the federal government continues to support and invest in the training of social workers in integrated behavioral health settings. Most recently, in 2014, the Health Resources and Services Administration (HRSA) granted over $26 million dollars to 62 social work programs to train and expand the behavioral health workforce in integrated primary care settings.[5,6]

Scholars have identified the new and potential roles social workers will fill on integrated care teams and have emphasized the added value they can bring to emerging models of care. Recent literature clearly describes how social work education prepares the workforce to serve as behavioral health specialists, patient navigators, and care managers,[2,6] but there is a limited understanding of what actively practicing social workers are currently doing in integrated care settings. Until now, work that has explored social worker roles in integrated care settings has been either theoretical in nature or limited by sample size or narrow geographical reach.[7,8,9] To address these gaps, this study used a convenience sample of 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, is contributing to integrated healthcare.

METHODS

In 2017, an electronic Qualtrics survey was developed and administered to HRSA-funded Behavioral Health Workforce Education and Training (BHWET) program master of social work (MSW) students and their field instructors. The survey focused on understanding the roles, tasks, and interventions of social workers in integrated health care. It also included factors such as setting type, level of integration, patient population, where tasks used in practice were learned, barriers and facilitators to practice, and compositions of interprofessional teams. 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
- Interprofessional Team Composition

Survey Development. The survey was developed using current literature, practitioner expertise, cognitive interviewing, and feedback from pilot data. The survey was first piloted at one school of social work (n=42) with 21 BHWET-funded MSW students and their 21 field instructors, and was refined based on results and feedback.[10] Next, cognitive interviewing was completed with four MSW students who were practicing in integrated care settings to better understand how respondents interpreted each survey item. The instrument was then reviewed by actively practicing social workers and nurses working in integrated settings.

The twenty-five tasks included in the survey were selected and defined using SAMSHA-HRSA's core competencies[11] and Horevitz and Manoleas' study[12] of key competency areas for social work practice in integrated primary care. (See Appendix A for a comprehensive list of tasks and definitions). Using a 5-point Likert scale (never, rarely, once a week, a few times a week, daily), participants were asked how frequently in a typical week they performed each of the 25 tasks. Further, respondents were asked to approximate the percentage of patients with whom they used the task and where the task was learned. Survey items about the level of practice integration were drawn from SAMHSA-HRSA Center for Integrated Health Solutions Standard Framework for Levels of Integrated Healthcare[13] and the Integrated Practice Assessment Tool (IPAT) version 2.0.[14]

Participant Recruitment. Given the specialized focus on integrated health, a convenience sample of BHWET funded programs was used to recruit participants. Students and field instructors were contacted through BHWET project directors who forwarded a pre-scripted e-mail to recruit respondents. If project directors were unavailable, the research team contacted administrators of the identified BHWET schools. Of the 62 funded BHWET schools, more than 50% of the directors forwarded the recruitment letter. Due to this recruitment strategy, the exact number of surveys sent out is unknown. Beyond participant e-mail, which was not linked to survey data, no identifying

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

3

information was collected. The email addresses were used only to contact the four respondents who were randomly chosen to receive the $100 gift card participation incentive. The University of Michigan and the University of North Carolina at Chapel Hill Institutional Review Boards reviewed and approved the study.

Analysis. Analysis was completed using Stata 15 (Stata, 2017). Descriptive and bivariate (t-test, chi-square) analyses were conducted to test associations between functions and skills of students and field instructors and covariates. Qualitative analysis was used to code open ended questions.

RESULTS

Demographic Summary of Participants

Three hundred and ninety-five respondents, from all ten Health and Human Service regions participated in the survey. Approximately two-thirds of the individual 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. Sample demographics were consistent with the national population of MSW students in which 80% of MSW students are female and between 25 and 34 years old.[15] However, only 54% of MSW students nationally identified as white compared to 79% in our sample (Table 1).

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

4

Table 1. Sample Description

	n	MSW Student n (%) or Mean (SD)	n	Field Instructor n (%) or Mean (SD)	n	Total Sample n (%) or Mean (SD)
Total	251		142		395	
Gender	246		137		383	
Male		24 (9.76%)		15 (11%)		39 (10 %)
Female		219 (89%)		122 (89%)		341 (89%)
Other Reported Gender		3 (1%)		0		3 (0.8%)
Age***	248	29 (8)	141	44 (12)	389	34 (12%)
Highest Degree	251		142		393	
Undergraduate		217 (86 %)		5 (4%)		222 (56%)
Masters		34 (14%)		129 (91%)		163 (41%)
Doctoral Degree		0		8 (6%)		8 (2%)
Race	249		142		391	
Black (non-Hispanic)		183 (74%)		113 (80%)		296 (76%)
White (non-Hispanic)		26 (10%)		13 (9%)		39 (10%)
Hispanic		15 (6%)		4 (3%)		19 (5%)
Other/Multi-racial		25 (10%)		12 (8%)		37 (9%)

*****p<.001*

Education Background

In this study, most field instructors (77%) were licensed clinical social workers (LSCW) with an additional 8% working towards licensure as provisional LCSWs. Few field instructors (7%) held more than one master's degree and 6% held a doctorate. Most field instructors graduated with their MSWs in 2009 (Mean: 2001; SD: 10.3; Range: 1971-2015). One-third of student participants reported receiving a Bachelor's of Social Work degree (36%).

Field Instructor Job Description

On average field instructors worked at their agency for 7 years (SD=7.04, range = 1 to 35). Respondents were asked to report their position title and responses were qualitatively examined. Position titles varied and were summarized to include the following major groups: social worker, behavioral health specialist, and care manager. Qualitative analysis revealed over 46% of field instructors fulfilled a leadership or administrative role along with providing direct care as evidenced by job titles such as director or supervisor. Field instructors were also asked to report their primary and secondary roles in their current position based on the following response options: *care manager*

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

5

(case manager); *care coordinator*; *discharge planner; behavioral health provider; community services link*; and *other*. The majority indicated their primary role was behavioral health provider (49%) followed by "other" (29%). Participants were able to qualitatively respond to "other" and those responses were later coded. Seventy five percent indicated an administrative or leadership position (22% of the sample). Few participants indicated primarily working as care managers (13%), care coordinators (3%), discharge planners (3%), or community service linker (3%). Approximately 35% did not have a secondary role. Of those who did, 15% indicated behavioral health provider, 13% indicated community service linker, followed by care coordinator (11%).

Setting Type

Most respondents reported working in outpatient settings (57%) followed by inpatient settings (16%), whereas 12% worked across both outpatient and inpatient. Respondents also indicated working in other types of settings that included school-based (13%); residential-type (2%); and justice-involved settings (2%). Separately from setting, participants were asked what system they worked within. Most participants (58%) worked within a hospital system (Academic, private, or "other" type hospital) and 42% worked in community-based agencies. Less than one-fifth of respondents (17%) identified working in a rural location.

Patient Population

Survey respondents indicated working with racially diverse groups of patients including those of black, white, Asian, Hispanic, American Indian, and other minority backgrounds. A quarter of the sample reported that *most or all* of the population they work with was white, 19% reported *most or all* patients were black, and 12% reported *most or all* were Hispanic. More than 50% of the sample indicated working in some capacity with patients of American Indian descent. Respondents indicated they were most likely to work with patients ages 18-65 (48% said this age group made up *most or all* of their patients), followed by patients under age 18 (42% said *most or all were under 18*), and less than 9% reported *most or all* of their patients were 65 years or older.

Most often respondents reported that patients were most likely to be insured (82%), but 73% indicated some portion of their caseload was uninsured. Two-thirds (66%) of respondents indicated Medicaid was the most frequently used insurance type. Respondents identified serving a variety of patients with health and behavioral health conditions. Participants reported most frequently that *most or all* of patients experienced psychosocial stressors (73%), mental illness (64%), depression

(48%), victimization (52%), and co-occurring health conditions (37%). Some participants worked with *most or all* patients with substance use disorders (21%), chronic medical conditions (19%), and acute medical conditions (13%). Participants infrequently worked *most or all* with individuals with physical disabilities (5%), neurological conditions (4%), and developmental disabilities (3%).

Tasks Used in Integrated Practice

Tasks and interventions performed by participants in their integrated settings varied widely. The five Likert scale response options were recoded into a dichotomous variable where the task was used *at least weekly* (1) or *rarely/never* (0). On average, respondents used 15 (SD=5.9) skills at least weekly. Most commonly used skills, tasks, or interventions (used at least weekly) were team-based care (83%); motivational interviewing (82%); psychoeducation (81%); understanding social determinants of health (80%); and adapting services to be culturally inclusive (80%). The least commonly used skills, functions, and tasks (used less than one time a week) were screening, brief intervention, and referral to treatment (SBIRT) (18%); medication management (34%); warm hand-offs (37%); functional assessment of daily living skills (42%); and behavioral activation (52%) (Table 2).

The number of tasks performed varied significantly by respondent type (field instructor vs. MSW student), team co-location, and setting type. Field instructors used a wider range of skills (15.8 vs 13.9; *p<.01*) and performed most functions more often than did students. The following 13 tasks were significantly used more often by field instructors: team-based care (91% vs 80%); psychosocial assessment (86% vs 73%); care management (75% vs 65%); patient navigation (65% vs 51%); contribution to the care plan (81% vs 68%); link with community resources (85% vs 73%); informal consultation (69% vs 56%); treatment team (81% vs 62%); facilitate communication (91% vs 70%); warm hand-offs (52% vs 30%); medication management (45% vs 28%); motivational interviewing (91% vs 76%); and problem-solving therapy (68% vs 56%).

Respondents working in co-located settings compared to those working in non-co-located settings reported using more skills weekly (p<.05). Similarly, respondents based in hospital systems (compared to community-based agencies) used more skills (compare means here; p<.05).

Table 2. Identified Skills Used Weekly in Practice by Respondent Type

Task	MSW Students		Field Instructors		All Respondents	
	Total	n (%)	Total	n (%)	Total	n (%)
Total	245	100%	128	100%	373	100%
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%)
Facilitate Communication on Team***	229	161 (70%)	121	110 (91%)	350	271 (77%)
Psychosocial Assessments**	241	176 (73%)	125	107 (86%)	366	283 (77%)
Link with Community Resources*	229	167 (73%)	123	104 (85%)	352	271 (77%)
Use Electronic Health Records	225	159 (71%)	115	90 (79%)	339	249 (74%)
Contribute to the Care Plan*	232	158 (68%)	121	98 (81%)	353	256 (73%)
Care Management*	236	153 (65%)	124	93 (75%)	360	246 (68%)
Treatment Team***	227	140 (62%)	120	97 (81%)	347	237 (68%)
Patient Education	228	149 (65%)	117	86 (74%)	345	235 (68%)
Relaxation Training	226	135 (60%)	114	72 (63%)	340	207 (61%)
Informal Provider Consultation*	229	127 (55%)	121	84 (69%)	350	211 (60%)
Problem Solving Therapy*	224	125 (56%)	116	80 (69%)	340	205 (60%)
Standardized Assessment	245	134 (55%)	128	83 (65%)	373	217 (58%)
Patient Navigation*	231	118 (51%)	123	80 (65%)	354	198 (56%)
Cognitive Behavioral Therapy	225	125 (56%)	116	64 (55%)	341	189 (55%)
Huddle	228	121 (53%)	120	67 (56%)	348	188 (54%)
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.
*p<0.05; **p<0.01; ***p<0.001

Respondents were asked to identify which of the following tasks were used at least weekly. Results are presented by student, field instructor, and for the whole sample. Not every respondent answered each item, as such the n of those who chose to answer is presented. Chi-square analyses were used to identify significant differences in skill use between social work students and field instructors.

Education of Tasks Used by Social Workers in Integrated Settings

Overall, respondents had knowledge of or education related to most surveyed tasks. 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%). There was a significant difference between where MSW students and field instructors learned tasks. Students most often reported learning skills and functions in their MSW programs whereas field instructors learned their skills on the job (*p<.05*). Few participants (<3%) indicated learning skills in other settings such as continuing education trainings or work-sponsored trainings.

Encounter Setting of Social Work Intervention

Respondents were asked about the amount of time they spent talking with patients face to face in the office, at their homes, and over the phone. While in-home visits/treatment were rare (71% never went to patient homes), 13% indicated that they primarily see patients in their homes. The majority of respondents indicated they talk with patients and families in the office *most or all of the time* (69%). The most frequent response to talking with patients over the phone was *some of the time* (47%). If respondents indicated seeing patients within the office at least *some of the time*, they were asked how many patients they saw a day. On average, respondents saw six patients (SD: 5.7; Range: 0-40) per day.

Barriers and Facilitators to Respondents Job or Field Placement

A 5-point Likert scale (*Never, Occasionally, Often, Very Often, Always*) was used to measure impact of barriers and facilitators to respondent roles and functions in their positions. For the remainder of this section all percentages indicate an answer of very often or always. Most participants felt that the organizational climate was supportive of their roles in general (57%), their roles on the interprofessional team (56%), and that they were a valued member of the team (60%). About 12% reported that differences in professional culture or language (i.e., jargon or the manner in which people speak) between medical providers and social workers negatively impacts social worker effectiveness. Almost 12% indicated that the medical practice in which they work was insufficiently informed by patient social determinants of health and 18% thought that medical providers tend to

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

9

lack training in behavioral health. Other reported barriers to effectiveness included team interactions dictated by the hierarchal salary system (15%); and that caseloads were too high (24%).

Elements of Team Integration

Based on the levels of integrated healthcare established by SAMHSA-HRSA,[13] respondents described to what extent their practices apply the following six characteristics of integration: team co-location, communication, EHR use, collaboration & team culture, and team composition.

Team Co-Location

Most often social work respondents were co-located with the rest of the integrated care team (62%); whereas almost 15% worked in the same building as other providers but in separate units; and over 23% worked in separate practices and separate buildings from other providers. Respondents who worked in hospital systems were significantly more likely to be co-located than community based agencies (*p<.001*). Similarly, respondents who worked in inpatient, outpatient, and both settings also were more likely to be co-located compared to participants in school or "other" reported settings (p<.05).

Communication

About 80% of respondents talked with the integrated care team in person at least weekly, with more than 42% speaking with the team in person 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). Respondents reported meeting as a whole team (68%) and with portions of the team (86%) frequently. Further, team meetings were often both planned (73%) and unplanned (68%). Frequency and communication type significantly differed by respondent type, setting type, and co-location status. Participants who were co-located were more likely to communicate with team members in person (*p<.001*) *daily or several times a week*, as well as participants who worked in inpatient setting (*p<.001*). Field instructor respondents, respondents working in hospital systems, and respondents working in inpatient settings were significantly more likely to use the phone to communicate to the integrated care team *daily or several times a week* (*p<.05*).

Electronic Health Record Use

Respondents were asked if all members of the integrated care team had access to the same electronic health record (EHR). About 53% responded affirmatively, although 15% said team

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

10

members *never* used 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 from the same EHR. Interestingly, even within hospital systems respondents indicated not all team members have access to the same EHR. There was no difference in EHR use by respondent type or rurality.
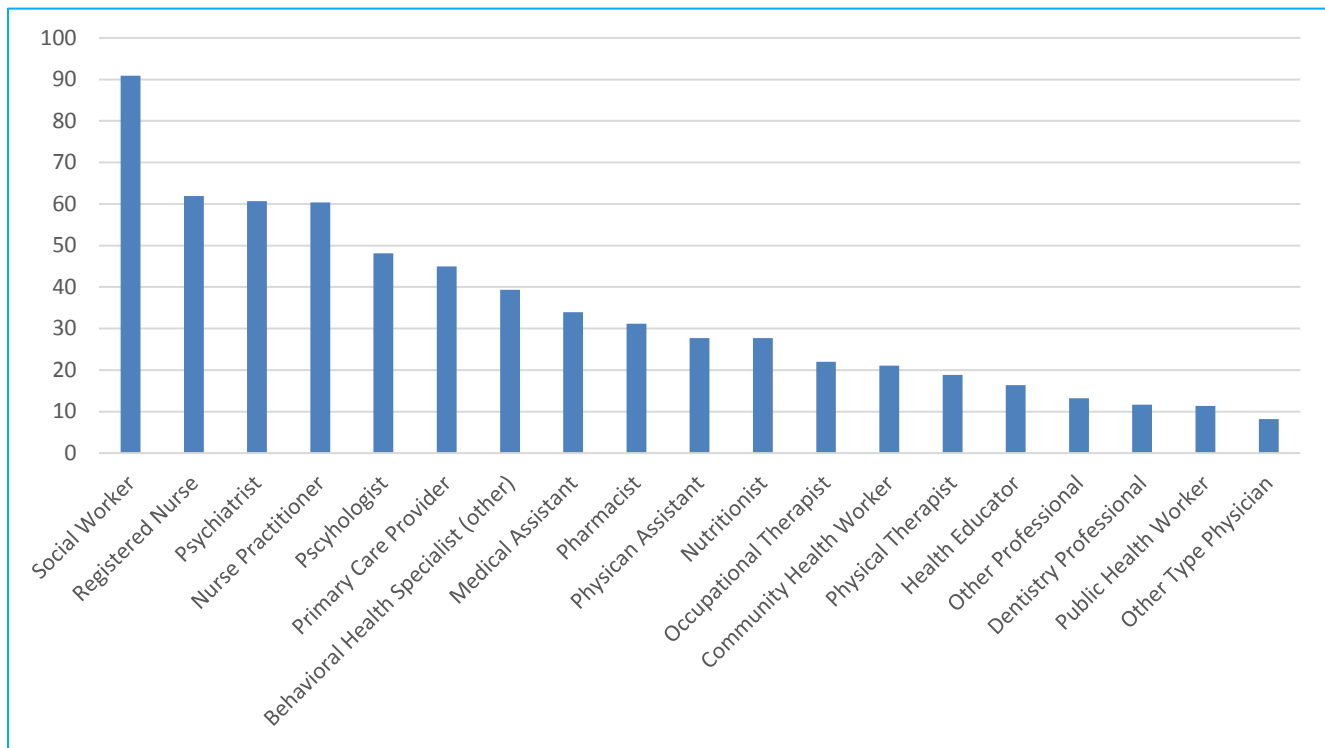
Collaboration and Team Culture

Over 60% of participants reported that all members of the integrated team collaborate on patients' plan of care *most or all* of the time while under 4% said they never do. Level of collaboration was significantly associated with setting and co-location type. Participants who worked within a hospital system, in an inpatient or outpatient setting, or on a co-located team were significantly more likely to report full team collaboration *most or all* of the time (*p<.05*) compared to participants who worked in a community-based agency setting and school or "other" setting. Participants were also asked to what extent team members understand each other's roles on the integrated team; 46% indicated only a basic understanding of other team members' roles and functions and 38% said they had an in-depth understanding.

Team Composition

Participants worked on interdisciplinary teams that included a variety of health professionals. On average respondents selected about 7 (SD=3.6; Range 1-18) of the available 18 types of health professionals listed. Beyond working on a team with other social workers (91%), respondents most often worked with registered nurses (RN) (62%), and nurse practitioners (NP) (60%). Most worked with physicians, with 45% working with primary care doctors, 8% working with specialty physicians, and 61% working with psychiatrists (see Table 3 for team composition). Participants were asked to identify other types of team members not provided as options on the survey. Over 13% offered alternative professionals which included Child Protective Services workers, speech pathologists, teachers or school administrators, recreation and vocational specialists, and peer specialists (Figure 1).

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

11

Figure 1. Types of Professionals Most Likely to Work on Teams with Respondents

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<.05*). Social workers in non-co-located settings were significantly more likely to work with community health workers (*p<.05*). Participants working in co-located settings and hospital systems worked with more types of professionals (*p<.05*).

DISCUSSION

The study identified that social work students and field instructors frequently utilize core competencies of integrated practice as demonstrated by responses to 25 tasks and interventions. Respondents indicated they perform activities that support team-functions, such as providing team-based care, facilitating communication across providers, and doing informal consultation for other team members, conduct standardized assessments, and use evidence-based behavioral health interventions (i.e. motivational interviewing, psychoeducation, and cognitive behavioral therapy). Respondents acted as care managers, patient navigators, and they contributed to the care plan and coordination of care through use of electronic health records. Respondents reported adapting interventions to be culturally competent as well as addressing patient social determinants of health which reflects training central to social work training.

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

12

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. For example, respondents regularly used an average of 15 distinct tasks and interventions which varied by setting type and co-location status. A diverse and flexible skill mix allows the social work workforce to adapt to specific needs of patients or gaps in training on their teams. An MSW will likely have the training to provide both behavioral health care, as well as care management activities, thus maximizing the functionality of the whole team.

The flexibility of social work practice observed in this study is mirrored by commentaries and theoretical work in the field, which highlight the natural fit of social workers in integrated models of healthcare.[9] Flexibility in the workforce can help optimize care when labor shortages or maldistribution of providers exists.[16] A flexible workforce has the right skill mix to meet patient needs, regardless of professional disciplines on the team.[16] Social workers have the diverse set of skills required to provide this type of flexibility and adapt their contribution to each team, and patient needs, as necessary.

The flexibility and range of roles, skills, and interventions filled by social workers on integrated care teams is a strength of the profession but may also contribute to role confusion by other health professionals who do not understand the full scope of practice of the profession.[17] For example, in this study only 38% reported the team had an in-depth understanding of each other's roles and functions. Similarly, social worker scopes of practice, licensure, payment, and job descriptions vary by state and may exacerbate the role confusion issues both within the interprofessional team, but also across the health care system. These issues may limit social workers ability to practice in dynamic ways on teams and within health systems that have a narrow understanding of social workers roles and functions.

Another complicating factor is that while some of the most frequently used skills (i.e., Motivational Interviewing, psychoeducation) are reimbursable interventions that utilize social workers clinical training, others (such as addressing social determinants of health and adapting services to be culturally appropriate) have intrinsic value that is more difficult to measure and may not be directly reimbursable. These skills are likely to add value by decreasing readmission rates or improving

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

13

patient medication compliance, the inability to bill for them directly renders the return on social work investment harder to calculate.[10] It is unknown if health systems are billing for these discrete interventions within integrated health settings or if social workers' practice is billed through cost-savings models. Further research to clarify these reimbursement issues related to social work practice is warranted.

Study results highlight how integrated services in which social workers participate vary in health settings across the United States. Respondents indicated considerable variation in characteristics of service integration, such as co-location, team communication, EHR use, collaboration between team members, and team culture. This variation was seen across both hospital-based health systems and within community-based agencies. For example, even within hospital-based health systems not all members of the treatment team had access to the same EHR. Without shared EHR, team communication and coordination may be limited. However, social work respondents working in community-based agencies identified significantly less components of integration compared to respondents working in hospital-based health systems. Beyond being less likely to be co-located with other providers on the interprofessional team, social work respondents in community-based agencies were less likely to share EHR records across the team and communicated with the team less frequently. Variation of integration components also complicates providing a clear picture of practice or social workers on integrated teams, as practice would significantly differ based on integration elements. However, this picture appears to reflect an accurate perspective of the field as health settings move towards more integration.

Limitations

Study findings should be considered in light of limitations. Although the study gathered data from a national sample, it is not nationally representative of all social workers in integrated care settings and generalizability may be limited. Further, the sample was drawn from schools receiving funding through HRSA's BHWET Program, which may have different training standards and protocols than non-BHWET funded schools. Readers should be mindful that this study included both student respondents and field instructors. It is likely the practice between the two types of respondents varies based on administrative requirements of the University or hospital system. Additionally, because integrated care occurs on a spectrum, the level of integration was not verified beyond self-reported descriptions and may be biased. Finally, respondents were surveyed on a carefully compiled list of tasks but actual activities and scopes of practice may extend beyond what was asked.

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

14

POLICY CONSIDERATIONS

Expanding Education and Workforce Development

Social workers appear to be a flexible workforce with a skill mix that can be adapted to patient and administrative needs in many healthcare settings. Findings suggest social work field instructors and MSW students learn these integrated care skills on the job and within MSW programs. As the majority of skills the MSWs indicated familiarity with were learned in MSW curriculum, this study supports of the importance of social work education that infuses behavioral health training that social workers can deploy in integrated settings. Continued and expanded efforts to sustain the BHWET training grants can help prepare the future social work behavioral health workforce. An evaluation of the 2014 and recently awarded 2017 BHWET programs is suggested.

Re-tooling Existing Workforce

Social work field instructors indicated learning the majority of skills for integrated care on the job. Although workforce development programs such as BHWET may help incentivize MSW students to work in integrated settings, it is equally important to provide trainings and opportunities for current social work practitioners to remain adaptable to a changing healthcare context. MSW programs can fill this need develop continued education and training programs and instructional materials for the existing social workforce to ensure re-tooling and skill building for integrated care core competencies.

Continuing Need for Interprofessional Education (IPE)

Social workers are working on interdisciplinary teams with a multitude of providers from a variety of disciplines. Past research identifies that the success of health care teams is dependent on the understanding of roles and functions of each member.[18,19] As social worker roles are flexible and vary significantly by setting, other providers may have difficulty understanding their role and function on the team. This finding highlights the importance of ongoing IPE to better acculturate future providers to the functions and skills of social work within integrated settings. While IPE within graduate programs is growing, health systems may benefit from implementation of interprofessional training for the existing workforce.

Improving Payment and Reimbursement Mechanisms

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

15

As social workers continue to provide interventions in integrated settings, systems must prioritize appropriate billing protocols that support social work functions and roles. Many of the regularly used skills identified by survey respondents, such as addressing the social determinants of health, have intrinsic value that is difficult to measure. This issue makes social workers return on investment harder to calculate. The recent release of 2017 CMS CPT Behavioral Health Care management codes provides one way for social work functions to be reimbursed. However, this is dependent on providers and practices understanding how to navigate the administrative components of implementing these new payment structures. Additionally, as health systems in the U.S. move to value-based models of care, researchers will need to better measure the value of social work functions. More research is also needed to uncover billing barriers in different settings and develop plans to address them.

Supporting Integration in Health Systems
This study identified that social workers are often deployed in settings within varying components of integration. To deploy social workers in their fullest capacity, findings suggest health systems will need continued support to implement integration elements in both hospital-health settings and across coordinated settings, like collaborations with community-based agencies. Increasing integrated services requires the implementation of improved administrative structures to better facilitate team communication, shared use of EHRs, and billing structures to account for team-based models of care.

Conclusion
Social workers' training and knowledge of psychosocial risk factors, behavioral health screening, assessment and intervention, and focus on the adaption of services to be more culturally inclusive makes the profession uniquely positioned to assist in the treatment of the "whole person" in integrated care settings. This study highlights the heterogeneity of social worker roles in different health settings. Findings suggest that many of the tasks and interventions respondents were most likely to use in daily practice may not be directly reimbursable in fee for service payment models. Workforce preparation and policy changes at the administrative and system levels require billing and reimbursement mechanisms to further support social work functions and roles in integrated behavioral health settings.

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Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

16

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Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

17

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Toward a Better Understanding of Social Workers on
Integrated Care Teams
August 2017

18

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